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

From the Field: Uttar Pradesh, Madhya Pradesh, and Rajasthan

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1. Uttar Pradesh (UP)

UP HAS the second highest maternal mortality rate (MMR) in the country, 440 out of 100,000 live births (India - 254), as per the 2004–06 Special Survey of Deaths estimates.[1] Infant mortality rate (IMR) in UP stands at 69 per 1,000 live births as per the 2008 SRS survey.[2]

1.1. Manpower

1.1.1. Medical Officers

There is a serious shortage of staff especially medical officers (MOs). Typically only 50 percent of positions are filled at the centers we visited in Jalaun, Jhansi, Lalitpur, Varanasi and Allahabad.[3] With the new policies, particularly Janani Suraksha Yojna (JSY), the workload of the MOs has certainly increased dramatically. Often, one MO is doing the work of two or three MOs apart from keeping up with the administrative demands. Although there is a serious need of additional MOs, incentives for them to join the government health services and actually stay there are lacking. Currently an MO is paid Rs 12,000 and specialists Rs 18,000 per month (which is approximately 1/5th of what is paid in the private sector). Although there was a recommendation to pay Rs 18,000 to MOs under NRHM contract, it was repealed by the Supreme court. All the MOs we spoke with said that more MOs would be willing to join if they were paid between Rs 30,000–40,000 per month, which is the normal pay scale in other states like Haryana and Punjab and other NRHM HFSs like Assam for hard duty.

currently, there is also a scheme to hire MOs and specialists on contract for Rs 1,000 per day. However, just the transportation to some of the remote areas cost about Rs 500 each way. Therefore, no specialist participates in this plan. Also, there are no proper living quarters for the medical staff. They are either housed in old buildings or situated too far from the village. JSY beneficiaries have increased almost tenfold from 100,000 in 2006–07 to 960,000 in 2007–08. However, recruitment of medical and para-medical staff has not kept up. For example, a very typical situation is depicted at the Women's Hospital in Orai in Jalaun District of UP. This hospital conducts about 600 institutional deliveries per month. Out of 11 positions of staff doctors, only five are filled, and only two are present at any given time because of other field duties. No anesthetist is available. There has been no increase in staff since the institution of JSY scheme. Administration and maintenance of the records is a huge task. They have not got any additional financial or administrative support. Dr Prabhavati Jain is the only senior administrator and manages everything from preparing timely JSY reports to the proper upkeep of the toilets. She also happens to be a gynecologist, and due to the shortage of staff, she has a full load of clinical responsibilities as well. Human resources available are strained to their utmost, and although the health facilities are capable of providing quality care, it is limited due to the meager human resources it has.

1.1.2. Nursing Staff

Nursing staff is short everywhere we visited. Contractual staff has not been placed everywhere. At least three ANMs are needed to make primary health centers 24×7 facilities. Most PHCs are working with only one MO and one ANM. ANM training schools stopped recruiting in 1997. Now 16 out of 45 schools are starting to recruit again. Since there is such a shortage of paramedical staff, rest of the institutions should be opened as soon as possible in order to train ANMs who would be easily absorbed especially given the high workload in JSY. Although most sub-centers have ANMs, most of the ANMs do not stay at the SC because of lack of facilities.

1.2. Infrastructural Capacity

Although there is huge increase in the number of institutional deliveries, capacity building has not kept up with it. Physical resources, similar to human resources, are strained.

Most functional centers are overcrowded with patients flooding the wards and the hallways. District hospital in Varanasi was lined with beds in the hallways. In CHC Phulpur, in district Allahabad, the maternity ward was so crowded that the nurses had to request all the attendants to leave even though they often take good care of the patients thus making up for the lack of nursing staff at the hospital. In district Varanasi, only 10 out of 49 SCs are accredited for institutional delivery. Mainly because there are no proper facilities for the ANMs to stay at the SC. The SC does not have a building and is operating out of a rented room. SC Phulpur in district Varanasi has a residential ANM and has been accredited only since 15 August 2008. In four months, 62 institutional deliveries have been conducted at this center. This center, however, does not have a toilet for the patients and they are using the ANM's personal toilet. Similarly, Sidhora SC, also in district Varanasi, is operating out of a very old government building. Still, it has been able to conduct 151 institutional deliveries in the last four months. Formerly an SC, Namayatpur PHC in district Jalaun is run by an ANM and an AYUSH MO. However, there is no proper building or labor room or quarters for the ANM to reside. Deliveries are conducted in the back veranda. Corner of the front outdoor lobby has been sectioned out as a bathroom. From April to October 2008, this center has conducted 275 deliveries. We were taken to the new building constructed for this PHC, far away from any village. But it has not been handed over because of leaks that were noticed immediately after the construction. It is uncertain when the building will be handed over.

An SC is the lowest service unit in the government-sponsored health program in India, which is most accessible to the rural population. However, SCs are in very poor shape. Two out of 22 SCs are accredited (have the basic facilities to conduct a delivery) for institutional delivery in district Jaunpur and 10 out of 49 in Varanasi district. Of these, some are operating out of very old buildings like Hirmanpur SC, where the ceiling is coming apart or lack basic amenities like a functional toilet as seen in Phulpur SC, district Varanasi. Similarly, in Allahabad district, out of 551 SCs, 65 have residential ANM, 95 have government buildings, and 30 have ANMs that commute daily to Allahabad. Often PHCs and CHCs are situated far from the population. Even some of the newly constructed PHCs were located far away from the village. Handia FRU in Allahabad district was 14 km from the closest village. New PHC Bhansi in Lalitpur district was relocated from its location in a village to a much farther and inaccessible location. Because of its location, it also lacks water supply. Not only does such a location make it harder for people to get to the services, it also makes it more challenging for the medical officers to actually stay at the facility.

Given the high load of JSY, hospitals have not been able to keep up with the high demand for services. Beds were in short supply at various hospitals and people were laid out in the hallways and even toilets. Wards were often dirty. Linen was consistently dirty at every hospital. Baby warmers were lacking in most hospitals. There are no provisions for attendants, food, clean water, or waiting area for patients' attendants.

1.3. Communication and Management

Each district has a district health society, a governing body that is headed by the district magistrate (DM), which is responsible for overlooking NRHM projects. The CMO is the CEO of the governing body. Executive body is chaired by CMO and other executive officers are district program managers. As mentioned earlier, RKS/Hospital management society is created to increase transparency at hospital level—CHC and PHC. Governing body is chaired by the DM and the medical superintendent of the hospital is the member-secretary. The executive body is headed by the medical superintendent of the hospital. Further at the village level, VHSC is headed by the panchayat head and ASHA is member-secretary. Therefore, there is supposed to be a close working relationship and communication between the NRHM administrative staff and the CMO office. However, that has not been accomplished yet.

Moreover, the government officials do not respect the NRHM administrative staff, which is hired on contract basis as part of the government system. This lack of integration creates barriers in communication and implementation of policies. In Jalaun district, the NRHM team, district project managers and the accountant are not given support by the CMO staff (for example, providing vehicles for field visits) in order to carry out their job of monitoring NRHM policies in the field. Also, many people including the CMOs in various districts, like Lalitpur for instance, did not know the role of DPMs and Block Program Managers (BPMs). There needs to be an initiative towards integrating these two processes, NRHM and the former medical system. As described above in the structure of the health committees, success of NRHM relies on these two working closely together. May be having NRHM offices in the DH and BPM office in the CHC would be a good start towards bridging this gap.

Each SC receives Rs 10,000 as untied funds per year. Each PHC receives Rs 25,000 as untied funds and Rs 75,000 from RKS funds per year. Each CHC receives Rs 50,000 as untied funds, Rs 75,000 from RKS, and Rs 100,000 as maintenance funds per year. Medical officers, hospital supervisors and senior administrators are unclear as to how to actually spend these funds. In CHC Kalpi in Jalaun, the medical supervisor was not comfortable using the RKS for a generator for the hospital. In Phulpur CHC in district Allahabad, neither the block medical officer nor the medical officer-in-charge knew how they could utilize untied funds, while the hospital lacks electrical fittings, is very short on sweepers and does not have even a single baby warmer in any of the labor rooms. Similarly, in Pindor PHC in Varanasi district, although in dire need of janitors and sweepers, the medical officer-in-charge did not know that they could use RKS funds to hire sweepers on a daily wage basis. A focused meeting needs to be organized for educating the MOs and supervisors on the details of the Program Implementation Plan (PIP) for the district and how to utilize the funds for the betterment of the facility. They should be encouraged to have a sense of ownership of the hospitals and should take the initiative to spend the money such that they can use their power to actually make a difference in the system.

VHSCs are based at the village level to decentralize the decision-making process. Funding for the SC is approved through the VHSC. It is headed by the gram pradhan, head of the village panchayat. As noted earlier, VHSCs are non-functional in majority of the areas we visited. In Phulpur SC, the ANM reported that the pradhan is not involved at all. ANM has to go house- to-house to get signatures of approval of expenditure. Similarly, another ANM we met at Pindor CHC in Varanasi district reported that the pradhan in their village wants

Rs 4,000 out of the Rs 10,000 to sign on any expenditure for the SC, a common complaint heard repeatedly.

1.4. ASHAs

ASHAs have been recruited throughout the state. There are about 130,000 women working as ASHAs in the villages of UP. Most of them are 8th grade pass. But in areas where there were not enough women who met this qualification, 5th grade educated women have also been hired, mostly in eastern UP districts. In Allahabad and Jalaun 50–60 percent of the institutional deliveries were accompanied by ASHAs. Recruitment of ASHAs has been very political in some areas like Jaunpur and Chandhori where ASHAs have been recruited by the pradhans, often their relatives, and are non-functional. For instance, as per the CMO of Jaunpur, 150 ASHAs have been recruited in this district, but only 100 are functional. When asked as to why the work done by the ASHAs cannot be evaluated and new women recruited to replace those not working, we were informed that there were not enough 8th grade educated women to replace those not performing. Additionally, their political connections make the situation more complicated.

For ASHA training, as per Dr Nita Jain, coordinator of ASHAs, training in UP, the first module has been modified by only 5 percent from the original national version. The second module is now a combined version of the original 2nd, 3rd, and 4th modules plus additional information on national health programs and activism. It is conducted for 12 days at one go to limit the days away from family and work. Due to the large size of ASHAs (1.3 lac), the first module was done in two phases. Sixty four percent of ASHAs have completed second module. ASHAs in the field face certain challenges that deserve some attention.

1.4.1. Payment

An ASHA from Chaursi village in Jalaun district reported that she had not received payments for her work during vaccination days that are held once a week at the Aganwadi center. Similarly, in Lalitpur, another ASHA, we encountered at the CHC while she was accompanying a pregnant woman, also reported that she had not received any payment for her work on vaccination day or during Pulse Polio week. In discussion with ASHAs at Shahpur SC in district Varanasi, it became clear that they lacked knowledge about the financial aspects of their job, such as how to fill out the vouchers, and so on. This should be a part of their training; however, it is not included in any of the modules.

1.4.2. Transportation Costs

ASHAs are given Rs 250 for transportation to bring a pregnant woman to an HF. They do not get this allowance if they are bringing in a patient from the village or town where the PHC or CHC is located. However, if they are coming from a much farther distance where they sometimes spend Rs 400 and above, they are not given additional allowance. Is there not a better way to compensate them, based on the distance traveled? For example, rates can be fixed if you travel below 10 km, or between 10 to 20 km, and so on. Or at least, the amount saved by not compensating the ASHAs who come from nearby areas, can be passed on to those who travel much longer distances.

1.4.3. Professional Mobility

At Pindor CHC, we met with an ASHA from Persara village in Jalaun district, who happened to be highly educated (BA). She is working with a population of 1600, and has brought 20 institutional deliveries in the last nine months, or 100 percent of deliveries in her village. Those ASHAs who perform well and have much higher qualifications, need to be encouraged to enroll in ANM or other para-medical courses for further training so that they can have a professional incentive and they could be utilized better.

1.5. Challenges for Further Increasing Institutional Deliveries

In UP, as per the NFHS II survey, 23 percent of the deliveries are institutionalized. Although many hospitals look much cleaner than they did in the past, the quality of care is still quite low. It is not surprising that patients in various places do not stay more than a few hours even though JSY requires them to stay for a minimum of 24 hours. For instance, in Kalpi CHC, district Jalaun, there were six deliveries the night before, but not a single patient in the wards. There are various challenges to further increasing this number, while improving quality of care. Some of the major challenges are discussed above, like manpower and infrastructural limitation leading to poor quality of care. Another major challenge in UP that we encountered was the problem with JSY payments. In district Lalitpur, JSY payments were not made in time. As many as 210 patients had not been paid since October 2008. CMO of Lalitpur reported that they had not received the funds in time, and they had used funds that were allocated for other programs to pay for JSY and now even those funds had run out. This hospital also happened to be empty with no patients in the wards. In Chandhori CHC, payments were not made in time either. On enquiry, we were told that funds had not come from the state in time. In every hospital that we visited in UP, every single patient had paid at least Rs 500 for delivery of a baby boy and Rs 250 for a girl to the ward helpers or nursing staff. This practice has become so widespread that at Chandhori CHC in Chondhori district, patients did not realize that it was not part of the actual fees for services, and they were told by the staff at the hospital that they were getting JSY payment of Rs 1400 partly to pay these fees.

Gujarat has initiated a scheme by involving private healthcare providers to reduce maternal mortality in the state. It is called the Chiranjeevi Scheme.[4]

1.5.1. What has the Scheme Achieved?

- The scheme was initiated in five pilot districts of Gujarat in November 2005. It was scaled up to cover the entire 25 districts in September 2006.
- It is one of the first public policy initiatives in the country to involve the private sector in such a big way to deliver maternal healthcare services. Capitation payment system used as the payment mechanism to transfer resources to private practitioner was the first of its kind to be used at such a large extent.
- Chiranjeevi scheme covers about 300,000 deliveries, of the total of 1.2 million deliveries being conducted in Gujarat annually.
- Under the scheme 235,289 deliveries (November 2005-September 2008) have been conducted, which is about 6.5 percent of all the deliveries conducted in the state during this period.

- Out of the total of 2,000 gynecologists in private sector in the state, 868 are empanelled in the scheme.
- The state spent Rs 218 million on the Chiranjeevi scheme in 2007–08, which is about 1.84 percent of the total state health budget.

1.5.2. What Does the Scheme Not Do?

- Quality of service component is ignored in the scheme.
- Package design is inadequate.
    - ♦ The package does not cover post-natal and neo-natal care and covers only one ante-natal visit.
    - ♦ The scheme assumes the C-section rate to be 7 percent across the state, but it varies from 2.9 percent in Dahod to 20.4 percent in Porbandar district.
    - ♦ In a scheme which was supposed to be cashless for the targeted beneficiary, out-of-pocket expenditure incurred by the beneficiaries in Dahod and Panchmahals districts were Rs 727 and Rs 2,100 respectively on an average.
    - ♦ The average length of stay of the beneficiary is less than the standard, both in case of normal and cesarean deliveries.
    - ♦ The payment mechanism used in the scheme provides incentive to the practitioner to under-provide and refer high risk cases as there is a big variation in the cost of normal and cesarean deliveries. The payment mechanism (capitation payment system) used in Chiranjeevi scheme has been previously used elsewhere in the world for events that are relatively certain and have fewer variations.
- The private practitioners are not clear about the package break-up.
- Beneficiaries are being charged for provisions which already exist in the package, such as cost of blood, laboratory tests, sonography and one ante-natal visit.
- About 10 percent of the beneficiaries availed the benefit of the scheme in spite of not having either BPL or ST certificates.
- Monitoring system in the scheme is very weak.
- In the household surveys carried out in Dahod and Panchmahals district of Gujarat, the sex ratio in deliveries being conducted under the Chiranjeevi scheme was found to be significantly less than that of non-Chiranjeevi scheme group.

1.5.3. What Needs to be Done?

- The package needs to be redesigned.
    - ♦ Indicators for quality of service should be incorporated in the MoU signed with the private practitioners. Practitioners need to be screened for the number of deliveries conducted in a year, rate of c-section and complications, sex ratio, length of stay, status of the child birth, maternal deaths and morbidity and satisfaction of the beneficiary.
    - ♦ Post natal and neo-natal care component should be a part of the package.
    - ♦ There should be periodical revision of the package.

- Monitoring system needs to be strengthened. Primary and secondary information should be used to monitor the scheme.
- There should be a mechanism to check referral of high risk cases by the private practitioners empanelled in the scheme.

2. Madhya Pradesh

2.1. Manpower

Institutional deliveries have increased significantly. However, as in UP, manpower strength is seriously lacking. In Mandedeep CHC, 40 km from Bhopal, the state capital, institutional deliveries have increased from four to five to 45–50 per month. Deliveries have increased ten times. However no additional staff has been recruited. The only female doctor is also in-charge of this CHC. Therefore the administrative and clinical demands of her job have increased exponentially. It is only natural that the quality of care will eventually be compromised. Similarly, in Abdaiduhaganj B FHC (field health center, a level below CHC) located 70 km from Bhopal, institutional deliveries have increased to 165 from 35–40 per month. However, there is no change in staff. In Goharganj PHC and anganwadi, no doctor had visited for several days. The dresser (the compounder) was seeing patients. Bareli CHC, 150 km from Bhopal, has seen a remarkable increase in deliveries with 200 deliveries per month. However, the wards and labor rooms were in the worst of conditions, overcrowded, dirty and dark, and in dire need for more nursing staff.

Like in UP, there are similar impediments such as lack of incentives for medical officers to work in the public system. However, it is also important to note that there is difference in the quality of hospitals even though they are run by the same number of staff and have the same infrastructural limitations. Ghandhinagar CHC in district Bhopal and Mandedeep CHC in district Raisen have the same number of deliveries and similar shortage of staff, yet the differences between the two facilities were obvious. Ghandhinagar was dirty and empty, labor room without a new born corner, and registration office closed during working hours. Similarly, Bareli CHC in district Raisen and Eichawar CHC in district Sehore have about the same number of deliveries. Eichawar's incharge has invested untied and RKS funds in hiring sweepers and buying labor tables. Although Eichawar had more patients in the wards, with significant overflow in the hallways, it was significantly cleaner and the labor rooms were well maintained. Although lack of manpower is a major problem, lack of ownership and initiative amongst the workforce employed, especially the medical officers and administrators varies across the state.

2.2. Infrastructural Capacity

As mentioned above, various health centers are lacking infrastructural input needed to improve quality of care. Eichawar CHC in district Sehore had patient beds lined up in the hallways. Maternity wards in Bareli CHC were dirty and overcrowded. Labor rooms had old labor tables and there was no proper baby corner. Number of JSY patients exceeds the capacity of maternity ward. JSY patients are also admitted to the gener-

al wards and general ward patients are forced to lie in the hallways.

2.3. ASHA

Thirty-five thousand ASHAs have been recruited and all of them have received at least the first module of training. Payment of ASHAs in MP is different than most other states. ASHAs are not paid Rs 250 for transportation because transportation of pregnant woman to the hospital is the responsibility of Janani Express, ambulance service with a toll free call number. If the ambulance is unreachable, the woman's family pays for the transportation and is later reimbursed by the state. ASHAs do not appear to be active in the field. In Mandedeep CHC, Raisen district, only four out of 45 deliveries were accompanied by ASHAs. In Abdaiduhaganj Basic Emergency Obstetric and Neo-natal Care Centre (BEMONC), 10 percent of deliveries are accompanied by ASHAs. In Eichawar CHC in Sehore district, only 65 out of the 249 deliveries in the month of September 2008 were mobilized by ASHAs. A major issue is the state guidelines, which makes all mobilizers eligible for compensation diminishing incentives for ASHAs to be involved. Since dais have been around for a long time, most women bring dais along.

Also, there are various cases for dais and anganwadi workers paying Rs 100 to get the Rs 350 even though ASHA had done the work during the previous nine months. Sehore CHC in-charge complained to the state administration about this confusion in the policy. After repeatedly writing letters, he was told not to pay anyone but ASHAs. However it was not clarified what is to be done in areas where there are no active ASHAs yet. At least in Sehore, the person-in-charge has decided to pay only to ASHAs the full amount while giving additional Rs 100 to dais that assist in the delivery. However, this is still not very effective because most women bring only dais along with them. There were cases reported to us by ASHA who said that dais would ask for half of ASHAs' compensation to allow for a woman to be brought in for institutional delivery. This issue is a major hindrance to institutional delivery throughout the state. In Lasulya Kangar anganwadi in Sehore district, ASHAs do not want to take any deliveries because of the fear of dais.

ASHAs have not been paid on time for their contribution in bringing children for vaccinations. In Abdaiduhaganj BeMoc, payments to ASHAs were held up for months. Similarly, in Mandedeep CHC, funds are not released in time for immunization work. Numerous ASHAs had not been paid for their work for immunization work for six months. We heard several stories about payments for ASHAs being held up for months and then being paid Rs 100 or so whereas they were supposed to be paid Rs 150. It is only natural that eventually ASHAs will avoid works for which they are not paid on time or less than what they were promised. In Goharganj anganwadi, the anganwadi worker had not seen ASHA for any of the immunization days. Also, these vaccination and pre-natal check up are held in anganwadi centers, which are typically one room in a shabby condition and overcrowded with small children. It is unclear how ANM do the prenatal checks for women, which may require a physical examination and vaccinations for the children all at the same time and in the same room when children are having their regular session at the anganwadi. Three of the four anganwadis visited in Sehore district were empty with no anganwadi worker to be seen during working hours.

2.4. Communication and Management

Decentralization of decision-making through VHSC has not been accomplished yet. VHSCs are not active in most places we visited. At an ANM meeting in Eichawar CHC, ANMs reported that VHSCs were either nonexistent or more focused on the sanitation issues of the village while completely ignoring their role in health-

care. In Lasulya Kangar anganwadi in district Sehore, ANM reported that VHSC is not active. At Sherpur and Pangrakit anganwadis, ASHAs were recently appointed and did not know anything about their roles and powers as the member-secretaries of VHSCs or the role of VHSCs for that matter. People on the ground are discouraged reporting any problems and are actually intimidated by the hierarchy above. They do not even know who is the person to call at the district or state level to report the problem. No doctor had shown up at Goharganj PHC for several days and a dresser was seeing the patients. The dresser present did not know whom to report to and seemed confused at the idea of calling up someone in Bhopal to actually do that.

Management and accountability needs to be much more precise to ensure that all the jobs are being fulfilled appropriately. There needs to be a person in charge of each worker in the system. Part of this is the job of VHSC. However, until VHSC is active in each village this gap needs to be filled to ensure a functional system. In Mandedeep CHC in district Raisen, untied funds are not available on time. Funds are released late (September as opposed to April), so the MO-in-charge cannot plan to hire sweepers or other daily wages staff until April. And when the funds do arrive they need to be used up quickly to submit utilization forms as we have noted earlier. The MO-in-charge here did not know whom to report this problem to. Similar to UP, there is a lack of understanding of proper use of untied and RKS funds. Bareli CHC is without a generator and lacks basic labor room equipment such as labor table and episiotomy scissors. The female doctor who reported this to us did not know that untied funds or RKS can be used for these requirements. If untied funds run out, more funds can be requested from the state for these specific needs.

On patient communication, there are signs everywhere explaining JSY and the payment systems. Announcements like the one below are posted at every hospital in local language. However, women are usually unaware of the payment, unless there is an ASHA involved, and it is typically the husbands who knew about the scheme. Therefore, strengthening ASHAs' place in JSY and not splitting their incentive with dais or anganwadi workers will be imperative for the success of this scheme.

2.5. Innovations

2.5.1. Urban Dispensaries

PPP with Sevabhartiya NGO Two functioning urban centers have been created with collaboration with Sevabhartiya. These centers are managed by this NGO, which has employed MOs and one gynecologist. Both the centers together have 25 USHAs (urban ASHAs) working in the community who were trained by the NGO in the same jobs as done by ASHAs in the villages. Each center is visited by about 30–40 out-patients each day. These centers were cleaner, well-staffed, and equipped with all necessary requirements, better than any other SC we visited.

Urban RCH Camps:

Urban RCH camps provide care in slums that are not very close to SCs or the population does not make it to the dispensaries. These are arranged in the slum areas once a month. It costs Rs 1 million per year, which includes salaries of two physicians, van, and equipment (ultrasound machine and so on). These camps pro-

vide services like ANC checks, vaccinations, basic labs, and treatment of common illnesses. They see about 50–60 patients per visit.

2.5.2. Janani Express Yojana

Janani Express Yojanas exist in all districts of MP. It is a transportation system always available by dialing a toll free number. Transportation costs generally given to ASHAs in other states are given towards this yojana. Therefore, ASHA only gets Rs 350 for institutional deliveries and first immunization. However, in the field in the districts that we visited, the availability and use of this transportation system was variable. It is unclear how the vans are functional without any GPS support or algorithm to prioritize where to go first when the calls come in. It is still unclear what to do with complicated deliveries. Only in Sehore district did we hear that 80 percent of women were brought by the express. In other districts there were not many people who used this. Instead, people generally came on their own and the beneficiary was compensated Rs 250 for transport.

In Eichawar CHC, district Sehore, MP, information for patients was displayed on hospital wall educating them about male sterilization, Janani Express, and the benefits of institutional delivery.

3. Rajasthan

3.1. Manpower

Similar to UP and MP, in Rajasthan also there is severe shortage of medical staff in the field. Under NRHM contract, 1400 medical officers have been recruited. Additional incentive is given to MOs under NRHM for rural duty—extra Rs 4,000 for “hard duty” for 556 remote PHCs and additional Rs 3,000 for working in a rural setting. Also, GNMs and ANMs are given an additional Rs 1,500 as rural areas incentive and Rs 1,000 for “hard duty” in addition to the base salary paid by the state government. However, rural areas we visited lacked staff and had not seen much change in manpower since the implementation of JSY.

Dungarpur is primarily a tribal district. It is almost impossible to attract doctors to stay there. Even the district hospital has only 16 out of the sanctioned strength of 46 physicians. Lack of manpower creates serious challenges for night duty and managing increased in-patient and out-patient loads secondary to JSY. Institutional deliveries have gone up to 70 percent since implementation of JSY in 2006, which also means significant increase in ANC visits. For total district peripheral centers, out of the sanctioned positions of 52 MOs, only 42 are filled. There are no specialists in any of the hospitals (only four out of the 18 sanctioned positions are filled.) In the district hospital Dungarpur, there are equipment like ultrasound and TMT available, but there is no one to operate them. Kotda, in district Udaipur, is home to one of the most backward tribes of Rajasthan. Literacy rate is less than 10 percent and has very poor connectivity to Udaipur city. Further, families are spread out on separate hills, which make the job of ASHAs and ANMs even harder. No doctors or admin-

istrators want to be posted here. There is one MO, who is also the block CMO as well as the block manager. There is no additional incentive for being based in Kotda, which has harder conditions than all the other rural areas. There are no appropriate living quarters for them. Food, communication and safety are also major challenges. Out of the 1,400 MOs recruited by the state, none had been posted in this area as of October 2008.

In district Jaisalmer only four of the 15 PHCs have infrastructure and manpower for institutional delivery. Four of the PHCs are not staffed by an MO. None of the block CHCs has a specialist. Because there is no anesthetist in any of the CHCs, no major surgeries can occur. Patients have to travel 200 km to Jodhpur for major surgeries. Barmer, another desert district on the border with Pakistan, is also gravely short of staff. One of the PHCs we visited, Chava PHC, was run without any MO. ANM from another PHC comes there every other day.

3.2. Infrastructural Capacity

Zennana Hospital is a 476-bed teaching Hospital in Jaipur. Since the launch of JSY in August 2006, the numbers of deliveries here have increased from 700 to 1,600 per month. However, the staff or the infrastructure has not increased which has led to increase in the work load. A lot of normal deliveries are coming to this hospital. Villagers prefer to come here as opposed to the closest PHC or CHC, mainly because peripheral centers lack proper infrastructure and staff. Overburdening with JSY patients is compromising medical teaching and is clearly affecting the quality of care as well. Nangal PHC, in district Dausa, has the lowest rate of institutional deliveries (five in August 2008) in a PHC in the state. This is because there is lack of infrastructure—no labor room, labor table or beds for pregnant women. The PHC is functioning out of a single room. Although funds have been approved, there is a longstanding dispute over the land for the building. There has been no intervention from the state and the residents around the PHC are deprived of accessible medical care. Chomu CHC in district Jaipur has also seen significant increase in deliveries, but the capacity of the hospital hasn't increased proportionately. It has remained as a 30-bed hospital, all of which are being used for JSY patients. As per the CMO they need 50–60 beds just for deliveries and another 50–60 beds for other patients. District hospital of Dausa has increased institutional deliveries from 674 in 2005–06 to 1700 in 2007–08 without any accompanying increase in wards or beds, or medical or paramedical staff. Beds were laid out in the hallways to accommodate JSY patients. Kotda CHC in district Udaipur (Photograph 7.1), run by one MO, is gravely short of basic infrastructure. Wards are dark and dirty and labor tables are rusted. In the Sindhori CHC in district Barmer, there was no female ward. Labor room was dirty and lacked a baby corner. It is assigned to be an FRU but has no FRU-related facilities such as blood bank, anesthetist, or female doctors.

Photograph 7.1 Kotda CHC, District Udaipur, Rajasthan

(september 2008)

3.3. ASHAs

ASHAs are called ASHA sahyoginis in Rajasthan. Formerly they worked as sahyoginis with the Department of Women and Child Development (DWCD) and there was one sahyogini for every 1,000 people. These women were hired as ASHAs and named ASHA sahyoginis. These ASHAs are paid Rs 600 per delivery (including Rs 250 for transportation) and Rs 100 for immunization after delivery by check. They are given additional Rs 150 for immunization session each month as well as Rs 100 to attend meetings at PHC each month and Rs 500 by DWCD. This total of Rs 750 is not given in a consolidated amount right now. Most ASHAs have finished two modules of training. Many ASHAs complained that their patients were not calling them during labor. Until June 2008, pregnant women were getting Rs 1,700 instead of the current amount of Rs 1,400 if they were not accompanied by an ASHA. So, even if an ASHA was involved for nine months, many families do not call their ASHAs because of monetary incentive. ASHAs seem to be relatively more active in districts like Jaipur, Dausa, and Dungarpur. In many of the districts, especially desert districts, ASHAs are not very active.

In district Dungarpur, 1,074 ASHAs have completed the first two modules of training. Currently 40 percent of deliveries in the district are accompanied by ASHAs. The ASHAs we encountered in this district were educated often up to 12th grade or beyond. They wanted a salary since they were doing a lot more in the field other than encouraging institutional delivery. They wanted to do more work, but wanted higher compensation. ASHAs who had graduated college, demanded a career track as well. In Kotda CHC, only 21 out of 119 deliveries were accompanied by ASHAs in September 2008. As per a medical officer, not enough 8th grade educated women exist in this area to work as ASHAs. Also, families are really spread out in terms of area

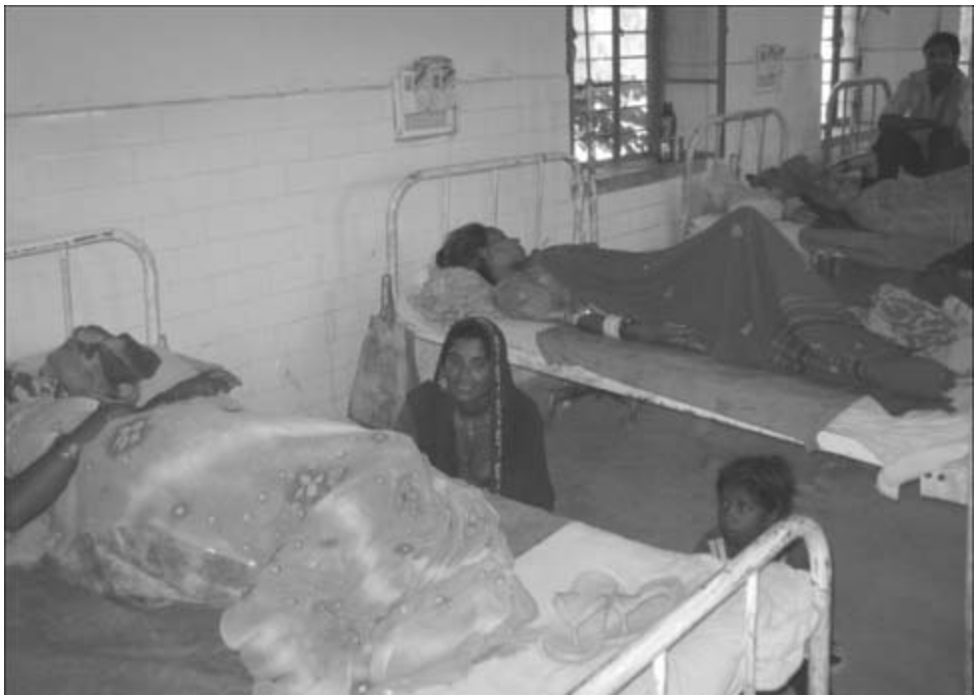
and ASHAs that are active are either not contacted or are not able to reach the expectant mothers on time. Also, transportation cost is a major problem in the desert terrain. Villages are on average 30–40 km from the nearest health center. Cost of transportation is usually about Rs 600 (double the amount given to ASHAs as transportation cost). This is another disincentive for ASHAs and families to bring women for institutional delivery.

In Jhadol CHC, also in district Udaipur, only 44 out of 135 deliveries were accompanied by ASHAs. District Jaisalmer is a desert district. ASHAs here are not very active, only 247 out of 486 ASHAs have been trained as of October 2008 and only 40 out of the trained ASHAs are actually working in the field. During September 2008, one out of every six deliveries was accompanied by an ASHA in Lathi PHC. Many of the ASHAs do not even live in the villages where they work and have been hired through political connections, many of them being relatives of local leaders. Jaisalmer does not have enough 8th grade educated women to recruit another batch. However, there are 750 trained dais. These women are trusted by the community. All the pregnant and post-partum women we met in the centers were accompanied by these dais. Dais are currently not part of the JSY scheme. If they are given some compensation, institutional deliveries, immunizations, and sterilizations would significantly increase. In Chava PHC in district Barmer only 10 percent of institutional deliveries are accompanied by ASHAs. Dais are involved with the rest of the deliveries either at home or by bringing them to the centers. Similarly, in district Bikaner in Dungargarh CHC, only 20 out of 187 deliveries were accompanied by ASHAs in September 2008 and the rest are cared for by dais.

3.4. Communication and Management

In various places we visited, untied funds have been used for overall improvement of the facilities. However, in majority of places we visited, the medical officers-in-charge and administrators did not have a clear idea as to how to utilize untied funds. Rampura Dabri SC in district Jaipur is run by one ANM who has untied NRHM funds (Rs 10,000 per year) to purchase basic furniture for the SC. However, she lacked information on NRHM programs and what the untied funds could be used for. For example, she did not know that she could get a sweeper with this money rather than spending her time cleaning. VHSC is not active and she did not know whom she could contact to get appropriate information from. In district Udaipur, Bhindar CHC had Rs 59,000 of the untied funds left unspent even though the hospital building needs significant work (Photograph 7.2). The two medical doctors have no administrative staff and they themselves are clinically overburdened. They can certainly use additional sweepers, a decent water cooler for the public, benches for attendants, a proper labor room, and so on. In district Barmer, Sindhori block MO-in-charge did not know how to use the funds and all of the funds were unspent even though the hospital was dirty and lacked even the basic infrastructure.

Photograph 7.2 Bhindhar CHC, District Udaipur, Rajasthan



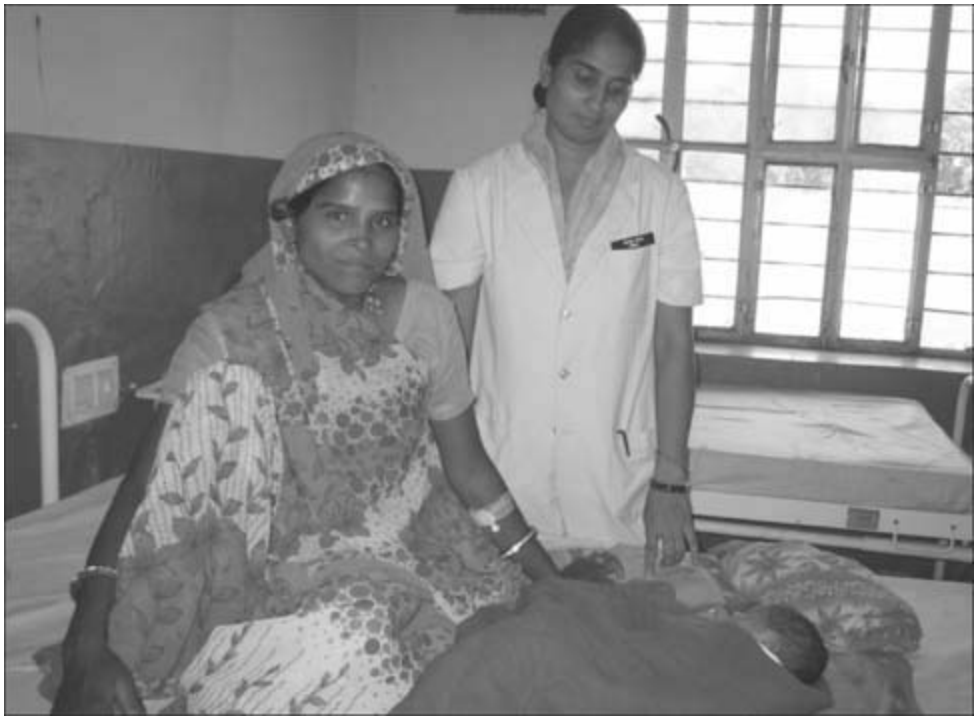
(October 2008)

3.5. Innovations

3.5.1. Yashoda Scheme

In collaboration with the Norwegian Indian Partnership Initiative (NIPI) three districts have hired yashodas from the nearby villages to support the staff for the increased number of deliveries in the hospitals secondary to JSY from 30 percent to 55 percent state-wide. These women provide basic information to new mothers about breast feeding, daily care of the child, and so on, and deal with other questions of young mothers. They also keep an eye on post-partum women for any signs of complications and relieve nurses for other clinical work and ASHAs to go back to the villages for their other duties. They are paid Rs 100 per woman who is present for an eight-hour shift. We had a chance to meet them in district Dausa, where they are performing very well and are a great source of help for young mothers (Photograph 7.3).

Photograph 7.3 Yashoda Working with a New Mother and Her Baby in Dausa District Hospital, Rajasthan



(September 2008)

3.5.2. Emergency Ambulance Services

Resulting from a PPP with EMRI, Satyam Computers and Government of Rajasthan/ NRHM, this is an emergency ambulance service with a toll free number, 108, which responds to medical, fire, and crime related emergencies 24×7. Ninty-five percent of the operation cost and all of capital expenditure is provided by NRHM (a total of Rs 500 million for the four phases) and five percent of the operation cost. The software is provided by EMRI. The final goal is to roll out 450 ambulances by the year 2010–11. In the first phase, 50 ambulances have been pressed into service in seven districts. It has a response time of 25 minutes in urban areas and 40 minutes in rural areas. Call centers are staffed by three doctors and two police staff members at all times.

3.5.3. Dungarpur

Dungarpur is mainly a tribal and rural district with over 95 percent of the 1.1 million people living in the villages. The district collector (DC) of Dungarpur has taken some significant steps to improve the healthcare in the district. This district has demonstrated remarkable improvement in IMR and MMR, which are now lower than the state average. IMR is down to 49 (state: 65) and MMR to 281 (state: 388). Following innovations have been

possible in these districts through the DC's initiative:

Pregnancy Tracking System

The Pregnancy Tracking System uses a software created by IL and FS, a firm based in Delhi. With a live database at the district level, information is sent by ANMs at the SCs through cell phone text messaging as ASHAs report to them regarding pregnant women in their areas. Their name, expected date of delivery, previous deliveries, and so on are recorded in this live database. This data is given to the blocks and then to districts. It is finally monitored by DC's office. They have provided ANMs with cell phones. This makes it easy to track down pregnant women as they get closer to the date of delivery. Also, they can be approached to make sure they deliver in a healthy facility. This software costs Rs 5 million. This program can be expanded to tracking children after birth for immunizations and schooling and also married couples for family planning counseling, and so on. This was designed and implemented last year and Dungarpur has institutional deliveries up to 70 percent, significantly higher than majority of the country despite lack of human resources and infrastructure.

Saas Bahu Sammelan

In order to target 30 percent of deliveries that are still occurring at home, this program is dedicated to educating women in the community, especially young married women and their mothers-in-law, who usually make decision about issues relating to pregnancy. These sessions are geared towards encouraging institutional delivery and awareness about breast feeding, and so on. Breast feeding, specially the first feed, which is the most important, is considered toxic in the tribal cultures. The Dungarpur health department is trying to change that mindset through organized awareness efforts such as the Saas Bahu Sammelans. These sessions are organized by ICDS and funded by NRHM (Rs 1,000 per meeting).

Kilkari Kits

Kits containing a set of gloves, soap, clean blade, soap and cotton are given to ANMs while they are trained for 21 days as skilled birth attendants (SBAs) at private centers in Udaipur. This is to make sure that even if delivery occurs at home, at least the SBAs have the basics to ensure a safe delivery.

Training of Bopas (Traditional Healers)

Sessions geared towards training traditional healers, who are trusted in the community, to convince pregnant women to deliver in the hospital and for young women to take their children to the hospital for vaccinations.

Sagwara CHC is the result of the PPP with the Bora community that has invested Rs 40 million in reconstructing this CHC with state of the art equipment (Photograph 7.4). They are contributing another Rs 7.5 million (with an additional Rs 7.5 million from NRHM) to expand JSY ward. This hospital also has cottage rooms, that are separate rooms for patients for additional cost of 150 rupees per day (these patients are not eligible for JSY benefits). Because these are private investors, they do not have to deal with tenders and can get quality work done without political hurdles. In terms of infrastructure, cleanliness and quality, this is by far the best CHC we have seen in the three states. Interestingly, the state minister of health had his mother admitted there while we were visiting. It takes Rs 2.5 million to run this hospital including electricity, water, salaries for doctors including unfilled vacancies, and costs of medicines.

Photograph 7.4 Sagwara CHC, District Dungarpur, Rajasthan

(September 2008)

Specialists on Contract

DC and DPM have proposed to hire specialists on contract with NRHM funds. Given that it is a tribal district, they have serious shortage of MOs, specially specialists. Fifty percent of all MO posts and about 90 percent

positions for specialists are unfilled at DH and CHCs. Contract will give them a monthly salary of Rs 40,000 (the starting pay for specialists in private sector is about Rs 60,000–80,000) for visiting CHC or DH for 2–3 set days per week for OPD).

3.6. Future Steps

3.6.1. Manpower

Medical and Para-Medical Staff

Special attention needs to be paid to the issue of medical and paramedical staff. Possible long-term solutions require incentives to attract highly qualified and experienced physicians, such as more competitive compensation, proper living facilities for those posted in rural areas, provisions for their children to attend schools in the nearby city, and so on. Also required is increase in the number of government medical schools and nursing schools to train more staff. Recent graduates should be required to spend certain number of years in rural duty after graduation early on in their careers while they are more flexible in terms of the places of posting similar to what is done in Haryana and Punjab. While more physicians and paramedical staff are trained, this situation can be tackled through hiring physicians on contract with competitive compensation. Dungarpur has a plan to hire specialists for two or three days per week to see patients in out-patient clinics in rural areas for Rs 40,000. Assam has hired physicians to work in their boat clinics to service its riverine islands for Rs 35,000 per month. These physicians spend days on the boat, working on the island in the Brahmaputra and sleeping on the boat. They have to be compensated appropriately in order to have proper participation. Clearly it does not work to hire a specialist for Rs 1,000 per day while they spend Rs 500 one way on transportation to the rural site, like it was tried in UP.

Dais

We saw dais functioning as an integral part of the health system. They have been in the community for a long time and are widely trusted. Many of them are working full time at the SC and helping at the PHCs already assisting in deliveries. Many MOs in UP and Rajasthan reported that a dai actually taught them a technique or two to safely undertake a tough delivery. Since they are already part of the community and help ANMs and ASHAs in conducting safe deliveries, there should be an incentive built in for them so that we do not marginalize them and keep them in the system. In some remote districts like Jaisalmer and Barmer, dais were bringing most of the women for institutional delivery and then assisting at the center. In district Allahabad we saw there is a conflict of interest between ASHAs and dais to bring in a woman for delivery. In reality their

work is complementary. ASHAs have the knowledge and the training, but dais have the technical skill and experience. If we can pay ASHA and dai together for bringing in a woman (while ASHA runs around getting the paperwork done, dai can stay with the woman and assist with the delivery), we will better accomplish the goal of safe delivery and spreading awareness. Dais currently are being paid out of ANM's pocket (Rs 150 or so a day) or by tips from the families of the pregnant woman. Even Rs 100 per delivery would be highly acceptable to them, we were told.

ASHA

ASHAs need to be empowered and strengthened in the community. Two modules of training have been accomplished in all the three states. Although modules vary by state the content is essentially the same as what has been designed by government of India. However, from what we saw, ASHAs were lacking knowledge on their role in VHSC. They were unclear as to how to get paid for the work that they were performing. JSY payments are straightforward. However, for other community work that an ASHA does, like motivating women or men for sterilization, they need to be trained so as to know how to make sure they are paid the appropriate amount and on time. Also, there were a few places, like district Varanasi and district Dungarpur, where we encountered ASHAs who were highly educated and were doing a great job. There needs to be a career track for such women, like support for ANM training, to keep them in the system and motivate them to continue to perform well. Another incentive structure for ASHA, that we heard from the health minister of Assam, Dr Himanta Sarma, was to increase incentive for ASHAs to Rs 2,000 for care of pregnant mothers from time of conception up to the last vaccination for the child. This will increase incentive for ASHAs by Rs 1,400, but would more importantly help ensure complete immunization for most children. This task would be made even more realistic with the implementation of Pregnancy Tracking System, as discussed above, which would not only make sure that all women deliver safely, but would also help monitor vaccination schedule of all children.

Communication between ASHAs, anganwadi workers, ANMs, and PRI is essential for the success of this program. We are hopeful that as ASHAs become more aware of their role in VHSC and as VHSC becomes more active in these states, this communication gap will be filled. Kamrup district in Assam was the only place where we saw this (Photographs 7.5 and 7.6). It presented a great example of this communication model where ASHAs, anganwadi workers and ANMs were constantly in touch. They met formally in meetings on Wednesday (health day) and on first Saturday of every month and also have significant informal communication about specific women whom all of them are taking care of.

Photograph 7.5 ASHAs, ANMs, AWWs, and PRIs, Kamrup District, Assam

Photograph 7.6 ANMs and Nurses in Rural Assam, Kamrup District, Assam

3.6.2. Infrastructure

All the states that we visited were lacking in infrastructure to take care of the huge load of JSY patients. Although there are detailed facilities surveys on the requirements of each center as per Indian Public Health Standards, the facilities are in a poor physical state in spite of the untied funds, RKS funds, and maintenance grants available under NRHM. Infrastructure building needs to keep up with the demand to deliver quality care. Medical supervisor needs to be encouraged to take initiative to use these funds as he sees necessary for the betterment of the facilities. In order to accomplish this, funds should also be released on time, which was an issue in various places, especially in MP. It may help if the CMO reviews the annual PIP with the all MOs to give an idea as to how to spend the money.

3.6.3. Communication and Management

In places where we saw policies implemented appropriately, DCs were very heavily invested in accomplishing the goals of NRHM like in districts Dungarpur in Rajasthan and Jhansi in MP. This only speaks of the importance of good leadership and management in the success of this program. Although DHS and VHSC were

not active in every district yet, in order to make sure that the facilities were purchasing the equipment they needed, DC of Dungarpur would have meetings with the supervisors of each facility, go through their facility survey in detail and help them purchase the required equipment. This provides direction in utilization of funds and sets a good model for medical supervisors to take initiative wherever they see gaps in their facility.

Communication between NRHM staff and the permanent government medical staff is lacking in most places we visited. The problem was especially visible in district Jalaun in UP. It may be helpful for the mission director to clarify to everyone that they are all working towards the same goals and that the NRHM employees are also government employees.

3.6.4. Pregnancy Tracking System

As discussed above, this innovation in Dungarpur can be very useful in all of the states that we visited and for that matter for all the 18 HFS of NRHM. This will not only keep a live database of all the pregnant women with vital information of them including expected date of delivery, which will help the staff on the ground follow up with these women. It can also eventually be extended to keep vaccination information of the children that are born. currently a similar system is functional in Tamil Nadu It will be worth the effort to study the model further.

Some of the challenges related to NRHM that were recurrent in various field visits in Rajasthan, Uttar Pradesh, Madhya Pradesh and Orissa are elaborated further.

3.6.5. Management

1. Integration of the new contractual staff with the previously existing healthcare administrative staff has not been accomplished. In Haryana, District Program Managers (DPMs) complained of lack of flexibility. Similarly, in Chittorgarh district, all of the BPMs and the DPM reported that they lacked space to carry out their responsibilities. In district Azamgarh, the DPM, who is responsible for NRHM- related projects in the district, was not invited to the DHS meeting. Even though both the Chief Medical Officer (CMO) and DPM have to sign on the checks related to NRHM, this has not been implemented yet.

2. Doctors are too overburdened with non- clinical duties and the ones in administrative positions lack the training to actually do their job well. In Nimwara block the BMO, who formerly worked as MO in the same block, suggested how burdened the MOs were with clinical, administrative, civil, financial, and training duties. Their leading capacity is lacking and all the enthusiasm is beaten out of them by overload of work. Activities are added without enough support and without any incentives to perform well. Hence most of them get fed up of the system and have no desire to take initiatives. Further, as per Nimwara BMO, no priorities are communicated and program implementation plan is not discussed at the block level.

3. Management of ASHA work and training has not been consistent in quality. In Azamgarh district in UP, a group of ASHAs who we spoke with had varying levels of knowledge about their job. Also staff nurses at the DH were frustrated since ASHAs are unclear about the various forms that they need to fill out. JSY has created a nuisance for the hospital staff since ASHAs are often fighting with them to get their names on the deliveries even if they showed up after the delivery. We actually got to witness one such incident where the ASHA wanted to get the money for JSY even though she was late and did not have any records that supported that she had accompanied the pregnant woman for ANC checks. No part of the training deals with the logistics of ASHA's duties, which creates more work for the hospital staff.

4. Orissa had been innovative with its management structure to meet the needs of the state. In Orissa, in addition to DPM and accountant, a DPU also consists of health information officer, district ASHA coordinator, works consultant (who looks over civil work since that state is undergoing massive construction work) and two assistants. This structure provides for better management of extensive NRHM schemes. Also computers are provided in 85 percent of CHCs and PHCs with Internet facility for better communication and data management. Orissa has also created a PPP model in areas where PHCs and SCs are not doing well and NGOs are more active. Facilities are given to these NGOs to run the centers. Ninety percent of resources are provided by the state and 10 percent by the NGO (Karuna Trust). Orissa is also working with the Geographic Information System, live database where infrastructure, HR, and location of health facilities are collected and updated every month and then correlated with maps. Urban Health GIS uses it to locate doctors in any city and also to list all the facilities in any particular institution (http://www.orissa-health.org). Orissa also has been very active in making VHSCs functional. Ninety-one percent of VHSCs are operational and 72 percent have bank accounts. At GKS meeting in Kanpura, Thandemunda and Barasal villages it was clear that ASHAs and ANMs are fully aware of their responsibilities and utilization of untied funds for SC, but VHSC funds are still underutilized. ASHAs in their uniform and very articulate: impressive knowledge about their job. SC ANM clear on utilization of funds, but GKS not clear on what do with their money, hence GKS money is untouched (see Photographs 7.7 and 7.8).

Photograph 7.7 ASHA, ANM, PRI, Anganwadi Worker and Various Villagers Present at the VHSC Meeting at Kanpura Village, Kamakanagar Block, District Dhenkanal in Orissa

(February 2009)

Photograph 7.8 VHSC Meeting at Village Barasal, Kankadahad Block, District Dhenkanal, Orissa

(February 2008)

5. Untied funds are underutilized partly because of the culture and partly because of lack of training and clear instruction on how to utilize them. This is the first time that there are untied funds at each HF level to be utilized for anything that might be needed to improve the quality of service. The medical staff is not used to this and no one wants to take initiative to spend the money as they constantly worry that they will be questioned on the expenditures. In addition, there is lack of communication from district level below regarding how to utilize these funds. For example, in Haryana, during the financial year 2007–08, Rs 1.8 million out of Rs 2 million of untied funds were unspent. In Budhakera SC, residential ANM was not aware of where and how to purchase the items she needed. Similarly, in Newal delivery hut, (SC given additional Rs 100,000 to equip for institutional deliveries), the ANM did not know how to spend the money and was not sure who to ask. MO at the PHC under which Newal delivery hut fell, tried to maintain tight control over the money. Karnal DH (Photographs 7.9 and 7.10) and Shahbad CHC were very dark and dirty, while both the hospitals had plenty of funds. Shahbad CHC had 5 MOs and a complete medical staff. However, there is a lack of coordination of policies and funds because of lack of a real leader with a clear understanding of how best to use these funds. As a result, Rs 250,000 are unspent because the doctors are too busy with clinical responsibilities to focus on planning expenditures for the hospital.

Photograph 7.9 Labor Room with Rusted Labor Table and Dirty Linen in District Hospital Karnal, Haryana

(February 2008)

Photograph 7.10 Disposable Gloves Reused Multiple Times in DH Karnal

The other challenge is the proper management and accountability of these funds. In district Chittorgarh, Nimwara BMO suggested that keeping track of all the funds is a huge task. For example, his block has 150 VHSCs, which means Rs 10,000 × 150 = Rs 1.5 million that need to be distributed just at a block level. If the system becomes truly decentralized at the block level, accountants and managers are needed to make sure that this amount is well-utilized and the policies are implemented.

In some states, several districts are not receiving funds on time because of various reasons. In district Sagar in Madhya Pradesh, medical officer-in-charge of Dhana PHC reported that funds are not received on time and there is no instruction as to how to utilize them appropriately. For the financial year 2008–09 funds were received in February and needed to be spent by March. E-banking is only up to district level in Madhya Pradesh. Accountant at CHC Rehali elaborated on delay of untied funds suggesting that they are received late because utilization certificates that need to be sent from the block to the state are all delayed. One of the MOs at Azamgarh DH informed us that the untied funds are underutilized because RKS is not functional, mainly because it is multi- departmental and everyone wants a cut from the funds to sign off checks to release the funds. For untied and annual maintenance funds as well, when utilization certificates (UCs) are submitted, they are asked for a percentage of the amount they have spent assuming that part of it must have been pocketed by the MO submitting the UC (Photographs 7.11 to 7.14).

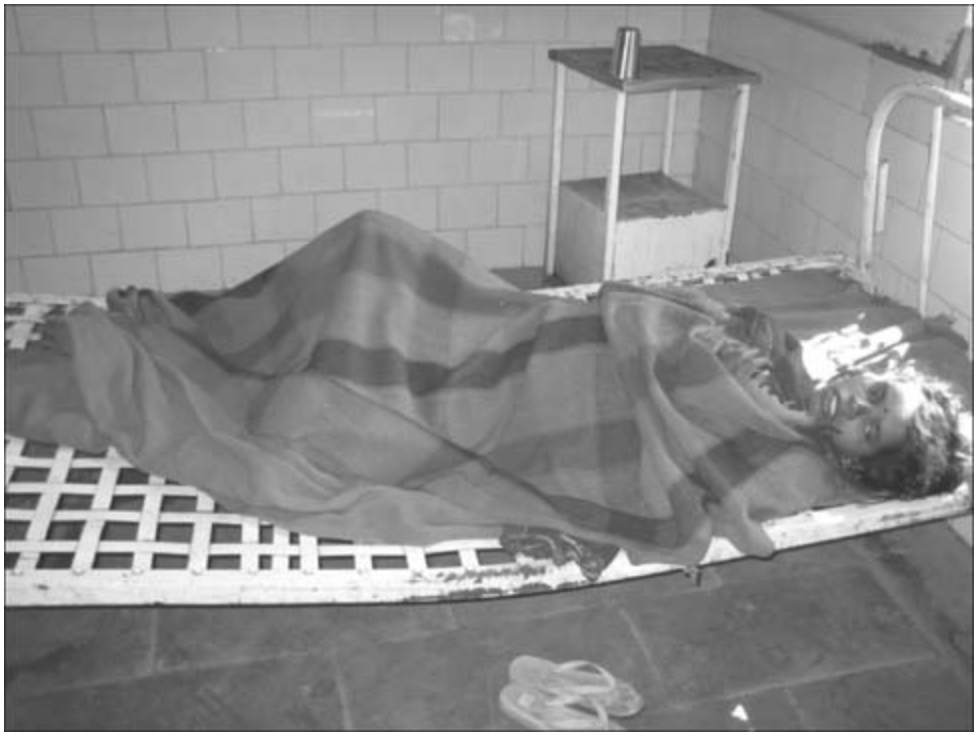
Photograph 7.11 Rehali CHC, District Sagar, Madhya Pradesh

(February 2009)

Photograph 7.12 Unhygienic New-born Corner in the Labor Room with Old Equipment

Photograph 7.13 Maternity Ward at Rehali CHC

Photograph 7.14 Maternity Ward at Garhokota CHC, District Sagar, Madhya Pradesh



(February 2009)

Management of funds other than untied funds has been problematic as well. Funds for other programs including JSY have been delayed. Payments for ASHAs and JSY beneficiaries were not made at CHC Rehali, district Sagar, MP from July 2008 to February 2009 (Photograph 7.15). Similarly, at Garhokota CHC in MP, ASHAs had not been paid for the last seven months. In Uttar Pradesh, at Sidholi CHC in Sitapur district, we met with two ASHAs, one from village Patwa and another from village Bari. Both knew that they were supposed to be paid Rs 600 at the time of delivery, but both had to pay the MO Rs 200 each in order to get their money (Photograph 7.16).They were unaware of availability of funds for transportation of patients and they were taking one of their patients, who had been referred to DH for bleeding complications, on a rickshaw and then a bus to the DH.

Photograph 7.15 ASHAs at Sidholi CHC, District Sitapur, Uttar Pradesh

(February 2009)

Photograph 7.16 Block Accountant's Records and Papers at Rehali CHC, District Sagar, Madhya Pradesh

(February 2009)

At Biswan CHC in Sitapur, we met with two ASHAs, one from Bhagipur who had facilitated six deliveries in 1.5 years and the other from Manpur who had facilitated 64 deliveries in the same time period. The one from Bhagipur explained that people do not want to deliver in the hospital because of the distance and also because others from the village did not get payment on time. Both these ASHAs had not received payment for deliveries for the month of December and January and previously had to pay money to the MO to get their JSY payments. MOs in charge of these hospitals were away for a meeting, and no one else at these centers had any idea about untied funds or other NRHM related funds and how they are utilized. In the Azamgarh district hospital, a group of ASHAs we spoke with informed us that each of them had to pay something to get their payments at the block level for deliveries. Out of the 15 ASHAs present there none had received any

payment for works other than ID, sterilization and pulse polio. They also told us that patients do not receive payments on time at the block level and had to visit as many as ten times before they could get their checks.

Orissa has been able to deal with some of the issues mentioned earlier. It has established a system of e-backing all the way down to block level. As a result, UCs are received on time and untied funds are sent electronically. There is block-level training of SC ANMs on utilization of funds. PIP of the district is discussed with MO. As a result untied fund utilization has gone up to 60 percent in one year.

3.6.6. Human Resources

In all the states we visited, hospitals are short of medical staff, especially physicians. They are paid significantly less in the public sector compared to the private sector. Hence, a lot of posts lie unfilled, especially in the rural areas. Physicians, who do join, continue to have private practice and are not always present at the hospital for their duties.

In Haryana, doctors are paid as per the 6th pay commission with the base salary of Rs 16,000 that adds up to about Rs 40,000 per month with allowances. Young physicians are required to spend two years in rural duty before applying for their postgraduate positions. Prior to implementation of the 6th pay commission, 42 out of 67 positions were filled in Karnal district. This ratio is expected to go up with the new pay scale. In Rajasthan, however, MOs are paid Rs 16,000 base salary and a rural allowance of Rs 4,000. Even though 1,700 rural medical officers were appointed, 150 resigned, and 250 never joined because of the low salary and high workload.

ID in Karnal district in Haryana are up from 47 to 72 percent. Dais are very active in the field. Until recently they were given Rs 100 by Red Cross to bring deliveries to the center. (ASHAs are also given Rs 100 per delivery.) Under the Jacha Baccha Scheme, ANMs are given incentive for ID. After three deliveries they are given Rs 400 for a baby girl and Rs 250 for delivering a boy. MOs and staff nurses are also given incentives after three deliveries to discourage home deliveries. However, in Chittorgarh, ID is behind target. For the year 2008–09, there were only 17,000 IDs performed as against the total of 29,000 deliveries (75 percent). As per the DPM, that has been because of lack of commitment on part of the staff. There are no real incentives for ANMs and MOs to encourage IDs specially when they are paid more by the families for delivering at home. Also, there is no career track built for paramedical staff to excel in accomplishing goals of NRHM.

In Pahuna PHC in district Chittorgarh, no MO was present. Dindoli PHC was locked when we visited. There had been only four deliveries conducted there in the last year. In Sagar block CHC only five deliveries were conducted over the last year and has an OPD of 20 patients per day. Physicians do not visit the hospital. When asked, the BMO-in-charge explained that the number of OPD patients is low because of low prevalence of disease in this block! Although a BPM has been appointed and travels 100 km one way for work, he has no real power. Out of Rs 300,000, Rs 200,000 remains unspent. For the spent amount, the BMO and the doctor have negotiated deals with the vendors. However, Rashmi CHC was overcrowded and visibly high patient load with about 150 IDs per month and an OPD of 150 per day. This was primarily because a surgeon was regularly present at the hospital.

Orissa has 4,000 positions of MOs filled out of the sanctioned 8,000. Also 1,476 on-contract physicians (mostly AYUSH) have been appointed. To encourage physicians to join the public sector, they are appointed at

class one scale as opposed to junior scale. Instead of starting at 8,000 plus allowances, now they are at 15,000 plus allowances with a total of Rs 28,000 per month. The major issue, however, is how to spread the work in the community, especially in some of the deep tribal areas. Physicians are given additional Rs 5,000 to work in tribal areas. Such areas like Kankadahad block where there is no water or electricity poses significant challenges. Even though there is serious need of a health facility in this area, it cannot run without a source of water. It is very hard for a physician to live in such an area. One of the MOs appointed to this PHC described it as a “punishment post”.

In district Azamgarh, ASHAs are bringing most of the deliveries to the DH instead of going to the nearest CHC or PHC. Burden of normal deliveries for the DH has increased dramatically with almost 300 IDs per month. However, there is only one obstetrician who manages the gynecology OPD of about 100 patients per day, training of students and staff, and so on. Labor room area and wards were, of course, very crowded. In this district, similar to others we visited in UP, about 30 percent of the ASHAs have been handpicked by the pradhans who happen to be their relatives. This causes problems in actually getting the work done. VHSCs are not active yet and pradhans demand money from ANM to sign on anything for the SC. We had an opportunity to attend one of the ASHA training sessions in Azamgarh DH. Training was being held in a small room by one of the PHC MOs. All the ASHAs had module II and about 50 percent were able to explain what they had learned in the first module. They all had been paid for the training period and provided with room and board for the period of training (Photograph 7.17).

Photograph 7.17 An ASHA Training Session in Progress at District Hospital Azamgarh, Uttar Pradesh

(February 2009)

3.6.7. Infrastructure

In most of the HFSs we visited, IDs were going up significantly, but infrastructure was lagging behind. Most of the SC buildings in Haryana and Chittorgarh are running in rented buildings. The Karnal and Kurukshetra DHs in Haryana were in abysmal conditions. Although newly constructed centers are coming up like Bhadson PHC in Haryana, such centers are rare.

Rehali and Garhokota CHCs in district Sagar in MP were the most poorly maintained CHCs with maternity wards without mattresses and blankets, dogs roaming in the maternity wards, and very poorly lit labor room with rusted equipment (Photographs 7.18 and 7.19). Gloves, medicines, or injections were not available. One of the patients at Garhokota CHC reported that he was asked to go and purchase these, although untied funds had just been received at this CHC. MO-in-charge, who had not been present when we arrived and was called later, did not have much idea of what had been done with the funds. Either way, looking at the condition of the hospital it was clear that not much had been done and no one was really interested in infrastructure and quality of services of this hospital. In Pahla PHC in district Sitapur, there were not enough beds for the patients, linen was very dirty, and no sweepers had been hired through RKS. None of the MOs were present, and the staff present was unaware of untied funds.

Photograph 7.18 Maternity Ward Beds without Mattresses in Garhokota CHC, District Sagar, Madhya Pradesh (February 2009)

Photograph 7.19 Dirty Bathrooms and Roaming Dogs in the Maternity Wards at Garhokota CHC, District Sagar, Madhya Pradesh

(February 2009)

Gop CHC in Orissa with 200 out-patients per day and 150 IDs per month had a very poorly maintained labor room with water leaking and without electrical fittings. Wards were dirty and without mattresses on the beds. This was surprising since untied funds were unused and training for utilization of untied funds had already been done. The DPM informed us that the BMO does not like to get the DPU or the BPU involved in helping with utilization of untied funds and he lacks the motivation to do so on his own. Cleaning and security has been outsourced for Rs 29,000 per month for cleaning with 12 sweepers and Rs 27,000 per month for security with 15 guards in some of the centers. The results have been remarkable. However, so far it is limited to the DH and FRUs. Orissa is undertaking a lot of construction work related to NRHM. Hopefully a lot of the gaps related to physical infrastructure will be filled as hospital buildings are renovated and SCs are constructed, with running water and power supply.

Notes

1. Data reported by the Registrar General of India in May 2009. Assam with 480 per 100,000 live births has the highest MMR in India.

2. According to the Registrar General of India (May 2009) as per the Sample Registration System. MP with 72 and Orissa with 71 have higher IMR than UP.

3. These are some other districts that we visited in UP other than our focus districts.

4. Singh, P.V. (2009).