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

Evaluation of NRHM: Sample Survey of ANMs, ASHAs, and People's Participation

Contributors: **By:** Nirupam Bajpai, Jeffrey D. Sachs & Ravindra H. Dholakia
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TABLE 6.1 PROVIDES information on the sub-centers (SCs) and ANMs based on our sample survey. It can be seen that on an average there is one ANM per SC and about 76 percent of the ANMs are staying in the same village where the SC is located. While in Rajasthan, the number of villages covered per ANM is in the range of 2 to 4, they are more than double in the case of MP and UP. In Sitapur (UP), there are on average 13 villages covered by ANM. Quality of healthcare at SC therefore obviously suffers. Number of ASHAs per ANM also varies substantially in these states. Number of villages with VHSC dealing with ANM also varies substantially from 2 in Jalore to 8 in Sagar. The average number of rooms in the SCs also varies considerably from only one in Chittorgarh to 6 in Azamgarh. About 74 percent of SCs have their own buildings. In terms of the physical infrastructure, about 26 percent SCs did not have delivery tables, 33 percent SCs did not have medical equipments, 40 percent SCs did not have electricity connection, 33 percent SCs did not have water supply for 24 hours per day, and only 5 percent SCs had a two wheeler. NRHM funds have not succeeded so far to remove this deficiency of physical infrastructure prevailing at SCs.

Table 6.1 ANM/Sub-centerss in Rajasthan, Madhya Pradesh and Uttar Pradesh

Details		Rajasthan		Madhya Pradesh	Uttar Pradesh		Total	%
		Jalore	Chittorgarh	Sagar	Azamgarh	Sitapur		
Total HF visited		4	7	10	11	10	42	100
Number of ANM staying in same village		4	6	7	9	6	32	76
Average number of	villages covered by ANM	2	4	8	7	13	–	–
	ASHAs under ANM	2	3	6	6	6	–	–
	villages with VHSC dealing with ANM	2	4	8	5	7	–	–
	ANMs at the SC	1	1	1	1	1	–	–
Number of sub-centers with own building		3	6	7	6	9	31	74
Average number of rooms in sub-centers		2	1	3	6	2	–	–
Number of sub-centers with	Number of sub-centers with Number of sub-centers with	3	5	6	8	9	31	74
Number of sub-centers with	delivery table							
Number of sub-centers with	medical equipment	4	5	7	11	1	28	67
	electricity connection	2	4	5	10	4	25	60
	24-hour water supply	2	5	7	11	3	28	67
	moped/two wheeler	0	1	0	1	0	2	5
Number of ANMs involved in selection of ASHAs		1	2	1	2	3	9	21
Number of ANMs that feel that ASHA has reduced their load		4	6	5	11	5	31	74
Number of ANMs that feel ASHA is contributing by mobilizing community to avail healthcare services		4	6	9	10	9	38	90
Number of ANMs that feel ASHA	identifying and accompanying complicated delivery cases	2	6	8	11	9	36	86
is contributing by	providing health information to the community	4	6	6	11	7	34	81
	providing new-born baby care	2	5	5	11	6	29	69
Number of ANMs that have received NRHM grant		4	6	9	11	9	39	93
Average amount received under NRHM (Rs per year)		10000	10000	10000	10000	10000	–	–
Number of ANMs with bank account		4	7	7	10	9	37	88
Number of ANM having joint account		4	7	9	11	9	40	95
Number of sub-centers where	repairs and renovation	0	6	8	6	5	25	60
untied funds are used for	purchasing equipment	4	6	6	5	0	21	50
	buying medicines	1	3	2	4	3	13	31
	electricity supply	2	2	4	1	1	10	24
	running water supply	1	3	1	2	1	8	19
Details								
% of fund utilization during	2005–06	–	65	58	–	–		
	2006–07	50	62	91	78	–	–	–
	2007–08	50	95	81	100	100	–	–
Number of ANMs encountering problems in spending funds		3	7	–	5	–	15	36
Number of ANMs that feel the funds are adequate		4	7	6	8	8	33	79
Adequate amount according to ANMs (Rs)		–	–	35000	15000	–	–	–

Details		Rajasthan		Madhya Pradesh	Uttar Pradesh		Total	%
		Jalore	Chittorgarh	Sagar	Azamgarh	Sitapur		
Availability of	ORS	4	7	9	11	8	39	93
	Chloroquine	4	7	9	10	7	37	88
	antibiotics	4	6	8	10	7	35	83
	pain killers	3	7	8	8	7	33	79
	TB drugs kit	4	7	7	5	3	26	62
	disinfectants	3	1	9	6	6	25	60
	disposable delivery kits (DDK)	4	3	1	4	0	12	29
	oral contraceptive pills	4	7	9	10	8	38	90
	condoms	4	7	9	11	7	38	90
Number of ANMs who get the refills	Weekly	0	0	1	1	0	2	5
	Fortnightly	2	0	1	0	0	3	7
	Monthly	2	2	5	1	1	11	26
	Rarely	0	5	0	9	6	20	48
Number of ANMs who conduct deliveries		3	3	6	9	5	26	62
Number of ANMs who conduct deliveries	at Home	3	3	6	5	0	17	40
	at the sub-center	0	0	0	4	5	9	21
Average number of deliveries conducted by ANM		4	1	2	3	18	–	–
Number of ANMs who report the deliveries conducted at home as home deliveries		4	5	4	6	3	22	52
Number of ANMs who report the deliveries conducted at home as deliveries in sub-center		0	0	1	2	5	8	19
Number of ANMs who send complicated delivery cases to	Dai	0	0	0	0	0	0	0
	PHC	2	0	2	4	0	8	19
	CHC	1	7	6	4	9	27	64
	District hospital	1	0	2	3	1	7	17
	Private hospital	0	0	0	0	0	0	0
Average number of dais in the area covered by ANM		4	6	6	3	3	–	–
Number of ANMs reporting that TBAs/dais are given incentives to conduct deliveries		0	0	2	1	6	9	21

Source: Our sample survey of ANMs.

Only 21 percent of ANMs are involved in the selection of ASHA with whom they have to work closely. However, 74 percent ANMs felt that ASHAs had reduced their work load and 90 percent ANMs thought that ASHAs contributed to NRHM by mobilizing the communities to avail public healthcare. Almost 93 percent ANMs received the NRHM un-tied grant of Rs 10,000 per year.

Ninty-five percent ANMs had joint bank accounts with Sarpanch of the panchayat. sixty percent ANMs used the fund for repairs and renovations; 50 percent ANMs for purchasing equipments, 31 percent for buying medicines, 24 percent for electricity supply, and 19 percent for running water supply. In short, the funds were used for overcoming the infrastructural shortcomings wherever they were used. However, utilization of the NRHM fund by the ANM also ran into problems reported by 36 percent ANMs. In Rajasthan and MP utilization was considerably less. This happened largely because of the joint account with Sarpanch, where the NRHM funds were made available. The Sarpanch used to demand his commission for signing the check that would be in the range of 20 percent to 50 percent of the amount. As a result, some ANMs would not spend the money and others may not be able to properly spend the money. However, 79 percent ANMs felt that the funds given under NRHM were adequate, though the physical infrastructure continued to be in the bad shape as found above.

The disposable delivery kits (DDK) are available only to 29 percent ANMs, which is a serious problem in view of NRHM's emphasis on safe deliveries. The ANMs get their drug kits refilled as reported to us not very regularly. Only 5 percent get it weekly; 7 percent fortnightly; 26 percent monthly; and 48 percent rarely. The refill of drug kits still remains a problem and AYUSH medicines are largely missing.

About 62 percent of the ANMs conducted deliveries, out of which 40 percent did it at home and only 21 percent did it at the SC. However, 19 percent ANMs reported the deliveries conducted at home as “institutional deliveries.” No complicated cases of deliveries were referred to either *dais* or private doctor. Most of them (64 percent) were referred to CHC, 19 percent to PHC, and 17 percent to district hospital. The number of dais available in an ANM's area on an average varied from 3 to 6. Only 21 percent ANM reported incentives given to trained birth attendant (TBA) or dai for conducting the deliveries. At the SC level, NRHM has started making some difference particularly by providing some discretionary fund for improving the infrastructure and getting some equipment, but there is still a huge gap in these matters before quality of the healthcare improves significantly. problems encountered in utilization of this fund by ANMs need to be particularly addressed quickly to achieve better progress.

1. Survey Results for ASHA

A trained female ASHA is the key element in NRHM strategy and action plan. She is expected to create awareness among the community to utilize public healthcare when needed. It is she who has been given the very important role at the ground level to act as an activist providing the link between the public health facility and the community. Table 6.2 provides information on different aspects of ASHA's background, selection, training, interface with community, and rewards. It is seen from the table that only 72 percent ASHAs were above 24 years of age as required, 28 percent were younger. Similarly, four percent ASHAs were unmarried and eight percent did not live in the same village where they worked—both of which again go against the criteria laid down for ASHAs.

Table 6.2 ASHAs in Rajasthan, Madhya Pradesh and Uttar Pradesh

Details		Rajasthan		Madhya Pradesh	Uttar Pradesh		Total	%
		Jalore	Chittorgarh	Sagar	Azamgarh	Sitapur		
Total ASHAs visited		5	12	19	19	23	78	100
Number of ASHAs with above 24 years of age		1	6	14	13	22	56	72
Number of ASHAs belonging to	SC/ST/OBC	4	10	12	13	16	55	71
	General	0	2	7	6	7	22	28
Average level of education		7	9	9	9	8	–	–
Number of ASHAs	Unmarried	0	0	2	0	1	3	4
	Married	5	12	16	19	20	72	92
	Widowed	0	0	1	0	2	3	4
Number of ASHAs who work and live in the same village/village panchayat		5	9	19	18	21	72	92
Number of ASHAs who have reported that	FGDs conducted before selection	3	6	13	8	21	51	65
	Shorlisting candidates for selection	1	4	9	16	21	51	65
	Gram Sabha meetings were held during the selection process	3	6	14	17	21	61	78
	Have worked as community based workers earlier	4	6	1	6	8	25	32
Number of ASHAs that have	Received any training after joining	5	12	17	19	23	76	97
	Average number of days of training	10	16	12	19	8	–	–
	Received any training in last one year	2	6	10	14	23	55	71
As per ASHAs the training was useful in	Developing and Improving knowledge and Skills	5	11	16	19	23	74	95
	Solving doubts and troubles	0	11	16	18	23	68	87
	Refilling of supplies	0	4	13	16	22	55	71
	Payments of performance incentives	0	4	13	9	21	47	60
Number of ASHAs who received compensation for attending training		5	11	14	18	14	62	79
Average amount received (Rs)		920	1230	1186	1692	654	–	–
Number of ASHAs who receive regular "On-the-Job" training		5	6	16	15	18	60	77
Number of ASHAs who have received	Drug kit	5	11	16	14	23	69	88
	ORS	5	12	16	13	23	69	88
	Iron tablets	5	12	16	17	22	72	92
	Oral pills	5	12	16	13	17	63	81
	Condoms	5	12	16	17	18	68	87
	Disposable Delivery Kit (DDK)	1	9	2	10	21	43	55
	Medicines	4	11	17	13	16	61	78
Creating awareness of the community on health, hygiene and nutrition		3	12	16	19	21	71	91
Mobilization of community in its access to health services such as	ANC (ante natal care)	5	12	17	18	22	74	95
	PNC (post natal care)	4	12	17	18	21	72	92
	Immunization	5	12	17	18	23	75	96
	Sanitation	3	6	15	19	21	64	82
Counseling women on:	Birth preparedness and safe delivery	5	12	17	18	23	75	96
	Care of new-borns	5	12	17	19	23	76	97
	Breast feeding and complimentary feeding	5	12	17	18	23	75	96
	Immunization of infants	5	12	18	19	23	77	99
	Use of contraceptives/family planning measures	5	12	17	18	22	74	95
Escort/accompany pregnant women or sick children to the nearest health facility		0	12	18	19	22	71	91

Informing the sub-center/PHC/ CHC about:	Births and deaths in the village	5	12	18	19	21	75	96
	Outbreak of health problem/disease	4	7	9	19	19	58	74
	Promoting construction of household toilets	0	4	16	18	20	58	74
Number of ASHAs who escort pregnant women to	Sub-center	–	1	0	1	3	5	6
	PHC/CHC	–	11	19	17	20	67	86
	Private HF	–	0	0	1	0	1	1
Average distance of HF (km)		–	12	14	7	9	–	–
Average number of pregnant women escorted by ASHAs during the past one year		0	9	14	15	12	–	–
Average amount received to accompany pregnant women to HF (Rs)		–	492	341	600	280	–	–
Number of ASHAs that spent over and above the amount received		–	2	0	8	18	28	36
Average amount spent (Rs)		–	200	–	225	276	–	–
Number of ASHAs who receive performance based incentives		5	12	17	13	13	60	77
Average amount per month (Rs)		640	788	618	640	317	–	–
Number of ASHAs who are happy with the incentives		1	1	16	4	4	26	33
Number of ASHAs demanding regular salary		1	11	18	17	22	69	88
Details								
Average amount (Rs)		2000	1390	1850	3471	3818	–	–
Number of ASHAs with bank account		4	12	7	19	19	61	78
Number of ASHAs who receive proper support from the ANM or the anganwadi worker (AWW) for:	Refilling drug kits	5	12	13	15	21	66	85
	On-the-job training	5	11	18	17	20	71	91
	Guidance on use of various medicine	5	11	15	17	21	69	88
	Doses and side effects of contraceptive oral pills	5	12	17	15	23	72	92
	Danger signs of pregnancy and labor pain	5	12	15	15	22	69	88
	Receiving performance based incentives	0	2	16	7	20	45	58
Number of ANM that support ANM and AWW for	Preparation of list of eligible couples	1	5	16	15	18	55	71
	Children below one year of age	4	9	16	18	20	67	86
	Bringing pregnant women, feeding mothers and infants to AWC/sub-center for nutrition, health checkup, and so on	5	12	18	19	23	77	99
Number of ASHAs recognized by the people of the village		5	12	19	18	23	77	99
Number of ASHAs who get support from people of her village		5	11	18	18	23	75	96
Number of ASHAs actively involved with the local PRI/VHSC		0	6	17	9	22	54	69
Number of ASHAs that receive proper support from the PRI or VHSC for	Creating awareness for health and hygiene among the villagers	1	6	16	13	22	58	74
	Conduct of cleanliness and sanitation programs	1	5	15	14	21	56	72
	Construction of household toilets	0	3	12	15	18	48	62
	Monetary requirements	0	1	2	11	15	29	37
Number of ASHAs who would like to work as ANM		4	11	18	19	22	74	95
Number of ASHAs feeling that there is an increase in institutional deliveries		2	12	17	18	16	65	83

Source: Our Sample Survey of ASHAs.

About the selection procedure, 65 percent ASHA said, there were Focused Group Discussions (FGDs) conducted before selection and candidates were shortlisted. Seventy-eight percent said, Gram Sabha meeting was held during the selection process. These processes are laid down, but are not followed always as it turns out. Thirty- two percent ASHA worked as community- based workers earlier. Almost all of them received training after joining. Almost 71 percent ASHAs received some formal training for 12 to 19 days during the first year of their work. Almost all ASHAs felt that the training was very useful in solving doubts and problems. However, only 71 percent felt that the training was useful in refilling supplies and only 60 percent felt that it was useful in receiving payments for performance incentives. About 80 percent ASHAs received some compensation ranging from Rs 654 to Rs 1,692 for attending the training. Seventy-seven percent ASHAs keep receiving on-the-job training. About 11 percent ASHAs did not receive drug kits. The problem seems to be confined to parts of MP and UP. The disposable delivery kit (DDK) was also not received by 45 percent ASHAs. Medicines for fever, and pain killers, and so on, were not the part of the drug kits for 22 percent ASHAs.

More than 90 percent ASHAs interviewed informed us about their active involvement in creating awareness in the community on health, hygiene, and nutrition; mobilizing community to utilize healthcare services such as ANC, PNC, immunization, and sanitation; counseling women on birth preparedness and safe delivery; newborn care, breast feeding, and complementary feeding; infant immunization; use of contraceptives and family planning measures; escorting pregnant women and sick children to the nearest HF;[1] and informing SC/PHC/CHC about births and deaths in the village. However, more than 25 percent ASHAs did not report outbreak of health problem or disease to SC/PHC/CHC, and did not participate in promoting construction of household toilets. The preferred destination of ASHAs escorting a pregnant woman was a PHC/ CHC (86 percent). Very few took the patient to a private HF. There is a marked variation in the reported average amount received for accompanying a pregnant woman to an HF by an ASHA. It varied from Rs 280 (Sitapur) to Rs 600 (Azamgarh). About 76 percent ASHAs complained about the money being inadequate since they had to spend extra money out of their pocket. About 77 percent ASHAs received performance based incentives ranging from Rs 317 (Sitapur) to Rs 788 (Chittorgarh).

About 85 percent to 92 percent ASHAs received proper support from the ANM or AWW (anganwadi worker) for refilling the drug kits, on the job training, guidance regarding use of various medicines, doses and side effects of contraceptive pills, and danger signs of pregnancy and labor pain. seventy one percent ASHAs also supported ANMs and AWWs in preparaing the list of eligible couples for family planning and children below one year of age. Almost all ASHAs supported ANMs and AWWs by bringing pregnant women, feeding mothers, and infants to SCs for nutrition and health checkup.

Only 69 percent ASHAs were actively involved with PRIs and VHSCs; and 74 percent stated receiving proper support from PRIs and VHSCs for creating awareness for health and hygiene among villagers; 72 percent for sanitation and cleanliness programs; 62 percent for construction of household toilets; and 37 percent for personal monetary requirements. Almost 83 percent ASHA felt that institutional deliveries have increased after NRHM that shows positive mindset and optimistic attitude of ASHAs.

Before we conclude the discussion on ASHA based on our survey results, it is worth examining the determinants of the two most critical expected outputs of ASHA, escorting pregnant women for delivery (EPWD); and constructing household toilets (HHT). The following models are tested:

1. EPWD = f (Av. distance of HF, Money received for escorting, Amount of performance incentive, ASHA's involvement in PRI-VHSC, ASHA's opinion on institutional delivery, ASHA worked as community worker, Dummies for Up and MP).
2. HHT = f (Amount of performance incentive, ASHA being happy with incentive, ASHA receiving support from PRI, Dummies for UP and MP).

It can be seen from models (1) and (2) that we have included explanatory variables from the behavioral or personal qualities and background of ASHA, her interface with PRI, environmental variables, and NRHM policy variables. The results of these models are reported respectively in Tables 6.3 and 6.4.

Table 6.3 Regression Results for Deliveries Escorted by ASHA (EPWD)

Variables		Coefficient	t-statistic	P-value	R-sqaure	Adjusted R-square	F-significance
Deliveries Escorted on All Variables							
Average distance of HF	Number	−0.22	−1.471	0.1458	0.6312	0.5885	0.0000
Amount received for escorting pregnant women for delivery	Amount (Rs)	0.002	0.487	0.6275			
Amount of performance incentive	Amount (Rs)	0.019	7.875	0.0000			
ASHA's involvement in PRI/VHSC	Dummy	3.28	1.630	0.1076			
ASHA's opinion on increase in institutional deliveries	Dummy	2.96	1.168	0.2468			
ASHA worked as a community worker	Dummy	−2.65	−1.363	0.1773			
Uttar Pradesh	State dummy	7.92	2.685	0.0091			
Madhya Pradesh	State dummy	9.53	3.932	0.0002			
Deliveries Escorted on Selected Variables							
Average distance of HF	Number	−0.210	−1.425	0.1586	0.6300	0.5930	0.0000
Amount received for escorting pregnant women for delivery	Amount (Rs)	–	–	–			
Amount of performance incentive	Amount (Rs)	0.019	8.055	0.0000			
ASHA's involvement in PRI/VHSC	Dummy	3.169	1.594	0.1155			
ASHA's opinion on increase in institutional deliveries	Dummy	3.276	1.345	0.1829			
ASHA worked as a Community Worker	Dummy	−2.826	−1.490	0.1407			
Uttar Pradesh	State dummy	7.720	2.657	0.0098			
Madhya Pradesh	State dummy	9.715	4.085	0.0001			

Table 6.4 Regression Results for Promotion of Household Toilets (HHTs) by ASHA

Variables		Coefficient	t-statistic	P-value	R-square	Adjusted R-square	F-significance
Promotion of Construction of HHTs on All Variables							
Amount of performance incentive	Amount (Rs)	0.0002	1.614	0.1108	0.4952	0.4602	0.0000
ASHA happy incentive	Dummy	−0.0213	−0.216	0.8293			
ASHA receives PRI support for cleaning and sanitation	Dummy	0.3413	3.732	0.0004			
Madhya Pradesh	State dummy	0.4951	3.651	0.0005			
Uttar Pradesh	State dummy	0.5712	5.483	0.0000			
Promotion of Construction of HH toilets on Selected Variables							
Amount of performance incentive	Amount (Rs)	0.0002	1.621	0.1093	0.4949	0.4672	0.0000
ASHA happy incentive	Dummy	–	–	–			
ASHA receives PRI support for cleaning and sanitation	Dummy	0.3412	3.756	0.0003			
Madhya Pradesh	State dummy	0.4796	4.187	0.0001			
Uttar Pradesh	State dummy	0.5696	5.518	0.0000			

It can be seen that both the models have fitted the sample survey data well with r-square around 0.5 or more. When we drop the statistically insignificant variables, the models on selected variables better fit the data as indicated by improved r-bar-square and F-significance.

The results on the number of deliveries escorted by ASHA (EPWD) is primarily determined by the amount of performance incentive, state dummies for both Up and MP, and ASHA's involvement in PRI/VHSC. All these coefficients are significant at 12 percent level. What is interesting is that the amount received by ASHA for escorting the pregnant woman for delivery is not statistically significant. It is the performance incentive that works much better because this escort service would create goodwill for the ASHA in the community and her overall performance would, hence, improve. Compared to Rajasthan (base case), UP and MP had better environmental effect with MP exercising greater effect. The NRHM's emphasis on ASHAs' selection through PRI seems to be working since her involvement with PRI/VHSC plays a positive role in determining her output.

Table 6.4 shows that the main determinants of promotion of construction of HHTs by ASHA is again the amount of performance incentive received by ASHA, the support she receives from PRI, and the state dummies for UP and MP. The question of ASHA's perception or opinions regarding adequacy of incentive is not relevant. Thus, both the models have shown that the NRHM's emphasis on ASHA's interface with PRI/VHSC and on the performance incentives given to ASHA is effective in determining her performance on ground. In this context, it is interesting to see that the performance incentive actually received by ASHA varies considerably from Rs 50 pm in Sagar (MP) to Rs 2,000 pm in Azamgarh (UP), though the average amount shows much less variation from Rs 317 in Sitapur (UP) to Rs 788 in Chittorgarh (Rajasthan). Thus, it is an effective policy tool in NRHM.

2. Public Participation: Survey Findings

Public participation under NRHM is formalized by specific institutional arrangements at various levels (see Chapter 2). Involvement of PRIs in the program is an important element ensuring people's participation. Similarly, there are specific committees like VHSC at village and sub-center levels and RKS at the PHC and CHC levels. The additional PHCs in UP, however, did not have RKS, only block PHCs had it. In Rajasthan, RKS is known as Rajasthan Medical Relief Society (RMRS) and it was in operation at the CHC level even before the NRHM implementation. Like RKS, the members of RMRS in Rajasthan included Block Medical Officer (BMO), the HF doctors and some non-official members from outside the government system. However, in UP, all members of RKS by and large are from the government system and their membership is ex-officio.

In RMRS in Rajasthan at the PHC/CHC level, the BMO is the chairman of the committee and a doctor of the PHC/CHC is the member-secretary; whereas at the sub-center level, VHSC has the Sarpanch as the chairman and ANM as the member-secretary. Thus, at one level, a politically elected person is a chairman with the government official as secretary and at the other level government officials occupy both the positions. We found that it had some implications on the efficiency and working of the committees. At PHC/CHC level in Rajasthan, the PHC doctors were happy with the chairman because he would understand the needs of the PHCs and would not unnecessarily interfere if some legitimate expenditure had to be made. on the other hand, at the SC level, the chairman (Sarpanch) would not often appreciate the need for expenditures and ask for their cuts/commission for co-signing the check. We encountered this problem in MP and Up as well.

As against Rajasthan, MP has the practice of putting deputy Tehsildar (a revenue department official at block level as the chairman and co-signatory with the medical officer to operate the RKs funds. The system again faces stumbling blocks and difficulties of similar nature as faced at SC level. Moreover, the deputy Tehsildar is usually busy with his/her own work and hence the delay in RKs meetings. At the CHC level, the RKs account is jointly operated by SDM (a revenue department official at the block) and BMO. The same problems are reported. As against this, Up has only one signatory to operate the RKs account after taking approval for expenditure in the monthly RKs meeting. The funds are operated by the medical officer alone, neither a political representative nor a revenue department official is involved in operating the funds.

Most of the VHSCs were formed during the last one or two yeas with ASHA as joint secretary; AWW, principal of the school, and some local leaders as members. As yet, most of the VHSCs were not found to be active, particularly the community representatives. There was no clarity about their role in the committee, the role of the committee, the importance of regular meetings, and so on. Even the Sarpanch who was chairing the committee had no idea about these things. In some cases he had not even heard about NRHM. The school principal also did not know much about the VHSC in which he was a member. Although the committee was formed months ago, he was informed about his membership only a few days back. The general awareness in the public and its representatives about NRHM and VHSCs and their rights and roles seemed to be limited. Representatives on the VHSCs are not aware about the roles and functions of ASHA, ANM, and AWW. Although ASHA is generally selected and appointed by Sarpanch with the Gram Sabha (People's Assembly) approving it, he had very little clarity on the role and duties of ASHA and ANM. Most of the time, the Sarpanch and other members thought that ASHA would take children for immunization and ANM would administer the doses.

If such is the awareness about the functionaries on ground on the part of local leaders and people's representatives on VHSCs, how does the system work? It works because ANM obtains signatures of some members of the committee in the register maintained as a record of the meetings of VHSC. The reason for such a lack of interest on the part of the members and chairman is the ignorance about their role and functions in the whole process. NRHM Mission Document clearly states the need for training and spread of information to the PRI members. However, the timelines provided no space and no explicit mention about the ‘training’ component. As a result, training at the grassroots level has not taken place leading to lack of appreciation and understanding, resulting in indifference and lack of interest. The training or campaign to spread awareness and information should not be confined only to members of VHSCs, but should also include community at large to have effective public participation in the program. The ‘sanitation', health, and hygiene part of the duty and responsibilities of VHSC is a critical component of NRHM and ASHA can be successful only if she receives support from PRI and VHSC as we have seen earlier corroborated by our regression findings.

The situation at the PHC/CHC level is somewhat better but largely comparable. Barring a few exceptions, the RKS at PHC/CHC level also faces the apathy and lack of interest of the people's representatives. In several cases, the RKS meetings are not held for months together and when the meeting does take place, no more than three to four members turn up. The usual practice is to take signatures of the members in the official register at their homes. Other than lack of awareness and information about the role, functions and duties of the members and the committee, one possible reason for the general apathy on the parts of the members is

that the funds available for spending on requirements remain uncertain and made available very late in the year. This delay in the release of funds is a systemic problem and can be traced upwards to the central government budget process.

The RKS generates own funds also through collection of out-patient and in-patient fees and user charges from patients. Besides, it also receives funds from the district as a part of NRHM program. In UP, block PHC also spends for additional PHCs and collects their revenues from OPD, and so on. The funds of the RKS were mainly used for the repair and maintenance work of the PHC/CHC building, buying furniture, buying required medical equipments, cleaning and sanitation purposes, and purchase of medicines that are not available in the HF for the below poverty line (BPL) patients. HFs also receive untied fund which is used to fulfill any of the above requirements for which the RKS fund is inadequate. A common problem encountered by some of the PHCs was on spending the RKS and untied funds. Proper guidelines to the doctors are lacking and hence sometimes they are reluctant to spend funds. On the other hand, there is a constant pressure built up on the doctors to spend the available funds as soon as possible irrespective of whether there was any requirement or not. The doctors also complained about undue increase in administrative work and responsibility due to the RKS and other NRHM activities. They faced constraints on taking administrative decisions on spending funds for legitimate purposes without approval of RKS members in the meeting that would not take place.

Regarding funds transfer from above, there are some interesting facts. At the PHC level, the frequency of funds transfer varies according to the type. For instance, the JSY fund for incentives provided to the patients for the institutional deliveries came regularly, but other funds such as RKS and untied fund were considerably delayed. This then transmits down and ASHA and ANM also receive delayed payments. Even doctors appointed on contract at PHC and CHC did not receive their salary for six to eight months. Since institutional deliveries are specifically targeted along with immunization of children, these two funds are relatively quickly released. The other funds as usual and may be more delayed showing hardly any visible improvements in the overall government management and efficiency. In fact, very often the funds are released as late as January end or February and the authorities at various levels insist that they should all be spent before end-March.

There are serious difficulties under such a situation when the people's participation in the form of committees has to approve the expenditures fast.[2] The problems only compound for the functionaries when the committee members lack interest, appreciation and commitment to a cause. Such crucial aspects and practical difficulties created by the systemic constraints from above have to be considered thoughtfully before an elaborate structure of people participation is proposed.[3]

3. District Program Management Unit (DPMU)

The team visited four DPMUs—Chittorgarh in Rajasthan, Sagar in MP and Azamgarh and Sitapur in UP. Each DPMU consists of a district program manager (DPM), district accounts manager (DAM) and district data manager. In UP, however, it also consists of a district community mobilizer. All the units visited started functioning only in the last one year with most of the staff recruited in the last quarter of 2008. Table 6.5 gives details about existing manpower in various DPMUs visited.

Table 6.5 Details of Existing Manpower in DPMUs

State	District	DPM	DAM	DDM	DCM
Rajasthan	Chittorgarh	1	1	1	–
Madhya Pradesh	Sagar	1	1	0	–
Uttar Pradesh	Azamgarh	1	1	1	1
	Sitapur	1	0	1	1

Source: NRHM Evaluation Survey (2009).
Notes: DPM District Program Manager
DAM District Accounts Manager
DDM District Data Manager
DCM District Community Mobilizer.

The district program managers (DPMs) of all the units reported that they receive funds from NRHM directly from the state through electronic bank transfer. These funds are further transferred to the block level in the same way from the district. The signing authority of transferring the funds lies with the CMHO (Chief Medical Health officer) of the district. Moreover, for the monetary requirements at the DPMUs, the funds were transferred to the joint account of the DPM and one of the other officers of the unit. some of the major heads under which these units receive funds are (*a*) RCH (Reproductive and Child Health) flexi pool fund, (*b*) NRHM flexi pool fund, and (*c*) immunization fund. Three of the units also shared with us the total budgeted amount and total expenditure incurred under these heads. Table 6.6 gives the details. As seen from the table, the utilization of the budget has been increasing with the passage of time.

Table 6.6 Details of Total Expenditure Incurred under NRHM

Years	Budget and expenditure	Madhya Pradesh	Uttar Pradesh	
		Sagar	Azamgarh	Sitapur
2005–06	Budgeted amount (Rs lac)	195.4	–	–
	Actual expenditure (Rs lac)	76.2	–	–
2006–07	Budgeted amount (Rs lac)	64.4	–	–
	Actual expenditure (Rs lac)	19.8	–	–
2007–08	Budgeted amount (Rs lac)	35.2	1338.4	–
	Actual expenditure (Rs lac)	32.7	642.0	–
2008–09	Budgeted amount (Rs lac)	700.0	1790.5	1455.48
	Actual expenditure (Rs lac)	662	1248.7	1233.11

Source: NRHM Evaluation Survey (2009) as reported by DPMUs.

The DPMs are also involved in monitoring the NRHM program in the district. An important indicator used by most of the units was the number of institutional deliveries conducted at the PHCs and CHCs in the district. They also monitored the number of JSY payments made at these health facilities and the number of deliveries accompanied by ASHA. Moreover, the DPMs also reported to be visiting some of the beneficiaries of JSY at the village level and interviewed them using structured questionnaires. These questionnaires are part of monitoring guidelines provided to the units by the state. The units also prepare reports as part of the monitoring process and send them to the state authorities. All the units have reported to have received feedbacks from the state on the basis of the reports sent by them.

The DPMs also reported certain problems and challenges they faced in the implementation of the program. One important challenge was the low availability of manpower, especially doctors, at the HFs in the district. They also reported lack of coordination and cooperation between the HFs and the DPMUs for the purpose of monitoring of the program. Lack of authority to take certain administrative decisions for the units was also a

problem faced by the DPMs. In the case of non-performance of paramedic staff at the village level such as AHSA or ANM, it is not possible for the DPMs to take any corrective actions directly. The feedbacks given by these units to the paramedic staff are also not necessarily accepted. The DPM in Azamgarh finds misreporting of facts by CHCs and PHCs as an important challenge.

Among the major suggestions given by the DPMs, one was to expand the authority given to the units to take direct actions and administrative decisions. Another suggestion was to create a post of program manager at the block level in order to decrease the administrative work load of the BMO. Some DPMs felt that the location of DPMU within the district administrative structure also plays an important role. If it is located within the office of the CMHO like in MP, it would affect the work of DPMU because a lot of routine clerical work in CMHO office would flow to them. On the other hand, if it is located outside CMHO office like in UP, they can concentrate on their work better. However, one could argue that a common location would facilitate better communication and management as we describe in Chapter 7.

Notes

1. During our field visits, we found that some ASHAs did not accompany pregnant women for delivery because they were not informed by the family of the patients. This was because if an ASHA did not accompany, the family would receive reimbursement of transport expenses.

2. As a consequence, sometimes, out of such funds sweepers, security guards, and so on, get appointed at the PHC/CHC level.

3. In some RKS, people's representatives are more dynamic and have clear idea about the facilities required to be created with reasonable priorities. In such cases, delays in funds create fewer problems.