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

Health Sector in Rural India

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INDIA'S ACHIEVEMENTS in the field of health leave much to be desired and the burden of disease among the Indian population remains high. Infant, childs and maternal mortality and morbidity affect millions of children and women. Infectious diseases such as malaria and TB are reemerging as epidemics and there is the growing specter of HIV/AIDS. Many of these illnesses and deaths can be prevented and/or treated cost- effectively with primary healthcare services provided by the public health system. An extensive primary healthcare infrastructure provided by the government exists in India. Yet, it is inadequate in terms of population coverage, especially in rural areas, and grossly underutilized because of the dismal quality of healthcare being provided. In most primary healthcare centers, drugs and equipment are missing or in short-supply. There is shortage of staff and the system is characterized by endemic absenteeism on the part of medical personnel due to lack of control and oversight.

As a result, most people in India, even the poor, choose expensive healthcare services provided by the largely unregulated private sector. Not only do the poor face the double burden of poverty and ill-health, but also the financial burden of ill health can push even the non-poor into poverty. On the other hand, a healthy population is instrumental for both poverty reduction and economic growth, two important developmental goals. In India, public spending on health is less than 1 percent of its GDP, which is grossly inadequate. Public investment in health, particularly in primary healthcare needs to be much higher to achieve health targets, to reduce poverty and to raise the rate of economic growth. Moreover, the health system needs to be reformed to ensure efficient and effective delivery of good quality health services.

The average figures for India hide a great deal of variation in the performance of different states, which are on different points along the health transition path. Health transition has three components—demographic, which involves lowering of mortality and fertility rates and an aging population; epidemiological wherein the pattern of diseases prevalent in the population changes from communicable to non- communicable such as the chronic diseases of adulthood; and social whereby people develop better ability to self-manage their health and have better knowledge and expectations from the health system. While Kerala, Maharashtra, and Tamil Nadu (TN) are much further along in the health transition trajectory, the densely populated states of Orissa, West Bengal, Bihar, Rajasthan, MP, and UP are still in the early part, with the other states falling in between. For instance, while in Kerala life expectancy at birth is 72; in MP it is merely 56. A few states and about a quarter of the districts account for 40 percent of the poor and over half of the malnourished, nearly two-thirds of malaria and kala azar,[1] Leprosy, infant and maternal mortality, diseases that can be easily averted with access to low-cost public health interventions such as universal immunization services and timely treatment.

Apart from variations due to income and education, health status in India varies systematically between rural-urban location, membership of scheduled castes and tribes, and age and gender. Health indicators for rural areas compare unfavorably with urban areas; people belonging to scheduled castes and tribes have much poorer health compared to those belonging to the upper castes; and children and women in India suffer grossly from the burden of disease and ill-health. Morbidity among women and children is endemic in India.

1. Dysfunctional Sub-Centers and Primary Health Centers (PHCs)

The rural primary healthcare system in northern and central India is, for the most part, dysfunctional. While being extensive, it is wasteful, inefficient and delivers very low quality health services, so much so that the private sector has become the de facto provider of health services in India. The geographical and quantitative availability of primary healthcare facilities, though extensive, is far less than the guidelines laid down by the government.

Access is important but people's experiences of what the facility has to offer in terms of medical care and whether it is worthwhile to use it are equally important. People's perception of “free” care is that of low quality. Therefore, even the available infrastructure is grossly underutilized, that is the public healthcare system in India suffers from gross supply side distortions that go beyond physical availability. This affects the delivery of basic services to its large population of poor whose quality of life depends on public goods. The simple availability of a building designated as public health facility is no guarantee that it is functional, and if it is, whether accessible to groups of people who may be restricted in their use of public healthcare services on account of caste, religion or gender. Even setting aside socio-economic barriers to access, and assuming the presence of a public health facility close at hand, the delivery of quality healthcare services is not guaranteed. The infrastructure is of poor quality and there is severe lack of even basic drugs and equipment. This is especially true for rural areas, and with regard to women's and children's health. Maternal, infant, and child morbidity and mortality rates are intolerably high in India. Not only social justice but also economic efficiency is compromised as India does little to protect the health and well-being of its future generations.

Like the public education system in India, the large public health system is also marred by endemic absenteeism and neglect on the part of healthcare providers. By way of incentives the employees are guaranteed a salary. There is little or no monitoring of and accountability by them. This removes any punitive pressure that acts as a corrective measure. Even the private sector, which provides most of the health services in India, is largely unregulated and there is no gate keeping on the standards of clinical practices adopted. Healthcare requires not only physical infrastructure and equipment, but also skilled and specialized human capital in the form of medical training and qualifications. Given the asymmetry of information between a doctor and his/her patient, low quality of medical consultancy not only lowers the efficacy of the health system, but can endanger people's health. The problem of unavailability of healthcare personnel is two-fold, especially in rural and remote areas. (*a*) In many cases, rural health posts remain vacant because of unwillingness on the part of qualified doctors and other healthcare workers to accept the placement. (b) Due to lack of effective monitoring and weak or non-existent accountability, even when a post is filled, the healthcare provider may simply be absent. While in both cases, public healthcare services fail to get delivered, absenteeism is costlier because it has an associated salary burden (Chaudhury et al. 2003).

One government failure in the health sector is the lack of any systematic efforts to track the system and facilities. There is no system in place to collect data on a regular and standard basis from service providers, nor is there any periodic evaluation of health personnel on their technical competence and ability. While, on paper, inspection and supervision and visits to healthcare facilities are provided for, there is little implementation. Without a reliable surveillance system and systematic data collection, the prevalence, magnitude, distribution, and modes of transmission of diseases cannot be judged and no rational basis exists for the formulation of appropriate policies. An integrated health management system with the use of information technology, to be discussed later in this book, could greatly assist this task.

The rural healthcare structure is extremely rigid, making it unable to respond effectively to local realities and needs. For instance, the number of auxiliary nurse midwives[2] (ANMs) per PHC is the same throughout the country despite the fact that some states have twice the fertility level of others. Moreover, political interference often results in an irrational distribution of PHCs and sub-centers. Government health departments are focused on implementing government norms, paying salaries, and ensuring minimum facilities rather than measuring health system performance or the outcomes. Further, the public health system is managed and overseen by District Health Officers. Although they are qualified doctors, they have barely any training in public health management. Strengthening the capacity for public health management at the district and taluk level is crucial to improving public sector performance. Also, there is lack of accountability, which stems from the fact that there is no formal feedback mechanism. How can the management capacity be strengthened and a feedback mechanism established? We examine some of these issues later in this book.

The highest priority for scaling up health services in rural areas is at the community level, (sub-centers, PHCs and Community Health Centers (CHCs)) where actual health services are delivered. Scaling up at this lev-

el would involve basic strengthening of the staffing, adequate supply of drugs and vaccines, and at least a minimal facility of transport. It also involves both the hard infrastructure of the health sector (buildings, diagnostic equipment, telephone, and possibly e-mail connectivity of these centers) and the soft infrastructure (better systems of management and supervision and better accountability to the users through local oversight of these centers). We believe that without strong community involvement and trust in these centers, the expanded and effective coverage of the rural poor is unlikely to be achieved. How can this be done? We will discuss some ideas towards the end of this book.

2. The National Rural Health Mission (NRHM)

It is under the above background that the National Rural Health Mission (NRHM) was launched by the Prime Minister on April 12, 2005 in an effort to improve public health services with a special focus on states with weak public health infrastructure and indicators. The NRHM has 18 high-focus states. The goal of the Mission is to improve the availability of, and access to, quality healthcare for people, especially for those residing in rural areas, the poor, and women and children, thereby bridging urban-rural disparities.

NRHM is undoubtedly the most ambitious rural health initiative to be launched in independent India by the United Progressive Alliance (UPA) government as a part of their Common Minimum Program. It has a time frame of seven years from 2005–06 to 2011–12. Thus it covers two years in the Tenth Five Year Plan (2002–07) and the whole of the Eleventh Five Year Plan (2007–12). It is essentially an initiative to meet some key health sector goals, where India seriously lags behind and was considered off-track in achieving the Millennium Development Goals (MDGs) by the year 2015 (Bajpai and Goyal 2004a, Dholakia et al. 2004). These MDGs related to infant mortality rate (IMR) and related indicators about maternal and child nutrition and health; and maternal mortality rate (MMR) and related indicators of institutional deliveries, ante-natal and post-natal care, and so on.

Rural areas in certain states arguably had extremely poor primary healthcare infrastructure both in terms of quality and quantity. Massive scaling up effort would be needed to provide improved quantity and quality of primary healthcare. A detailed study was carried out by the Earth Institute, Columbia University and the IIM, Ahmedabad over four years covering six major states in the country, namely UP, MP, and Rajasthan in northern India and AP, Karnataka, and TN in southern India (Bajpai and Dholakia 2006, Bajpai et al. 2005, 2008a, b). This study estimated the scaling up effort required to provide adequate facilities as per the existing norms of services to cover the whole rural population of the states in terms of both manpower and financial resources. Table 2.1 provides a summary of the financial estimates for the six states.

Table 2.1 Estimates of Resource Requirements to scale up primary Healthcare in Rural Areas of selected states in India

States	Year	Additional resource requirements*		Additional effort as % of current budget allocation to health**
		Per capita (in Rs)	Total (in Rs billion)	
Madhya Pradesh	2006–07	262	17.42	115
Uttar Pradesh	2006–07	288	52.58	116
Rajasthan	2007–08	263	16.90	49
Andhra Pradesh	2008–09	203	16.89	49
Karnataka	2008–09	144	8.59	35
Tamil Nadu	2009–10	133	8.88	31

Source: Bajpai et al. (2005, 2008a, b).
Bajpai and Dholakia (2006).
* Includes both recurrent and capital expenditures.
** Health includes sanitation and water supply besides Family Welfare schemes.

It is clear from Table 2.1 that (*a*) the available healthcare facilities in rural areas differ considerably from state to state; (*b*) each state has at least some deficiency in the facilities even in the quantitative terms compared to the existing norms of the satisfactory service level; (c) the magnitude of the scaling up efforts required as a percentage of the current budget allocation to health, sanitation, and water supply differed substantially; and (d) the requirements of additional resources are enormous in absolute terms in some of the large states. Moreover, the considerable interstate variation in the healthcare infrastructure also indicates substantial variations in the health output and outcome indicators. District Level Health Survey (DLHS) have been conducted every 4 to 5 years since 1998–99. The data on selected health outputs and outcomes for the year 2003–04 available from the second DLHs are summarized in Table 2.2.

Table 2.2 Health Output and Outcome Indicators for Indian States, 2003–04

States	Unmet needs (in %)	Women taking at least 3 ANC checkups (in %)	Fully immunized children (in %)	Institutional deliveries (in %)	Infant mortality rate (2003)
High Focus States					
Bihar	38.3	16	20.7	18.8	60
Chhattisgarh	22.1	44.4	56.9	18.1	70
Himachal Pradesh	11.8	64.9	79.3	45.1	49
Jharkhand	34.2	27.5	25.7	21.2	51
Madhya Pradesh	21.2	32.3	30.4	28.7	B2
Orissa	19.8	41.7	53.3	30.8	B3
Rajasthan	22.1	28.8	23.9	30.3	75
Uttar Pradesh	34.3	21.5	25.8	21.4	76
Uttarakhand	26.9	21.2	44.5	24	41

Assam	23.6	39.4	16	23.2	67
Meghalaya	55.3	42.8	13.5	32.5	57
Mizoram	25	54	32.6	52.6	16
Sikkim	18.2	66.7	52.7	57.8	33
Tripura	24.8	62.7	32.6	61.1	32
Non-High-Focus States					
Andhra Pradesh	10.7	86	62	59.4	59
Chandigarh	15.3	73.6	53.5	47.4	19
Delhi	16.4	67.2	59.2	50	2B
Goa	43.1	84.3	76.9	91.2	16
Gujarat	16.3	57.3	54	52.2	57
Haryana	14.7	43.1	59.1	35.7	59
Karnataka	15.1	78.6	67.8	57.9	52
Kerala	15.1	96.5	78.5	97.6	11
Maharashtra	12.6	69.2	70.9	57.9	42
Puducherry	16.6	97.8	89.3	97.2	24
Punjab	10.3	63.5	72.9	48.9	49
Tamil Nadu	18.1	94	91.4	86.2	43
West Bengal	11.2	62.7	5.3	47	46
Source: DLHS 2 (2002–04).					

It can be seen from the Table 2.2 that there is a marked variation in all these healthcare outputs and outcome indicators. The southern states with the exception of Orissa have relatively more favorable levels of these indicators. The northern states with the exception of Delhi, Haryana, and Punjab, on the other hand, have relatively unfavorable levels of these indicators. Thus, in terms of healthcare indicators, there is a clear north-south divide. In order to reduce the interstate disparity in healthcare related indices and thereby in the living conditions and quality of life among states, UPA government launched the NRHM as a central government initiative, to begin with, in the 18 states with weaker health indicators clubbing north-eastern states with the weaker north Indian states and Orissa. These 18 states were called High Focus States (HFS). However, since data on Arunachal Pradesh, Jammu & Kashmir, Manipur, and Nagaland were not available, these states have not been included in the table.

Expenditure on health by governments in India declined from 1.3 percent of GDP in 1990 to only 0.9 percent in 1999. The central government contributed only 15 percent while the state governments shared 85 percent of such expenditures. The health and family welfare programs displayed only a limited extent of synergy and coordination at the implementation level. The health related issues like sanitation, drinking water, hygiene, and nutrition were not integrated with health programs. Hospitalization is very expensive for an average rural

resident requiring about 58 percent of his total annual expenditures. Almost 40 percent of those hospitalized have to borrow heavily or sell assets to meet the expenses, and more than a quarter of the persons hospitalized fall into poverty on account of the hospital expenses. The curative health services are heavily biased for the non-poor in the sense that “over every Rs 1 spent on the poorest 20 percent population, Rs 3 is spent on the richest quintile”. Lack of community involvement and ownership of public health programs has led to poor accountability and effectiveness of such programs.

The NRHM's vision, strategies and its various components are described on the NRHM website and its documents as follows:

2.1. Vision

The vision of the Mission consists of the following main elements:

- Provide effective health care to rural population throughout the country.
- commitment of the central government to raise public spending on health from 0.9 percent to 2 to 3 percent of GDP.
- Undertake architectural correction of the health system to enable it to handle effectively increased allocations.
- Promote policies that strengthen public health management and service delivery in the country.
- Revitalize local health traditions and main-stream Ayurveda, Yoga, Unani, Sidha, and Homeopathy (AYUSH) treatments into public health systems.
- Decentralize programs for district management of health.
- Define time bound goals and report publicly on their progress.
- Improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

2.2. Strategies

The strategies of NRHM are divided into core and supplementary strategies.

2.2.1. Core Strategies

- Divide the whole country into HFS and the rest. The HFS are those 18 states which have weak public health indicators and/or weak infrastructure. All north-eastern states are included in HFS. This is done to reduce regional imbalance in health infrastructure.
- Enhance capacity of Panchayat Raj Institutions (PRIs) to own, control, and manage public health services through continued training.
- Install a female health activist at the village level to ensure household level access to health care.
- Prepare Health Plan for each village through a local team of the panchayat.
- Strengthen sub-centers through a untied fund for local planning, action, and induction of more Multipurpose Workers (MPWs).
- Strengthen existing PHCs and CHCs to meet Indian Public Health Standards (IPHS) normative standards and provide 30- to 50-bed CHC per 100,000 people to improve curative health care.

- Implement an inter-sectoral District Health Plan including drinking water, sanitation, hygiene, and nutrition prepared by the District Health Mission (DHM).
- Integrate the vertical health and family welfare programs at block, district, state, and national levels.
- Provide technical support to national, state and district health missions for public health management;
- Strengthen capacities for data collection, assessment and review for evidence-based planning, monitoring, and supervision.
- Formulate transparent policies for deployment and career development for human resources for health.
- Develop capacity for preventive health care at all levels for promoting healthy life styles and reduction in consumption of tobacco, alcohol, and so on.
- Promote non-profit sector, particularly in underserved areas.

2.2.2. Supplementary Strategies

- Regulate private sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.
- Promote Public-Private Partnership (PPP) for achieving public health goals.
- Revitalize local health tradition by mainstreaming AYUSH.
- Reorient medical education to support rural health issues including regulation of medical care and medical ethics.
- Provide health security and insurance to the poor by ensuring accessible, affordable, accountable, and good quality hospital care.

2.3. Components of Action Plan

There are 10 components for the action plan of NRHM as follows:

2.3.1. Accredited Social Health Activists (ASHAs) Selection and Training

Under the NRHM, provision was made for at least one ASHA to be provided for every village with a population of 1000 people. The ASHA (called a Village Health Worker [VHW] in southern states) was, by design, a daughter-in-law of the village. Theoretically she is supposed to have passed at least 8th grade, but in practice the one with the highest level of schooling is nominated by the gram panchayat. These women are then made to pass a basic reading and writing test. The ASHAs generally underwent a 23-day classroom training session where they were imparted some training in dressing wounds, dispensing medicines for oral dehydration, coughs, colds, and fevers; identification of diseases like TB; prenatal and postnatal care, and community mobilization. In most cases but not all, ASHAs were also given an additional 5-day onfield practical training under the supervision of an ANM. Her induction training will be for 23 days in all, spread over 12 months, while on-the-job training will continue throughout the year. States are allowed to make modifications in the proto-

type training material to be developed at the national level. Training of trainers, using both distance learning model as well as with the help of NGOs, Integrated Child Development Scheme (ICDS) training centers, state health institutes, and so on, are provided. ASHA will be promoted all over the country with special emphasis on the 18 high focus states. The central government will bear the cost of training, incentives, and medical kits for ASHA. The remaining components will be funded under the financial envelope given to the states under NRHM.

The Medical Kit

ASHAs will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments; and the kit is supposed to be replenished from time to time. The kit consists of various first aid paraphernalia, such as bandages and cotton, oral rehydration salts (Citrate I.P.), antifungal ointment (500 gm), Gentamycin eye drops, and Antiseptic Benzyl Benzoate (450 ml bottle required to be stored in a cool dry place).

Function and Role

The main task of an ASHA is to liaison between people of her village and the ANM and the doctor of the PHC when required. She serves as the primary contact of the public health system for the people. It was envisaged that the presence of an ASHA would reduce the burden of the ANM, thereby increasing her efficiency, and also increase the outreach of health services, thereby improving access of the population to public healthcare, specifically the marginalized populations, women, and children. Not just a provider of basic curative medicines and first aid, an important part of her role was to facilitate preventive care. The ASHA motivates members of her community, especially expectant mothers, to use the health services offered and encourage institutional deliveries as opposed to potentially unsafe home deliveries.

Incentives

The ASHA does not receive a fixed salary,[3] but gets a performance-based compensation. She will be an honorary volunteer for (a) promoting universal immunization, (b) referral and escort services for reproduction and child health (RCH), (*c*) construction of household toilets, and (*d*) other health care delivery programs. She will also facilitate preparation and implementation of the Village Health Plan along with anganwadi workers, ANMs, functionaries of other departments, Self-Help Group (SHG) members, and Village Health and Sanitation Committee (VHSC) of the panchayat. The ASHA maintained a register with a log of how much and for whom she facilitated the receipt of institutional care. Once this register is verified by the ANM, it is further approved by the Sarpanch, the head of the gram panchayat. The ANM then sends a payment request to the District Level Health Officer, who will dispatch the payment to the nearest PHC. Usually payments are only dispatched once every three months. Lastly, the ANM needs to pick up the checks from the PHC and deliver to the ASHAs. Needless to say, this process is convoluted and inefficient.

2.3.2. Strengthening Sub-Centers

Each sub-center will be given an Untied Fund for local action at the rate of Rs 10,000 per year. It will be deposited in a joint bank account of the ANM and Sarpanch and operated by the ANM in consultation with VHSC. Essential drugs, both AYUSH and allopathic, will be supplied in adequate quantities to the sub-centers. Additional outlays for MPW (male), additional ANMs wherever needed, new sub-centers as per 2001 population norm, upgrading existing sub-centers including buildings will be considered.

2.3.3. Strengthening PHCs

In order to improve the quality of preventive, promotive, curative, supervisory, and outreach services, the PHCs will be strengthened through (a) adequate and regular supply of essential quality drugs and equipment, (b) provision of 24-hour services in 50 percent PHCs by addressing shortage of doctors through mainstreaming AYUSH manpower, (c) additional outlays for intensification of ongoing communicable disease control programs, new programs for control of non-communicable diseases, upgrading 100 percent PHCs for 24-hour referral service, and provision of a second doctor at PHC level (1 male, 1 female) as per need.

2.3.4. Strengthening CHCs for FRU

All the 3,222 existing CHCs should be converted into 24-hour First Referral Units (FRUs) with postings of anesthetists. IPHS norms for infrastructure, staff, equipment, management, and so on should be fulfilled by CHCs. Rogi Kalyan Samitis (RKS) or patient welfare committees should be formed for hospital management. Citizens' charter at CHC/PHC level should be developed, displayed, and complied with. Additional outlays for creation of new CHCs (with 30 to 50 beds) to meet the 2001 population norm and to meet their recurring costs for the NRHM period could be considered.

2.3.5. District Health Plan

District Health Plan would be prepared by collating Village Health Plans integrating health related sectors. District will become the core unit of planning, budgeting, and implementation. Centrally sponsored schemes could be rationalized or modified accordingly in consultation with states. vertical Health and Family Welfare programs at District and State levels would merge into a common District Health Mission (DHM) and State Health Mission (SHM). There would be a provision of project management unit for each district with contractual appointment of professionals for improved program management.

2.3.6. Converging Hygiene and Sanitation Under NRHM

The existing Total Sanitation Campaign (TSC) is also implemented through PRI. The DHM will, therefore, guide the activities of TSC through VHSC and promote household toilets and school sanitation program. ASHA would be incentivized by DHM for this purpose.

2.3.7. Strengthening Disease Control Programs

National Disease Control programs for malaria, TB, kala azar, filaria, blindness, and iodine deficiency and Integrated Disease Surveillance Program shall be integrated under NRHM for improved program delivery. New programs would be launched for control of non-communicable diseases. Provision of a mobile medical unit at district level will be made for improving outreach services.

2.3.8. PPP for Public Health Goals

This would also include regulation of private sector because it provides 75 percent of health services in the country. The regulation would be transparent and accountable. DHM must have representation of the private sector. Need-based, thematic, and geographic areas for PPP should be identified and guidelines should be developed. Public sector should play the lead role in defining the framework and sustaining the partnership.

2.3.9. New Health Financing Mechanisms

A task group will examine health financing mechanisms including risk pooling for hospital care. DHMs should progressively move towards paying hospitals for services by way of reimbursement on the principle of “money follows the patient”. Services of healthcare will be standardized and costing will be done periodically by a committee of experts in each state. National Expert Group will monitor and advise on such costs. For all CHCs, the wage component will be paid on a monthly basis while all other recurrent costs will be reimbursed for the services rendered from the District Health Fund. Technical, managerial, and accounting support will be provided to DHM for managing risk pooling and health security. The central government will provide subsidies to cover a part of the premiums for the poor and monitor the community based health insurance schemes.

2.3.10. Reorienting Medical Education

In order to support and include rural health issues in the health/medical education, medical and paramedical education facilities would be created in states on as and when needed. A task group will be working out the details.

2.4. Institutional Mechanisms

Under NRHM, the architectural correction in the public health system is attempted by introducing a whole new set of institutional arrangements. These institutions are proposed right from the village level to the national level. VHSC is a new committee proposed at the village level with membership of panchayat representatives, ANM/MPW, anganwadi worker, teacher, ASHA, and community health volunteers. Similarly RKS is proposed for management of public hospitals at the block level. DHM with leadership of Zila Parishad and head of District Health Department as convener and having representatives of all relevant departments, NGOs, private professionals, and so on is an integral part of NRHM at the district level. SHM, chaired by the Chief Minister and co-chaired by the Health Minister with Health Secretary as convener and representatives from related departments, NGOs and private professionals as members, is the state-level body proposed. In all these institutions, a systematic effort is made to involve representatives of public, community, and private professionals. The NRHM Steering Group, with Union Health Minister as chair and Deputy Chairman of Planning Commission, Ministers of Panchayati Raj, Rural Development, Human Resource Development, and Public Health professionals as members to provide policy support and guidance to NRHM, is constituted at the national level. Integration of the departments of health and family welfare at national, state, and district levels is proposed. The executive body of NRHM will be the Empowered Program Committee chaired by Secretary, HFW, and standing Mentoring Group would guide and oversee the implementation of ASHA initiative.

All these institutions and the program itself would require considerable technical support. This is sought to be achieved by repositioning the existing health resource institutions like Population Research Centers (PRCs), Regional Resource Centers (RRCs), State Institute of Health and Family Welfare (SIHFW). Moreover, NGOs as resource organizations will be involved. It would also require strengthening health information system. However, the basic institutions proposed are (a) Program Management Support Centre (PMSC); and (b) Health Trust of India (HTI). PMSC will have management inputs and manpower in all relevant fields of health management to ensure improved governance with empowerment of communities through IT based systems like e-banking, social audit, and right to information. The HTI is proposed to be a knowledge institution with participation of PRIs/NGOs, and so on and networking skills. It will also serve as a think tank for long-term vision and building relevant capacities of PRIs, and so on.

Regarding the role of the state governments, NRHM would provide conceptual framework. The states are expected to work out operational modalities through their action plans in consultation with the NRHM Steering Group. NRHM would prioritize funding for addressing inter-state and intradistrict disparities in health infrastructure and indicators. states are expected to sign Memorandum of Understanding (MoU) with the Center indicating their commitment to increase contribution to Public Health Budget (by 10 percent each year), increased devolution to PRIs as per 73rd Constitution Amendment Act, and performance benchmarks for release of funds.

Role of PRIs is critical for the success of NRHM. States would commit to devolve higher funds to PRIs. It is the DHM led by the Zila Parishad that would guide, control, and manage all public health institutions in the district, that is sub-centers, PHCs, and CHCs. ASHA will be selected by and be accountable to the village panchayat. The VHSC of the Panchayat would prepare the Village Health Plan to promote inter-sectoral integration. ANM will operate her joint bank account with Sarpanch for utilizing the Untied Fund of Rs 10,000 per year for local action in consultation with the VHSC. PRI is also involved in hospital management through RKS. For all this, members of PRIs have to be provided regular training. The NGOs will provide their inputs at all the levels besides getting involved in the social audit.

In order to revitalize local health traditions, AYUSH manpower and drugs will be provided at all levels, from the drug kit of ASHA to an additional AYUSH doctor at PHC to two rooms for AYUSH practitioner at CHC.

2.5. Funding Arrangements

NRHM will subsume all the health and family welfare programs including RCH-II, National Disease Control Programs for malaria, TB, kala azar, and so on. Thus, the budget for NRHM will consist of all these existing programs as well. NRHM envisages an incremental 30 percent budget over existing budgetary outlays every year to meet the goal of increasing the public health outlay from 0.9 percent to 2–3 percent of GDP. The states are expected to raise their contributions by minimum 10 percent per year to support the program. The funds from the center will be released to states in the form of 'financial envelopes' with high weightage to the 18 HFS.

2.6. Monitoring and Evaluation

since NRHM has overall time limit of seven years from 2005 to 2012, broad timelines for major components of the program are given below:

1.	Merger of Multiple Societies Constitution of District/state Mission	June 2005
2.	Provision of Additional Generic Drugs At SC/PHC/CHC level	December 2005
3.	Operational Program Management Units	2005–06
4.	Preparation of Village Health Plans	2006
5.	ASHA at Village Level (with Drug Kit)	2005–08
6.	Upgrading of Rural Hospitals	2005–07
7.	Operationalizing District Planning	2005–07
8.	Mobile Medical Unit at District Level	2005–08

Such a broad calendar of activities is useful for monitoring the progress. For evaluation, clear outcomes of the NRHM as the targets are to be specified. The Mission Document specifies such targets to be achieved by the year 2012. Some of the main targets are:

- IMR reduced to 30 per 1,000 live births.
- MMR reduced to 100 per 100,000 live births.
- Total Fertility Rate reduced to 2.1.
- Upgrading CHCs to IPHS norms.
- Increase utilization of FRUs from less than 20 to 75 percent.
- Engaging female ASHAs in every village with drug kit for generic ailments.
- Availability of generic drugs for common ailments at sub-center and hospital level.
- Good hospital care through assured availability of doctors, drugs, and quality service at PHC/CHC level.
- Improved facility for institutional delivery through provision of transport to the Below Poverty Line (BPL) families.
- Availability of assured healthcare at reduced financial risk through Community Health Insurance.
- Provision of household toilets.

- Improved outreach services through mobile medical unit at district level.

For monitoring and evaluation of the program, health MIS should be developed up to CHC level. Sub-centers, PHCs, and CHCs would be reporting on their performance regularly to the people's bodies like panchayats, RKS, and DHM. DHM would also monitor compliance to Citizens' Charter at the CHC level. Annual district reports, state reports and national reports to be tabled in the elected bodies at respective levels. External evaluation/social audits through professionals and NGOs and mid-course reviews and corrections are also provided in the program design.

Notes

1. Also known as Black fever, it is a parasitic illness. The disease is characterized by sudden onset of headache, chills, and fever which can persist for two to three weeks. India accounts for half of the 600,000 infections annually recorded worldwide. Most of the cases in India come from the states of Bihar, UP, West Bengal, and Orissa, with Bihar alone accounting for 90 percent of India's black fever victims.

2. The ANM is a frontline health worker who deals with all aspects of health and family welfare. Her domain usually consists of half a dozen villages, one of which is a sub-center village. At one level she operates from the sub-center where clients come for services. At another, she visits homes for contacting women, children, and men for providing services, giving medicines, and tendering advice, and so on (Nagdeve 2002).

3. At the February 2009 meeting of the IAP, we were informed that a decision has been taken to pay Rs 500 per month as a fixed amount to the ASHAs in addition to their existing performance-based incentives.