

# Implementation of National Rural Health Mission: An Initial Review

**PACS**  
SERIES



A Report from PACS

Enabling the poor to do what they want to do

## Poorest Areas Civil Society (PACS) Programme

(2001-2008)

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Management Consultants:  
Development Alternatives



Pricewaterhouse Coopers (P) Ltd.

## **POOREST AREAS CIVIL SOCIETY (PACS) PROGRAMME**

The Poorest Areas Civil Society (PACS) Programme is the single largest anti-poverty programme being implemented in India by a network of Civil Society Organisations. Supported by the UK Government's Department for International Development (DFID) and managed by Development Alternatives and Pricewaterhouse Coopers (P) Ltd, the PACS Programme focuses on the 108 poorest districts of India. Over 80% of India's poorest districts are located in the states of Maharashtra, Bihar, Jharkhand, Uttar Pradesh, Madhya Pradesh and Chhattisgarh.

PACS has reached out to 94 districts, 468 blocks and 19,467 villages. It has reached out to the most backward areas in the Programme States, which lack infrastructure and adequate Government services. It has implemented 178 projects (half of which are network projects) in partnership with approximately 665 civil society organisations till date.

PACS has promoted approximately 40,000 diverse Community Based Organisations (CBOs) across the six Programme States, of which 35,000 are Self Help Groups (SHGs) with largely women as members. The remaining groups are working as 'pressure groups' as well as issue based groups for grassroots coordination and advocacy.

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The views expressed in this publication do not necessarily reflect the views of the UK Government's Department for International Development (DFID).

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**Development Alternatives, New Delhi, 2007**

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# Implementation of National Rural Health Mission: An Initial Review



A Report from PACS

**Implementation of NRHM – An Initial Review**  
for Civil Society Organisations

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## A word about the book

'Health for All' is a great rhetoric and portrays a picture of healthy young children playing in the sun, with a golden smile on every child's countenance. But, the truth is stranger than fiction. In spite of all the missions and commissions, all you can see is the omission of its implementation at the field level, as is the case with the National Rural Health Mission or NRHM in short. More than two years have passed since the launch of NRHM, but things have not brightened up for the rural poor who finds the ANM missing at the Primary Health Care Centre, which is situated in some dilapidated building, with no facilities for delivering a baby in a hygienic atmosphere. And, so on and so forth....

No doubt, it is an uphill task to reach out the last man or woman in the mud hut to provide the basic health facilities at the grassroots level as India is a vast country, with its ever burgeoning population. Still, the 570,000 villages of India need better primary health care facilities than what they are getting today.

In fact, these are the findings of the Independent Commission on Development and Health in India (ICDHI), which conducted an initial review of the implementation of the Mission's agenda at the state level and gave its feedback to NRHM as well as the State Rural Health Missions. This people's commission, comprising eminent persons from the Health and Development sector, identifies the present health care system and development programmes and provides clear recommendations for future action.

This document **Implementation of National Rural Health Mission: An Initial Review** is basically a people's initiative to assess the current health and development status and facilitate the process of need-based and people-centric sustainable development and health.

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## Preface

Poorest Areas Civil Society (PACS) Programme began in the year 2001 with an aim to help millions of poor people in 108 poorest districts of the country. PACS is a development intervention that works with Civil Society Organisations. The programme is currently spread in 94 poorest districts of six states namely, Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh and Maharashtra. These selected districts perform poorly on indicators related to health, education, governance, income and production etc. These districts score high on lack of infrastructure, lack (and poor quality) of government services and exploitation. The Programme is supported by Department for International Development (DFID UK) and managed by Development Alternatives & PricewaterhouseCoppers (P) Ltd. PACS programme has been evolutionary one, not to say that thematic priorities were not clear earlier but thematic focus has shifted to making interventions sound and managing for better impact through work on livelihoods and other required areas.

PACS Programme focuses strengthening Civil Society Organizations (CSOs) for evoking civil society action in poorest areas. The rights based approach of PACS has been a catalytic strategy to trigger CSO response in poorer districts. The programme has reached out to over nine million households and approximately over 45 million population spread across six programme states. More than 83% of the populations reached are from Scheduled Castes (38%), Scheduled tribes (21%), other backward classes (23%) and 17% from general class who are economically vulnerable and marginalized.

The various processes witnessed active partnership developed at various levels - from village level to block, district, state and national levels. The partnership processes ensured that hitherto excluded and marginalized people from the hard to reach areas are included and they take part actively and in most cases lead the processes. At present, 178 PACS projects are running, wherein 665 CSOs are involved.

The capacity building initiatives continue being done at various levels: project level, programme level and at the central level which range a wide

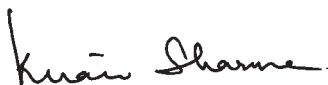
## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

variety of issues viz., Campaigns for awareness raising on NREGA and RTI, workshops on Gender, CSO governance, training for resource mobilization, etc, with the focus on capacity building as against service delivery. Studies have been initiated to monitor the implementation of key programmes of the Govt. (e.g. on RTI, NREGA and NRHM). Various media strategies (involving and training journalists on RTI and other issues, radio programmes, community radio) are being successfully employed to further the work on RTI, NREGA and other issue based campaigns.

Monitoring, Evaluation, and Learning System (MEAL) has been a major achievement in the PACS programme to enable PACS programme partners to reflect, plan, and implement the project activities in a result based approach. Overall, MEAL has made a mark in reflection, learning, actions and systematic improvements in the implementation of PACS projects.

At the close of the PACS Programme after seven years of intensive field work, we would like to encapsulate the learning of the various initiatives into a set of 12 guidebooks in the form of manuals and reports, making the gradient low so that a large cross section of development practitioners can understand about the vital issues of the poverty crisis and how to deal with them.

This report on **National Rural Health Mission** is part of the above-mentioned PACS Series and is a fruition of the PACS experiment. We are thankful to **Voluntary Health Association of India (VHAI)** and all the CSOs who have been part of this venture and helped us in making this programme a great success. We hope that this PACS Series is not only interesting but educative as well for all those engaged in the field of development and believe that empowering the poor is the optimum path that leads to the goal of Sustainable Development.



(KIRAN SHARMA)  
PACS Programme Director



## **CHAPTER 1**

### **INTRODUCTION**

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# 1

## Introduction

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The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions. The difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. The thrust of the Mission was on establishing a fully functional, community owned, decentralised health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and with gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes. As a prerequisite, all institutions were to be made consistent with the Indian Public Health (Institutions) Standards for all health facilities. From narrowly defined schemes, the NRHM was shifting the focus to a functional health system at all levels, from the village to the district with active PRI and community ownership and participation.

Since the mission had already started being implemented in states, ICDHI felt it was important to conduct a review of the process of implementation of Mission's agenda at the state level and give its constructive feedback to NRHM as well as the State Rural Health Missions. The Ind. Comm. was very conscious that it was too early to evaluate the functioning of the mission in most of the States as though the Mission had officially been signed in April 2005, it was still in the process of being implemented and operationalise in many parts of India. Therefore, the objective of the initial ICDHI field survey was to look at the process of implementation and initial experiences of the implementation at the district and peripheral level rather than looking for any health impact. The purpose of the ICDHI endeavour was therefore not to see how the Mission was

functioning in all or any State but to see if any insights could be gained to enable the members to consider the procedures observed in the field, together with an assessment of the opinions and perceptions of different stakeholders in the community.

The main objective of the review thus, was to identify positive lessons from different states and to suggest areas requiring increased or changed emphasis to facilitate easier implementation of the concepts of NRHM.

## Background

### Vision, Goals, Strategies and Outcomes of the mission

The National Rural Health Mission has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable and at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilisation, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

- o Facilitate increased access and utilisation of quality health services by all.
- o Forge a partnership between the Central, state and the local governments.
- o Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- o Provide an opportunity for promoting equity and social justice.
- o Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.

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- o Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.

### The Objectives of the Mission

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH.
- Promotion of healthy life styles.

### The core strategies of the Mission

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat. Strengthening sub-centres through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing Primary Health Centres (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

- Provision of 30-50 bedded Country Health Centre (CHC) per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralised administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels).
- Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.
- Technical support to National, State and District Health Mission, for public health management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.
- Promoting non-profit sector, particularly in underserved areas.

### The supplementary strategies of the mission

- Regulation for Private sector, including the informal Rural Medical Practitioners (RMP) to ensure availability of quality service to citizens at reasonable cost.
- Promotion of public private partnerships for achieving public health goals.
- Mainstreaming AYUSH - revitalizing local health traditions.
- Reorienting medical education to support rural health issues, including regulation of medical care and medical ethics.

## INTRODUCTION

- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

A detailed operational framework spells out this vision, objectives of the NRHM, and the detailed strategies by which these are to be achieved in the seven year period.

### Independent Commission on Development and Health in India

Voluntary Health Association of India (VHAI) facilitated setting up of Independent Commission on Health in India in 1995, renamed as the Independent Commission on Development and Health in India, as a people's initiative to assess the current health and development status and facilitate the process of need based and people-centric, sustainable development and health. Through analysis of existing data and in-depth study, the Commission consisting of distinguished persons from the health and development sector identifies the maladies affecting the present health care system and development programmes and provides clear recommendations for future action.

### Review of National Rural Health Mission

Since NRHM is now almost two years old, it was felt that the Commission will conduct a review of the implementation of the Mission's agenda at the state level and give its constructive feedback to NRHM as well as the State Rural Health Missions.

The following States have been taken up for this purpose:

1. Bihar
2. Jharkhand
3. Madhya Pradesh
4. Chhattisgarh

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5. Uttar Pradesh
6. Himachal Pradesh
7. Assam
8. Andhra Pradesh
9. Orissa

The objectives of the 'Study to monitor the implementation of the National Rural Health Mission (NRHM)' are:

- o To do a perceptual analysis of the process of implementation of NRHM with adequate data back-up
- o To assimilate information on the early impact of NRHM on health care delivery system, PRI and community.
- o To make recommendation to the central and state govt. for further streamlining of the processes.
- o To look at the state of affairs vis-à-vis ASHA, how well ASHA concept is functioning in various states.
- o Perception of NRHM in the community, PRI and District Health Office level, and effective community participation
- o The extent of inter sectoral coordination in NRHM states, both at the State and even at the peripheral level.. How far various ministries are interacting to make it successful.

### Collection of information

For the purpose of review the information has been collected at three different levels:

1. Central Level
2. State Level and
3. District Level and below

## INTRODUCTION

### Central Level

The central level information was collected by ICDHI Members themselves through interaction with Mission Director, NRHM, Joint Secretary In charge NRHM and Dy. Director, NRHM. In addition, available reports were also examined.

### State Level Information

The state level information was collected by VHAI Colleagues along with implementing partner NGO. For this, discussions were held with Mission Director of concerned States, Secretary, Health & Family Welfare and other concerned officers.

### District Level and Below

This information was mainly collected by implementing partner NGO. However, in many places VHAI Colleagues also participated in the collection process. For collection of information, a set of questionnaire was prepared by Dr. L.M. Nath, Member ICDHI. This questionnaire was developed so as to cover up rural health services, namely for CHC, PHC, Sub Centres and for the community. These questionnaires were based on the guidelines developed by ICHI Members for review as given on the following page. For collection of information, the focus was on generation of qualitative data about areas relevant for review of NRHM. It was not intended to be quantitative or statically representative. In each selected district, community health centre, primary health centre and two sub centres were visited. In the villages, ASHAs available were interviewed. In addition focus group discussions were held with village community and PRI Members.

## Guidelines

Following guidelines were used by the partner organisations for collecting information.

	<b>Objectives</b>	<b>Tasks / Activities</b>
1.	The structure, personnel and financial of NRHM both at the Centre and the State	Collection of State NRHM Report from the central NRHM Office; State PIPs; other relevant Reports
2.	Effectiveness of Public-Private-Non-profit Partnership in the Mission;	Collection of the list of MNGOs; their FNGOs Discussion with the MNGOs' and FNGOs' personnel to know what is happening at the field level. Any collaborative effort with the private sector and other Civil society organisations.
3.	Examining behavioral change communication strategies	At the Centre / State / district and PHC level
4.	Looking at the state of affairs vis-à-vis ASHA; reference to their Training, Back up support & Financial matters	Interaction with the ASHAs Interaction with the members of PRIs, PHCs with and Community. Interaction with the selection, ANMs, PHC Doctors. Cross - checking with the State Report
5.	Re-look at CHCs, PHCs, Sub Centers and health facilities in NRHM districts, including a Sample Facility Survey	Reference - Form provided by the Commission
6.	Community perception of NRHM and how effective is the participation of Panchayati Raj Institutions;	<b>Key queries</b> – What is NRHM – Has the programme started its activities –What are the things that have been implemented – Selection, training & functioning of ASHA – Has NRHM made any difference – Was the Community involved in any activity / decision making process. – Any suggestions
7	Inter-sectoral coordination in the work of NRHM.	At the various levels with particular focus on ● ICDS ● Water and Sanitation & ● Education
8	Improvement in the quality of services at various levels following the launching of NRHM	At various levels - CHCs / PHCs and Sub Centers Discussion with the Health functionaries and beneficiaries.

## INTRODUCTION

### Selection of the area

Three districts, one well-performing, one medium-performing and one poor-performing in each State were identified for field visits. The identification was done on the basis of detailed district level analysis done by Prof. Ashish Bose in another study to look into the available infrastructure and achievements of health outcome for 593 districts of the country.

Following districts were selected for field visits in the states taken up for monitoring.

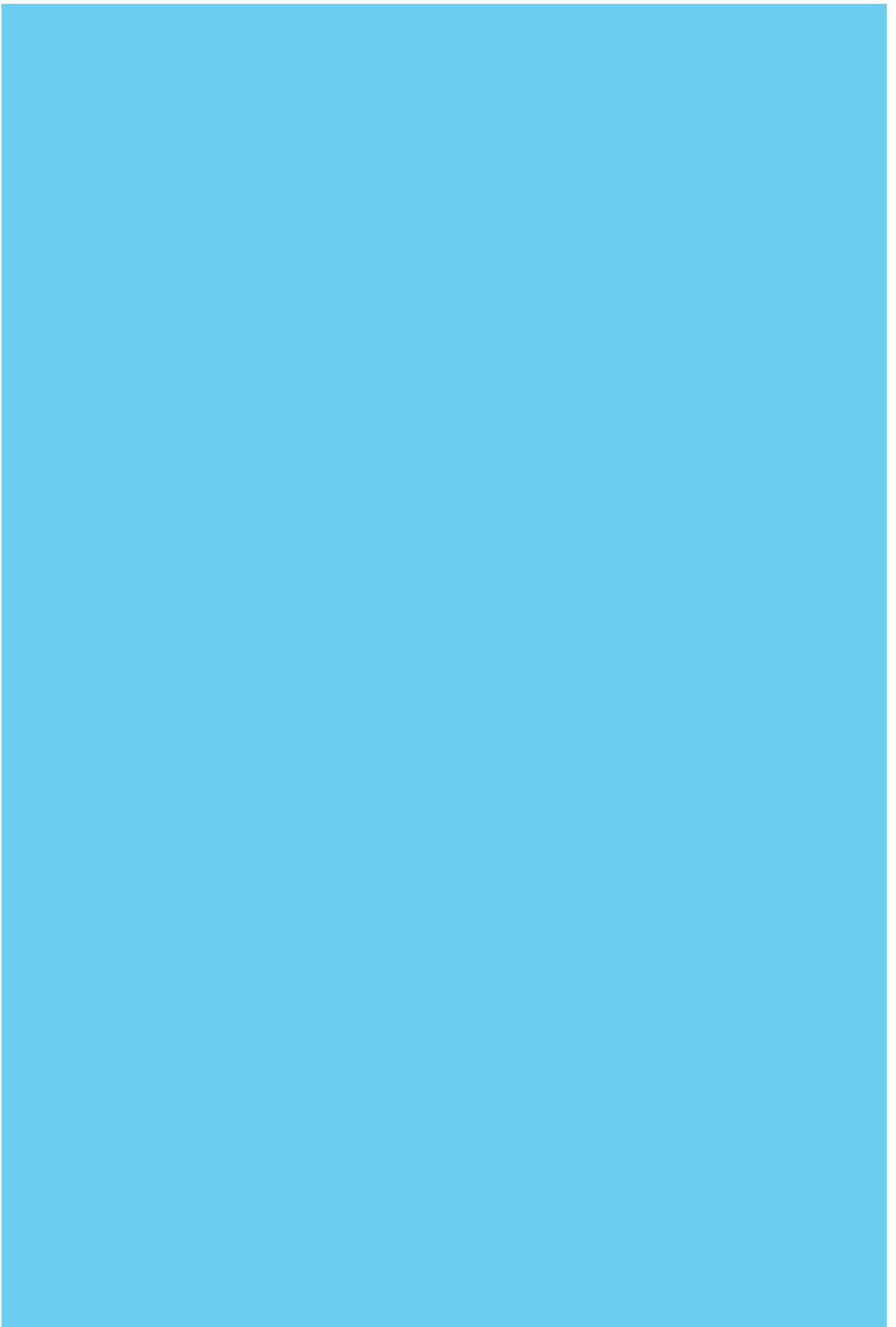
Sl. No.	States	Identified Districts	State Organisation
1	Bihar	1. Saran 3. Jamui 4. West Champaran	Bihar VHA
2	Madhya Pradesh	1. Gwalior 2. Tikamgarh 3. Mandla	Madhya Pradesh VHA & Tarun Sanskar in Mandla Sambhav - in Gwalior and Tikamgarh
3	Jharkhand	1. Gumla 2. Deogarh 3. East Singhbhum	Jharkhand VHA
4	Chhattisgarh	1. Mahasamund 2. Sarguja 3. Dhamtari	Chhattisgarh VHA
5	Uttar Pradesh	1. Varanasi 2. Shahjahanpur	Uttar Pradesh VHA
6	Andhra Pradesh	1. East Godavari 2. Kurnool 3. Nizamabad	Andhra Pradesh VHA
7	Assam	1. Dibrugarh 2. Dhubri 3. Nagaon	Assam VHA
8	Himachal Pradesh	1. Chamba 2. Sirmour 3. Kangra	Himachal Pradesh VHA
9	Orissa	1. Jagatsinghpur 2. Jharsuguda 3. Malkangiri	o Orissa VHA o Aparajita Orissa

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## CHAPTER 2

### Some Selected Indicators of States for NRHM review



## 2

## Some Selected Indicators of States for NRHM review

Demographic, Socio-Economic and Health Profile of States taken up for NRHM review

SNo	Item	Progress								
		Assam	Jharkhand	Orissa	Bihar	Chhattisgarh	Himachal	Madhya Pradesh	Uttar Pradesh	All India
1	Total population (Census 2001) (in million)	26.66	26.9	36.80	82.9	20.83	6.08	60.35	166.20	1028.61
2	Decadal Growth (Census 2001) (%)	18.92	23.36	16.25	28.62	18.27	17.54	24.26	25.85	21.54
3	Crude Birth Rate (SRS 2005)	25	26.8	22.3	30.4	27.2	20.0	29.4	30.4	23.8
4	Crude Death Rate (SRS 2005)	8.7	7.9	9.5	8.1	8.1	6.9	9.0	8.7	7.6
5	Total Fertility Rate (SRS 2004)	2.9	3.5	2.7	2.3	3.3	2.1	3.7	4.4	2.9
6	Infant Mortality Rate (SRS 2005)	68	50	75	61	63	49	76	73	58
7	Maternal Mortality Ratio (SRS 2001-03)	490	371	358	371	379	NA	379	517	301
8	Sex Ratio (Census 2001)	935	941	972	919	989	968	919	898	933
9	Population below Poverty line (%)	36.09	-	47.15	42.60	-	7.63	37.43	31.15	26.10
10	Schedule Caste population (in million)	1.83	3.19	6.08	13.05	2.42	1.50	9.16	35.15	166.64
11	Schedule Tribe population (in million)	3.31	7.09	8.15	0.76	6.62	0.24	12.23	0.11	84.33
12	Female Literacy Rate (Census 2001) (%)	56.03	39.38	50.97	33.57	52.40	68.08	50.28	42.98	54.28

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

### The State of Public Health in the States taken up for review of NRHM

SNo	Indicator	Source of year	Assam	Jharkhand	Orissa	Bihar	Chhattisgarh	Himachal Pradesh	Madhya Pradesh	Uttar Pradesh
1	Infant Mortality Rate	Sample Registration System, RGI's Office 2005	68 58 All India	49 58 All India	75 58 All India	61 58 All India	63 58 All India	51 58 All India	76 58 All India	73 58 All India
2	Maternal Mortality Rate	Sample Registration System 2003	490 301 All India	379 301 All India	358 301 All India	371 301 All India	379 301 All India	379 301 All India	379 301 All India	517 301 All India
3	Non Hospitalised treatment from government sources (Rural)	National Sample Registration System 2003	27% 22% All India	13% 22% All India	51% 22% All India	5% 22% All India	15% 22% All India	68% 22% All India	23% 22% All India	10% 22% All India
4	In patient treated in public Hospitals	National Sample Survey 60th	74.2% 41.7% All India	46.6% 41.7% All India	79.1% 41.7% All India	14.4% 41.7% All India	53.5% 41.7% All India	78.1% 41.7% All India	58.5% 41.7% All India	26.9% 41.7% All India
5	Average medical expenditure per Hospitalisation' (Rural)	National Sample Survey 60th Round 2004	Rs 3157 Govt. Rs 8179 Pvt. Rs 3238 Govt. Rs 7408 Pvt.	Rs 2961 Govt. Rs 6214 Pvt.	Rs 3096 Govt. Rs 7713 Pvt.		Rs. 4038.00 Govt. Rs 6086 Pvt.	Rs. 6035.00 Govt. Rs 14652 Pvt.	Rs. 3238. Govt. Rs 6185 Pvt.	Rs. 7648 Govt. Rs 9169 Pvt.
6	Anaemia among children (6-35 month age)	National Family Health Survey 2005-06	76.7%	77.7%	74.2%	87.6%	81%	58.8%	82.6%	85.1%
7	Anaemia among ever married women aged 15-49	National Family Health Survey 2005-06	69%	70.4%	62.8%	68.3%	57.6%	40.9%	57.6%	50.8%
8	Full Immunisation	National Family Health Survey 2005-06	31.6%	34.5%	51.8%	33%	48.7%	74.2%	40.3%	22.9%
	Rural	DO	31.9%	29.8%	51.6%	31%	43.1%	73.6%	31.5%	20.5%
	Urban		29.3%	51%	52.8%	46%	74.7%	80%	68.7%	32.6%
9	Institutional Births	National Family Health Survey 2005-06	Total 22.7% Rural 18.3% Urban 59%	Total 19.2 Rural 11% Urban 54.1%	Total 38.7% Rural 34.6% Urban 65%	Total 22% Rural 19% Urban 48%	Total 22% Rural 19% Urban 48%	Total 45.3% Rural 42.1% Urban 79.1%	Total 29.7% Rural 20.2% Urban 59.9%	Total 22% Rural 17.5% Urban 39.9%
10	3 Antenatal Care Visits	DO	Total 36.3% Rural 32.3% Urban 69.9%	Total 36.1% Rural 28.8% Urban 67.1%	Total 60.9% Rural 58% Urban 79.2%	Total 16.9% Rural 36.2% Urban 15.3%	Total 54.7% Rural 14.5% Urban 49.2%	Total 62.6% Rural 61.2% Urban 76.2%	Total 40.2% Rural 34.6% Urban 58.4%	Total 26.3% Rural 22.6% Urban 40.9%
11	Post Natal Care	DO	Total 3.8% Rural 10.9% Urban 37.1%	Total 17% Rural 10.5% Urban 44%	Total 38.2% Rural 35.9% Urban 54.1%	Total 115.3% Rural 13% Urban 33%	Total 25.3% Rural 17.6% Urban 63.6%	Total 40.8% Rural 39.6% Urban 52.3%	Total 9% Rural 20.2% Urban 29.7%	Total 14.2% Rural 9.9% Urban 31.1%

SOME SELECTED INDICATORS OF STATES FOR NRHM REVIEW

Shortfall in Health Infrastructure of States taken up for review of NRHM

SOURCE: Bulletin on Rural Health Statistics in India 2006

SNo	Item	Shorfall							
		Assam	Jharkhand	Orissa	Bihar	Chhattisgarh	Himachal	Madhya Pradesh	Uttar Pradesh
1	Sub-centre	0	1099	1356	6101	—	—	1528	5823
2	Primary Health Centre	216	476	—	848	141	—	487	730
3	Community Health Centre	106	7	61	522	46	—	188	711
4	Multipurpose Worker (Female)/ANM*	0	S	438	1595	1543	718	721	2281
5	Health Worker (Male)/MPW(M)	NA	S	2535	7823	1840	283	1576	14789
6	Health Worker Assistants(Female) LHV	NA	52	553	1150	S	91	118	1532
7	Health Assistant (Male)	NA	212	1111	1318	S	78	24	S
8	Doctor at PHCs**	NA	S	S	35	S	S	353	NA
9	Total specialists at CHCs	NA	630	NA	192	423	NA	867	1131

\* @ One ANM per sub centre

NA- Information not Available

S - Surplus

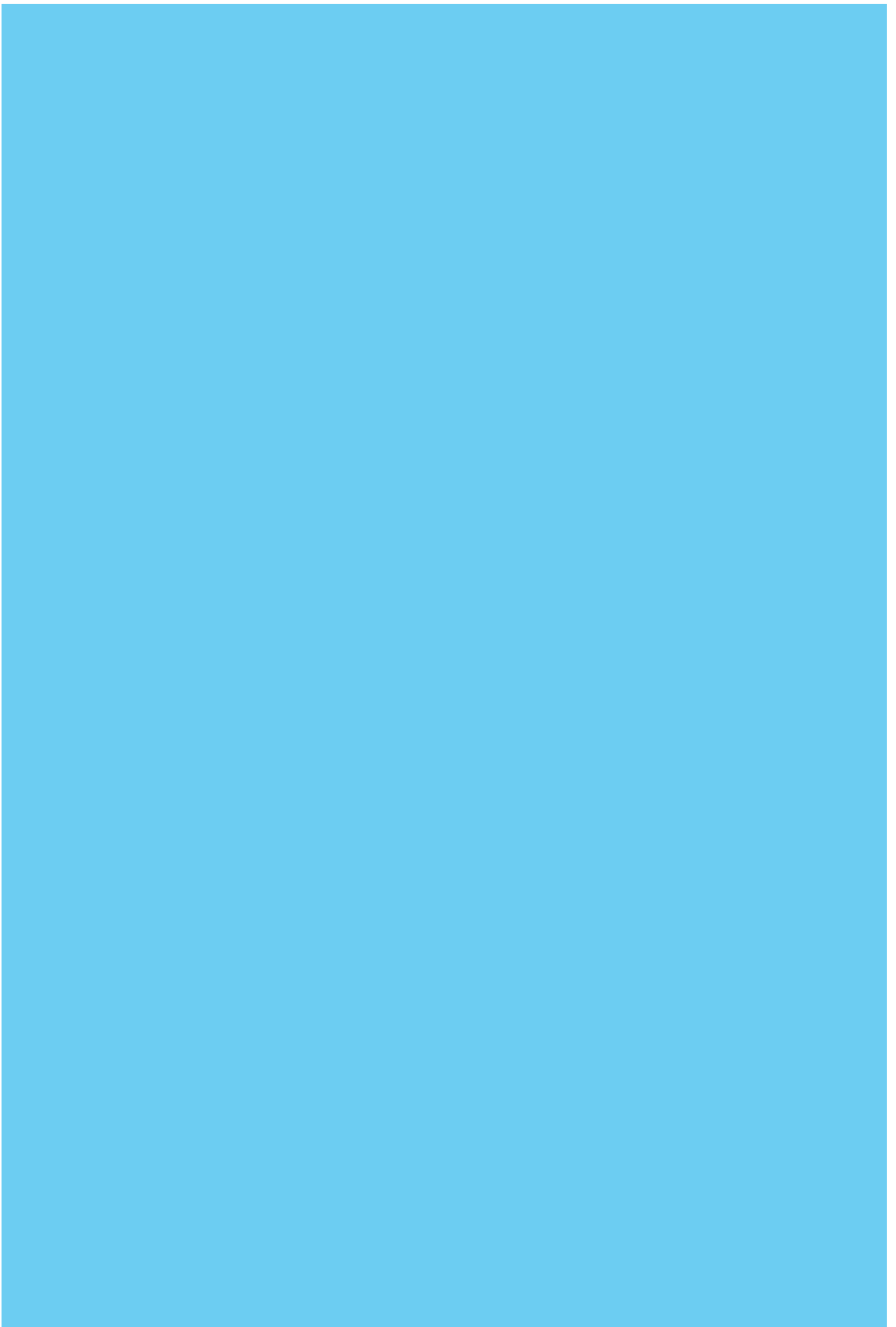
\*\* @ One Doctor per PHC

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## **CHAPTER 3**

### **Conclusions and Recommendations**



# 3

## Conclusions and Recommendations

The objectives of the NRHM at first glance are the same objectives that all health plans in India have had for the last 50 years, reducing maternal mortality, infant mortality etc, etc. At first sight, a disappointing recital of the same old objectives, the same goals repeated as if they were fresh and bright insights about what needed to be done. On further reflection came the realisation that there is something different about the NRHM - something that for some strange reason is not adequately emphasised even in NRHM documents and discussions. What is new is not only that adequate funds have been made available to really make a difference, not merely a token injection of insignificant funds into a system that was so financially constrained that nothing short of a massive infusion of resources could hope to make a visible and sustained difference in health impact. The real difference was that the plan provided for making the community and the peripheral health staff partners in the path to achieving positive changes in the health system. This combination of funds and the very real attempt to make the community partners in achieving health goals was the real innovation in the NRHM.

The Commission found that this aspect of the NRHM was so radically different that not even the health system really realised that this sharing of power and decision making responsibility with civil society was the real difference and innovation in the NRHM.

So innovative is this idea that by the time the scheme trickled down to the community level, the concepts had reverted to the mean, the norm of health system action where the authoritarian health system 'knew what was good for the people and what they needed'!

This was both the hope and the failure of the system.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

The study was carried out in three districts of each of the eight States. In each district, the District Health Office, 3 CHCs, 3 PHCs, and 3 Sub-centres were visited. Discussions were held at the State level that provided State specific data. In additions, apart from discussions with district level officials like CMO, DPM (Wherever in position), etc, formal and informal discussions were held with Mother NGOs and Field NGOs in the district, with health committees at the village and District level, with PRI members and with the members of the community. This collective effort generated a great deal of information. The detailed district and State specific data is attached as annexure.

In this section, significant observations that reflect the situation in general are discussed.

1. In most of the areas visited, there was some evidence that attention was being paid to activating public sector health facilities by attending to civil works such as maintenance and repair and also making efforts to improve the staff situation. Ad hoc contracts and the recruitment of qualified ISM practitioners against medical officer vacancies, were also evident in some situations.
2. A significant observation was that almost every facility visited reported a quantum increase in availability of medicines and other consumables and supplies. Not only was the supply enhanced, but the general impression was that the chain for replenishment and addition to the supplies was in place and generally functioning well.
3. In the states of M.P. and Bihar, whichever health facilities (ranging from the district hospital all the way down to the sub-centres) the teams visited, on inquiring they were informed that there was an increase in the number of patients during the current year. This is also substantiated by the data for the places where we had district level data for two or more years. However, this increase is not the invariable norm in all the states. In states like Orissa, Himachal Pradesh and Assam, there is not only no increase in the patient load, but some facilities are showing decrease in the attendance.
4. This increase in attendance is an important development and points not only the fact that more persons are getting medical care, but also

## CONCLUSIONS AND RECOMMENDATIONS

that the community has an increased acceptance of the public sector health care facility in Bihar and MP.

Why exactly this is happening has not been investigated. The reasons could be one or more of the following:

- o Availability of medicines and other consumables at health facilities
- o The activation of the facilities which were earlier defunct and non-functional

It is recommended that the phenomenon of an increased acceptance of health facilities and enhanced patient load be investigated so that lessons can be learnt and incorporated in future programmes, and steps taken to ensure that this favourable feature is sustained. The results of the study will also help in designing appropriate IEC material. Equally important is that we know why this phenomenon is limited to some states and why other states are showing either no increase or even decrease.

5. Another very significant and almost universal finding is related to institutional deliveries. This change was very noticeable. Institutional deliveries are being carried out in facilities that very seldom, if ever, conducted a delivery earlier. It is most likely that this change has come about very largely due to the Janini Suraksha Yojana. While the numbers of institutional deliveries are steadily rising, and this is a desirable change, the emphasis on this programme will have to continue as the change in terms of the proportion of the total births in the villages is still very far from any realistic target. Unfortunately, in many places, the usual statistics from government sources are misleading because they club institutional deliveries with deliveries conducted at home by 'trained staff'.
6. Safe deliveries are just one step towards comprehensive care. It is important that the mother and child, who deliver in institutions and even those who deliver at home, receive care for themselves and for the new baby. Our teams found no evidence of a coordinated action being triggered by the institutional delivery to automatically initiate a follow-up process for the mother and child by the normal public sector health system.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

7. The JSY programme is not without its problems. The most obvious one is about the money supposed to be paid/reimbursed to the new mother and to the ASHA. Information about the exact quantum and the process for the payment of the money is by no means clear – both to the community, and even to some health care providers.
8. Transport to the point of referral is also not without its problems. In several of the more isolated and peripheral habitations, the arrangements for transport are just not available, especially in emergencies and at night. When some one in the village is prevailed upon to provide transport, the cost quoted is frequently more than the programme provides. Some examples of successful innovative approaches to tackle this problem were found in the field. In some places, a helpline has proved very useful to expedite the provision of transport in emergency situations.

It is recommended that all districts take steps to inform the community and all health care providers of the financial arrangements under the JSY so that all three stakeholders the health care system, the – mother and the ASHA – have no ambiguities about the financial arrangements.

Data returns from the districts should clearly differentiate between the numbers who were delivered in health care facilities and those who delivered at home.

The provision of a helpline for transport is an example worth emulating widely. It could be done in collaboration with a local Mother NGO or FNGO and will have the additional benefit of civil society and public private collaboration.

It is also recommended that focus of JSY should not only be on promoting Institutional delivery but promoting safe delivery as well as Post-natal care.

It is also recommended that a formal link/process be initiated to activate a routine follow-up of the mother and child after they return home following an institutional delivery. Such follow-up should be both

## CONCLUSIONS AND RECOMMENDATIONS

domiciliary and clinic based. The domiciliary follow-up can be both by the female MPW and the responsible ASHA.

9. Though the situation varied in different locations, it was very noticeable that even the persons appointed to be the Mission Director at the district level, and the rest of the district health staff did not seem to understand the very important concepts underlying the NRHM. The intention to shift a large part of the decision-making responsibility to the community appears to be absent from the understanding of those implementing the programme at the field level. Similarly, the role of the PRI is not really conceived in its totality. The level of knowledge and understanding was very different at the level of the senior officials at the State level.

It is recommended that all district level staff undergo another round of training, this time focussing primarily not on budget and administrative requirements but on the concepts underlying the Mission and role and responsibilities of the community and PRI members.

It is also recommended that Best Practices/places have to be developed for the training of district level staff and others.

10. PRIs are seen as critical to the planning, implementation, and monitoring of the NRHM. Implementation of the NRHM in achieving its outcomes is significantly dependent on well functioning village, block and district level panchayats. Generally, the members of the Panchayati Raj Institutions had heard of the NRHM. However, most of those questioned said that they had got their information from the mass media or indirectly as a part of the selection of ASHAs from their areas. Generally, they did not know the role assigned to them and the financial and decision - making responsibilities assigned.

It is recommended that PRI involvement in various health related activities should be looked in totality rather than in a piece meal manner as NRHM, RCH, etc. There has to be synergy between different activities.

It is recommended that orientation of PRI members should be incorporated in all state PIPs as a specific measurable activity to be monitored closely. There should be a separate budget – line and financial

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

allocation for the same. This should also be reported as a specific activity in all regular reports.

NGOs could be involved in PRI strengthening in a variety of ways, including: consciousness raising, provision of technical advice, support in participatory planning, capacity building and facilitating monitoring processes, such as community and social audits to improve accountability.

Transfer of funds to PRI is a critical must before they can be expected to play a meaningful role in HFW activities. While several states have taken steps to make complete financial devolution commensurate with functions, but it still has a long way to go. With financial devolution, other processes such as fiscal management, systems training and appropriate checks and balances will need to be introduced.

The head of the District Health Mission could be the head of the District Panchayat, but not the District Magistrate.

11. In most places, the untied funds have reached the district headquarters and also the sub-centres. The other levels such as PHCs, CHCs are somewhat lagging behind. It was noted that there was a degree of confusion in many places regarding the way the money was to be spent, especially about the responsibility of the Sarpanch / Female MPW to use the funds in a locally responsive way. In one rather backward district, a query about the untied funds from the District Health Office NRHM coordinator got the unequivocal response that the funds have all been utilised. A look at the records showed that exactly the same amount was "spent" and that too on the same date by all the sub-centres in the district. It turned out that the responsible officer felt that she could decide what was needed by all the sub-centres in the district and ordered furniture. While it may have been true that the furniture was needed, since the purpose of meeting the local needs and empowering the marginalised was definitely a casualty.

The concept behind having untied funds and the laid down procedure needs to be re-emphasised. This is a part of the deficient conceptual understanding which should be addressed.

## CONCLUSIONS AND RECOMMENDATIONS

12. In almost all the districts visited, a large number of ASHAs had been selected and the first round of training had nominally been completed for a very large number of nominees. The term 'nominally' is used because there were serious doubts about the relevance and quality of training. This is unfortunate because the training guidelines are detailed and well laid out. It is sad that the implementation leaves much to be desired. We found that locations that followed the guidelines in spirit and word were few and far between. Some training sites went so far as to merely hand the guidelines to the trainees with the advice that they should read the handout. In other locations, though there were staff who had gone through the training of trainers' course, they were not used in the training programme using the plea that everyone should get a chance to get a share of the funds available for training. Our discussions with ASHAs in most districts emphasised the urgent need to strengthen the training. Many ASHAs were at a loss to explain even their own role and responsibilities. Even the financial arrangements for ASHAs were not well understood by even the beneficiary group.

It is recommended that the training process at the district level be looked at. Those who have been through the TOT process should be involved in the district level training. The training process must be supervised and a detailed report submitted, detailing the names of the persons actually assigned to conduct each session. Concepts, tasks and financial arrangements must be clearly understood by all ASHAs.

13. The process followed for the selection of ASHAs is well defined in the Mission documents. Though the process was followed in many locations, it was by no means the norm and our team found many examples where the selection process was influenced by other considerations. True community participation in the process was not the norm. Some ASHAs interviewed even appeared to believe that they would eventually be regularised into government service!

It is recommended that the District level person responsible for the mission be reminded that the procedure for getting ASHA nominations was clearly defined and should be followed.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

Another area of concern needing immediate attention is lack of back-up support to ASHA. The mission framework for implementation mentioned about setting up of ASHA support system at different levels from state and below needs to be operationalised at the earliest.

As a component of the follow-up of training and continuing education for ASHA, a regular news letter for ASHA can be brought out.

14. Though NRHM is envisaged as an umbrella programme encompassing different Health programmes like RCH, Disease control, etc, it misses out on a crucial component required i.e. health promotion. In the complete framework of implementation, there is hardly any mention about the need for systematic health promotion efforts.

It is recommended that a structured health promotion strategy should be put in place. It should include components like physical activities, nutrition, etc. Just provisioning of village health and sanitation days, which has become a routine didactic affair, will not be sufficient. There is also the need to relook at the ways *Health Melas* are being organised. They should not be looked upon only as a means to provide secondary care services but also seen as an opportunity for educating people and promoting health services.

15. As a result of the review process, the commission realised the fundamental weakness in the operationalisation of the mission. NRHM has identified communitisation, flexible financing, innovations in human resource management, monitoring against IPH Standards, and building capacities at all levels as the principal approaches to ensure quality service delivery, efficient utilisation of scarce resources, and most of all, to ensure service guarantees to local households. The central place given by the NRHM to the communitisation process including decentralised planning is the major difference between the approach adopted by the NRHM and other various programmes launched earlier. Unfortunately, this crucial fact has not permeated to the district health system. The review process revealed that even after almost 18 months of the launch of NRHM, decentralised planning at district and below is conspicuous by its absence. Some states like MP and Chhattisgarh

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have initiated the process but the state PIPs, for the first two years of implementation for almost every state, followed the top-down approach of planning using data generated at state level. There has been no village health planning so far. This is like putting the cart before the horse. The need to have a health system that is responsive to the local health situation is of paramount importance if the felt and actual health needs of the community are to be addressed by the public sector health system. Unless the system is responsive to the ground reality, a community ownership and effective participation is not possible on a sustainable basis. Micro-level health planning has long been emphasised at all levels, from the planning commission to even the Central Council for Health and Family Welfare, but has never come into fruition. The reasons these laudable and important objectives have not been achieved in the past, and are not likely to be effective even under the NRHM, are clear. The willingness and technical capacity to make sense of the health situation at the periphery is by and large absent.

The health Committee at the village does not have, at this time, the knowledge and skills needed to recognise the specific health issues of their areas, to prioritise them, and plan appropriate interventions. Nor can the usual village health committee decide what is possible, what is technically or financially feasible, or even what actions fit into the existing range of National Health Programmes and priorities. It is self-evident that the health system will have to join in supporting the health committee in rationalising their health priorities and then drawing up a plan of action to address those needs.

The unfortunate fact is that the manpower of the public sector health system available to the villagers, is also not trained to recognise and prioritise health problems and relate this list to achievable interventions. Public Health expertise is absent at the sub-centre or even PHC level. Even the CHC is conceived as a purely curative care institution and in all states, except two states in India; there is no mandatory requirement to have a person with qualifications in Public Health at the district level.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

These important aspects of Community ownership, involvement and action should be reinforced at the district level so that community empowerment becomes the norm and permeates throughout.

If the public sector health system is to respond to the mandate for micro-level planning, it is essential that suitably trained human resources are available at the district level and preferably at the CHC. Instead of conceiving of the CHC merely and only as the First Referral Unit by virtue of it being the most peripheral public sector health facility to have clinical specialist care, it should be seen as also providing the first level of preventive and promotive supervision for the area covered by the (four) PHCs in their catchment area.

Specialist, with qualification in the speciality of Public Health must be posted at CHCs and the District Medical Officer of Health must have qualifications in some discipline of Public Health. The so-called NHRM public health manager does not meet this requirement. To ensure that suitable manpower is drawn to this speciality, a Public Health Cadre must be separated out.

We are quite clear that absence of Community involvement, little systematic attention to decentralised planning along with the absence of properly qualified and trained man-power in Public Health are some of the major barriers to achieving the goals and concepts behind the NRHM.

16. Another area of concern in NRHM is communitisation of health care delivery system with intensive community involvement, inter-sectoral coordination and involvement of PRIs. However, as of now, not much progress seems have to happen on all these fronts. Village level health and sanitation committees are only for namesake and no training of their members has taken place. PRI involvement is non-existent. Community especially at sub centre and APHC level is not able to appreciate any change since the launch of NRHM.
17. As of now, there is very little systematic involvement of NGOs in the implementation of NRHM. The NGO involvement is limited to implementation of MNGO and FNGO schemes. Partnership with Non governmental organisations is sought mostly for special drives for

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immunisation, Leprosy, Malaria, Blindness Control, HIV/ AIDS control etc but not on a sustained basis. Some NGOs, especially in Orissa and in UP (SIFPSA partners), were involved in the selection of ASHAs in few blocks. At many places in Assam, Orissa, and MP, NGOs were also involved in training of ASHAs.

Therefore, it is recommended that there should be well defined roles for NGOs in state guidelines. MNGOs/FNGOs should be involved intensively in the implementation of NRHM, especially in training of ASHAs and PRIs, creating awareness about NRHM in the community, monitoring of implementation of JSY, setting up of JSY helpline, activation of VHSCs, etc.

Preference should be given to MNGOs in state and district committees.

18. **Public-Private Partnership:** Useful Partnerships with Non-governmental providers have been attempted in some of the states as Public-Private Partnership. For example: running of mobile medical units in Jharkhand and Madhya Pradesh; provision of diagnostic facilities in Bihar and Himachal Pradesh. One good example of effective partnership is management of Primary Health Centres in most difficult parts of Arunachal Pradesh by NGOs like Voluntary Health Association of India and Karuna Trust, where over a short period of time, visible improvements have been seen.

Therefore, it is recommended that similar initiatives of involving NGOs in running/managing health services like CHCs, PHCs, Sub Centres as in Arunachal Pradesh, should be expanded to other states also.

19. It was remarkable how different the level of understanding was at the top echelons of the decision-making chain at the State Headquarters level. Some of the Officers who very kindly spared time to brief our team had obviously given a great deal of thought to the NRHM. They had clothed the bare bones of the Mission document very innovatively to reflect the State ground reality and health priorities.

If only they could communicate their understanding to their peripheral officers, the Mission would have a much greater chance of making an even more of an impact on the health situation in India.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

20. We also had discussions with the officials at the Centre. They could not have been more clear and more cooperative and helpful. Without any hesitation they shared all the reports and documents at their disposal and took pains at the senior level to ensure that our team was fully briefed and prepared.

There are still many challenges that remain to be met but the Independent Commission feels that if the same 'cutting to the core' attitude in decision-making does not percolate down from the Centre to states and periphery , we may never truly have healthcare reaching out to the peripheral community.

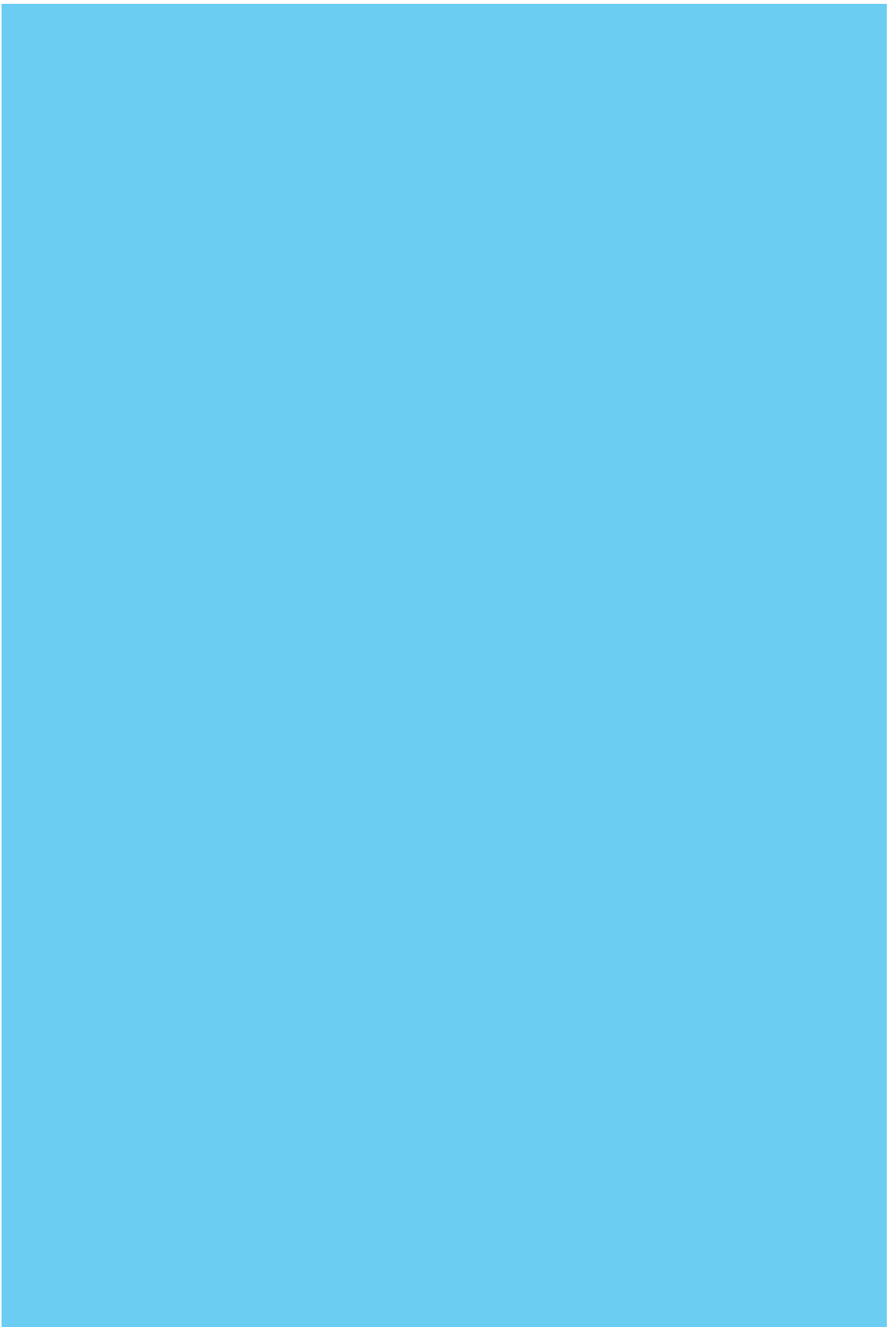
The danger we see is the old dilemma of the conflict between the various roles at the Centre. Perhaps, the Centre should accept that its role and forte is the conceptual policy and planning, together with the mobilisation of resources. The day to day implementation of the project should now pass to another level.

One of the grave hazards facing the NRHM is the lack of ownership at two levels. At the community level, the programme does not yet belong to the community. It is still seen as just another measure imposed on the people. The second danger is perhaps even more serious. There does not seem to be any real sense of ownership at the State decision – making level. It is very much a Centre – specific programme. The signals that will be sent by the Centre moving away from actual implementation, may persuade the States that the NRHM is, after all, their programme.



## **CHAPTER 4**

## **ANNEXURE**



# 4

## Annexure

### Observations

#### Patient Load at Different Facilities:

A consistent observation in most of the settings was an increase in the no. of patients attending the OPD. To get a trend and to link this increase with the mission an attempt was made to get the data from the previous years too.

*Patients Treated during the year 2004, 2005, and 2006 in Various States*

S. No.		2004-05		2005-06		2006-07	
		Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance
<b>ASSAM</b>							
	Hafflong Hospital Nagaon	30547	84	31179	85	10140	28
	CHC Rowata	7025	19	9113	25	9088	25
	PHC Lanka	31990	88	39574	108	37108	102
	PHC Jogijan District Dibrugarh	10316	28	11121	30	12246	34
	District Hospital						
	Dibrugarh CHC Naharoni	22793	62	27014	74	27501	75
	PHC Borbarua	30234	83	18003	49	21026	58
	PHC Khowang	8765	24	6590	18	7724	21
	District Dhubri						
	CHC Gauripur	41278	113	25355	70	29671	81
	CHC Gazarikandi	42765	117	38228	105	0	0
	PHC Golakgunj	68382	187	46645	128	39560	108
	PHC Raniganj	8711	24	8604	24	7484	21

IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

S. No.		2005		2006		2007 (UP TO JUNE'07)	
		Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance
	<b>CHAMPARAN (West)</b>						
	<b>BIHAR</b>						
	District Repot Champaran West			159767	438	154046	851
	District Hospital Bettiah Referral			53714	148	50580	279
	Hospital Gonohar			11506	32	10722	59
	PHC Chanpatia			15017	41	14440	80
	<b>JAMUI</b>						
	District Report						
	Jamui			94516	259	58898	325
	SDH Jamui			42720	117	31636	175
	FRU Chakai			24584	67	9618	54
	PHC Khaira			33456	92	13924	77
	PHC Laxmipur				39	7115	39
	<b>SARAN</b>						
	District Report Saran			158845	435	107677	595
	District Hospital Chhapra			63211	173	55272	305
	PHC Dariyapar	*No Information available for		14312	39	8848	49
	PHC Baniapur	for 2005 similarly no breakup available for any year		9447	26	7065	39

ANNEXURE

S. No.		2004-05		2005-06		2006-07	
		Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance
<b>HIMACHAL PRADESH</b>							
	Chamba	820412	2248	856926	2348	832482	2281
	RH Chamba	213371	585	215550	591	226273	620
	CHC Brahamaur	41315	113	45819	126	36891	101
	CHC Salauni	16308	45	19345	53	19170	53
	PHC Bathree	16952	46	17991	49	17503	48
	PHC Garola	10248	28	9407	26	8711	24
	Kangra	2149253	5888	2151799	5895	2460083	6740
	ZH						
	Dharamshala	316847	868	303335	831	313674	859
	CHC Ddasiba	32377	89	28924	79	31041	85
	CHC Gangath	35623	98	29873	82	33878	93
	PHC Paragpur	10892	30	9341	26	12569	34
	PHC Paprola	5433	15	4876	13	4687	13
	Sirmaur	730809	2002	770062	2110	651579	1785
	RH Nahan	214566	588	231743	635	175086	480
	CHC Shalai	21729	60	17355	48	19543	54
	CHC Samgrah	16737	46	15257	42	15254	42
	PHC						
	Naura Dhar	12678	35	11132	30	11243	31
	PHC Narang	12750	35	15681	43	12110	33

IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

S. No.		2005		2006		2007 (upto June 2007)	
		Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance
<b>MADHYA PRADESH</b>							
	District Mandala						
	District Hospital Mandala	115902	318	126624	347	59847	331
	CHC Beejadandi	14329	39	14578	40	3400	19
	CHC Narainaganj	20950	57	22560	62	25640	142
	PHC Jamthar	1890	6	2090	6	2280	13
	PHC Babaliya	3409	9	2600	7	2748	15
		<b>2004-05</b>		<b>2005-06</b>		<b>2006-07</b>	
		<b>Total</b>	<b>Average Daily OPD Attendance</b>	<b>Total</b>	<b>Average Daily OPD Attendance</b>	<b>Total</b>	<b>Average Daily OPD Attendance</b>
	District Hospital Indore	93852	257	100945	277	122931	337
	CHC Depalpur	61176	168	62956	173	64352	176
	CHC Sanwer	71855	197	78476	215	81268	223
	PHC Kshipra	11967	33	13194	36	19459	53
<b>ORISSA</b>							
		<b>2005</b>		<b>2006</b>		<b>2007 (upto June 2007)</b>	
	<b>District Jagatsinghpur</b>	<b>Total</b>	<b>Average Daily OPD Attendance</b>	<b>Total</b>	<b>Average Daily OPD Attendance</b>	<b>Total</b>	<b>Average Daily OPD Attendance</b>
	District Hospital Jagatsinghpur	152315	417	114432	314	99710	273
	CHC Kujang	55750	153	56833	156	54668	150
	PHC (N) Pankapala	11125	31	9173	25	10090	28
	PHC (N) Hansura	6103	17	7215	20	8260	23
	PHC (N) Malahunka	6368	17	6262	17	4663	13

## ANNEXURE

S. No.		2004-05		2005-06		2006-07	
		Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance	Total	Average Daily OPD Attendance
<b>UTTAR PRADESH</b>							
	District						
	Hospital						
	Varanasi	361400	990	405000	1110	99710	273
	CHC Jakkhini, Rajatalab	39511	108	42492	116	43211	118
	PHC						
	Chiraingaun	33537	92	33445	92	33133	91
	PHC Pindra	30847	85	32186	88	31373	86
	PHC Harahauan	31263	86	31328	86	32161	88

The trend as given in the table clearly indicates increased utilisation of OPD services. It is difficult to ascribe specific reason for this but possible reason for increased utilisation could be:

- Availability of Medicines & Supplies
- Availability of Personnel, especially Doctor
- Better infrastructure

### Strengthening of CHCs

#### Assam

In the state, 100 CHCs are in place while there should be around 232 CHCs as per population norm. All the existing CHCs have been identified for up-gradation as per IPHS norms. Work has been initiated in 93 CHCs for up-gradation. 2 SDH, 29 CHCs and 2 PHCs are functioning as FRU. In all 18

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Specialists have been appointed on contract during 2006-07. 216 AYUSH doctors have been appointed on contract during 2006-07.

One peculiar system observed in Assam was that administratively, CHC functions under block PHC.

The visit to some of the CHCs in Dhubri, Dibrugarh and Nagaun showed that in most of the places CHCs are not equipped to provide in patient service; they always refer patients. In CHC Tiloi of Dibrugarh District, patient is paid Rs. 500/ for transportation cost which is not sufficient to cover the actual expenses. This CHC is providing only OPD services, even facilities for normal delivery are not available. Such women are referred to Block PHC.

### Jharkhand

In the state, against the requirement of 201 CHCs, 194 CHCs are in place, thus there is a shortfall of 7 CHCs. In all 60 CHCs have been identified for up-gradation as per IPHS norms. 60 CHCs are also identified for physical up-gradation work (State PIP), but no work has been initiated.

There is also severe shortage of specialists at CHC. Against the requirement of 776 specialists, only 146 specialists are in place. No specialist has been appointed on contract during 2006-07. No institution is functioning as FRU.

A total of 159 AYUSH doctors have been posted at CHCs on contract.

### Orissa

In the state, 231 CHCs are in place while there should be around 314 CHCs as per population norm. All the existing CHCs have been identified for up-gradation as per IPHS norms. Work for physical up-gradation has been initiated in 5 CHCs. A total of 18 SDH, 51 CHCs and 18 PHCs are functioning as FRU. In Orissa, there is dearth of specialists as out of 924 required posts of specialists at CHC level, only 496 posts are sanctioned. No specialist has been appointed on contract.

## ANNEXURE

From the visit to CHCs by the review team, it was observed that presently CHC infrastructure is being improved. Construction work is going on at various places like CHC Kujang. All the required equipment and instruments have been purchased.

At present, the CHC Kujang is managed in the old PHC building of the Govt. Another new construction is undergoing which will be used for indoor services. The CHC does not have sufficient rooms for all facilities. The equipment like iron bed, examination table, computer has been kept in the outdoor due to lack of space. As a result of which the doctors face difficulty while examining the patients.

Treatment of specific cases like primary management of wounds, fractures, burns, draining of abscess and cases of poisoning are dealt with in the CHC. The CHC is also providing ANC, PNC, Newborn care, intranatal care including universal immunisation. Family planning operations like tubectomy are carried out in the hospital. The CHC is having one operation theatre where surgeries are being carried out. In addition, the CHC is providing 24hour service for delivery cases only. However, one major gap is that though the examination of female patients is conducted in the presence of a lady attendant, there is lack of privacy as the labour room has no screen on its doors and windows. Sanitation and cleanliness is not at all maintained in the labour room. The room is flooded with rainwater in the rainy season, thus creating unpleasant situation both for the patient and the doctors.

The CHC is having its own laboratory with adequate equipment and chemicals and is maintained in an orderly manner. Only routine blood, urine, stool and sputum tests for TB are carried out at the laboratory. For other tests like ICT for malaria, BTCT, RTI/STD with wet mounting etc., patient is referred to private pathology clinics.

Bihar

In the states 70 CHCs are in place while there should be 622 CHCs as per population norm. All the existing CHCs have been identified for

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

up-gradation as per IPHS norms in the state PIP. Work for physical up-gradation has not been initiated in any CHC. As per NRHM state report, no institution at any level has been functioning as FRU. In Bihar, there is dearth of specialists as out of 280 required posts of specialists at CHC level (based on existing no. of CHCs), only 88 posts are in place. As per state NRHM report, 1825 specialists have been appointed on contract.

Presently, the focus of the state is on making CHCs as 24x7 institutions. The state is planning to upgrade all its PHC and Referral hospitals to the CHC level standard. Since, currently the operational PHCs in the state are roughly one in every block (roughly 1.5Lac population), the state PIP mentions up-gradation of 201 PHCs and Hospitals into CHCs every year for next 3 years. In the district Saran which the review team visited, 15 PHCs will be taken up for this work. However, work has yet to be started.

### Chhattisgarh

In the state, against the requirement of 164 CHCs, only 118 CHCs are in place, thus there is a shortfall of 46 CHCs. In all, 113 CHCs have been identified for up gradation as per IPHS norms and physical up-gradation. Physical up gradation work has already been completed in 32 CHCs.

There is also severe shortage of specialists at CHCs. Against the requirement of 916, only 49 specialists are in place. In all, 231 Specialists have been appointed on contract during 2006-07.

- 110 AYUSH Doctors have been appointed on contract at CHCs.
- 18 SDH, and 24 CHCs are functioning as FRU
- 669 Staff Nurses have been appointed on contract in 2006-07

From the visit to CHCs by the review team, it was observed that presently CHC infrastructure is being improved. Construction work is going on at various places like CHC Baghbahera. All the required equipment and instruments have been purchased.

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### Himachal Pradesh

In the state, 66 CHCs are in place. 36 CHCs have been identified for up-gradation as per IPHS norms. Physical up-gradation work has been initiated in 15 CHCs. In all, 15 SDH, 32 CHCs and 2 PHCs are functioning as FRU. A total of 13 Specialists have been appointed on contract during 2006-07. There is shortage of specialists. There is no general surgeon and anaesthetist posted in the FRU and for want of an anaesthetist Caesarean and Gynaecological cases are also not being dealt with.

The FRU has received the latest equipment: defibrillator; atmospheric oxygen store equipment; fully automatic dental chair, etc. There is no shortage of medicine now.

### Madhya Pradesh

In the state, against the requirement of 417 CHCs, only 229 CHCs are in place, thus there is a shortfall of 188 CHCs. In all, 96 CHCs have been identified for up-gradation as per IPHS norms as well as physical up-gradation.

There is also severe shortage of specialists at CHCs. Against the requirement of 916, only 49 specialists are in place. A total of 13 Specialists have been appointed on contract during 2006-07. In all, 200 Ayush doctors have been appointed on contract at CHCs.

- 18 SDH, and 24 CHCs are functioning as FRU.
- Monthly health day camps are regularly organised every month.

In all the CHCs visited, no emergency care facilities were available, all cases were referred to the district hospital. Operation theatres were not in functional condition.

Both at Gwalior and Tikamgarh district by and large the displayed services at CHCs were not available; most of the check-ups are to be done at private institutions.

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### Uttar Pradesh

In the state, 386 CHCs are in place while the requirement is of 1097. Thus, there is a shortfall of 711.

- 100 CHCs have been identified, to be developed as per IPHS standards.
- 270 CHC/PHCs are being upgraded to provide 24 hours delivery service.

In many places up-gradation is going on, new buildings are under construction but the old ones do not have enough space. The CHCs do not have sufficient manpower, there is a severe lack of specialists in all the visited districts and this affects the services delivery. Against the total sanctioned posts of 1544, specialists at CHCs, only 413 are in place, thus having a shortfall of 1131. (If one calculates the requirement on the basis of requirement of 4 specialists per CHC for the required 1097 CHCs than the total requirement comes out to be 4388 out of which only 413 i.e. less than ten percent are in place).

- 450 Ayush doctors have been appointed at CHCs.
- The quality of services being provided by the CHCs visited by the team is not considered very good by the beneficiaries.
- The maintenance of the building and the condition of the ward was not found satisfactory.
- Most of the CHCs lack equipments like ECG, Ultrasound, X-ray, Incubator etc. There is lack of Lady Medical Doctors/ Gynaecologist, lack of Emergency Obstetric Services and Blood bank.
- During the discussion with patients it came out that most of the Doctors are busy in private practices. They charge Rs. 50/- as consultation fee and prescribed medicines have to be purchased from the local chemist.

The observations related with functioning of CHCs can be summarized as:

- Huge backlog in all the states – e.g. UP-711, Bihar-552

## ANNEXURE

- Severe shortage of specialists in all the states
- In states like MP, Orissa and Chhattisgarh work is initiated for up-gradation – both physical up-gradation as well as up-gradation as per IPHS norms.
- Very few specialists appointed on contract in Assam, Bihar, MP and Himachal.
- In Bihar, No CHC functioning as FRU
- No CHC as per IPHS Norms

### Strengthening of PHCs

#### Assam

The state has 610 sanctioned PHCs, out of which 168 are providing services on 24x7 basis. There is no PHC without a Doctor. In all, 39 Doctors have been appointed on contract during 2006-07. 216 AYUSH Doctors have also been posted. In 41 PHCs, 3 staff nurses have been posted. A total of 990 Staff Nurses have been appointed on contract during 2006-07.

In the PHCs visited by the review team Water and electricity facility; Generator; Kitchen and laundry; telephone, computer and Internet facilities were not available.

In Dibrugarh District, the PHCs visited by team have appointed two additional GNMs each and two PHCs are offering 24 hr services through out the week.

#### Jharkhand

The state has 330 PHCs in place against the requirement of 806 PHCs, thus having a shortfall of 476 PHCs. No PHC is working on 24x7 basis. In no PHC, three Staff nurses have been appointed. No Staff Nurse has been appointed on contract during 2006-07

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

### Bihar

In the state of Bihar, two types of PHCs are existing (1) Regular PHCs covering almost 1.5 lakh population with three medical officers (2). Additional PHCs (APHCs) covering around 20,000-30,000 population with one Medical officer.

One Government is going to convert all regular PHCs into CHC/FRU as mentioned above and all Additional PHCs into Regular PHCs with two medical officers. Going by the State population of 2001, state requires 2787 PHCs. There are 1243 Additional PHCs (APHC) working in the State. Thus, the state is still short of 1544 PHCs. There are 121 PHCs which do not have their own building. So, the state has to build 1665 PHCs buildings. The state PIP plans to construct 331 PHC buildings every year for the next five years.

In each district, one additional PHC (APHC) will also be handed over to NGOs as part of PPP. As of now, 16 APHCs are handed over to NGOs.. Similarly, no work has been initiated for up-gradation of PHCs to CHCs. However, money for infrastructure development has been received and the process for tendering has been started. In all, 397 PHCs have also started providing 24x7 services. However, as per State NRHM report, none of the PHCs have three staff nurses.

### Orissa

The state has 1279 sanctioned PHCs. None of the PHCs have started functioning on 24x7 basis. There are 46 PHCs without a Doctor. In no PHCs, three staff nurses have been posted. In all, 15 Staff Nurses have been appointed on contract during 2006-07

In Orissa, the norms for PHC are different than other places. There is a new PHC which is managed by a medical officer with a pharmacist and an ANM along with a helper. This PHC provides only OPD and Referral services. Though 2-4 beds are there, but these beds are used only for keeping patient, under observation.

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Laboratory services are absent in all the PHCs, malaria slides are only collected by the HW (F) and are sent to the CHC for confirmation. Other tests like BTCT, diagnosis of RTI/STDs with wet mounting, gram, stain, rapid test for pregnancy and HIV, YAWS surveillance are not conducted.

### Chhattisgarh

The state has 518 PHCs in place against the requirement of 659 PHCs, thus having a shortfall of 141 PHCs. In all, 192 PHCs are working on 24x7 basis. However, in no PHC three Staff Nurses have been appointed. 669 Staff Nurses have been appointed on contract during 2005-07

Mahasamund district has 37 sectors and 27 PHC, out of which 15 are old and 12 new.

In the PHCs that we visited, Komakhan is according to the IPHS norm, whereas the other PHC, Bhitidih, is run from a sub-centre building. It neither has beds, nor staff residence.

However, both these PHCs are not offering services for 24x7 hours. A single doctor is posted who also does not reside at the location. These doctors also work at CHC many times due to which on many occasions they missed evening OPD at PHC. The Doctor at Bhitidih is newly posted with around one year experience after graduation so he doesn't know much about NRHM except the name. He also informed that there might be a training for MOs on NRHM but when, where, is not clear. The PHC also had NRHM news letters lying with the staff nurse which he has not even bothered to look at. On an average, this PHC caters to 20-30 patients per day and there is no change in number of cases attending the OPD. There are no facilities for indoor admission or even delivery.

### Himachal Pradesh

The state has 439 sanctioned PHCs, out of which 95 are functioning on 24x7 basis. There are 11 PHCs without a Doctor. No Doctor has been appointed on contract during 2006-07. In no PHC, 3 Staff Nurses have been posted. 125 Staff Nurses have been appointed on contract during 2006-07

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

### Madhya Pradesh

The state has 1192 sanctioned PHCs against the requirement of 1670 PHCs thus having a shortfall of 188 PHCs. In all, 95 PHCs are functioning on 24x7 basis. There are 253 PHCs without a Doctor. In all, 204 Doctors appointed on contract during 2006-07. In 378 PHCs, three staff nurses have been posted. 480 Staff Nurses have been appointed on contract during 2006-07.

In most of the PHCs visited by the review team, facilities for indoor admission were very poor. Staff availability with reference to population coverage was inadequate. PHCs are largely run by single doctor, who has to also supervise a large number of subordinates.

Most of the staff members are living in cities, commuting to PHCs, and on daily basis, reducing the hours of presence in PHCs and sub centres in all the districts visited by the review team.

### Uttar Pradesh

The state has 3660 PHCs in place against the requirement of 4390 PHCs, thus having a shortfall of 730 PHCs. In all, 225 PHCs are working on 24x7 basis. However, in no PHC 3 Staff nurses have been appointed. In all, 75 Doctors have been appointed on contract in the period 2005-07. A total of 507 Staff Nurses have been appointed on contract during 2005-07.

In the state, there is a substantial gap of over 730 PHCs that need to be built. In all, 270 CHC/PHCs are being upgraded so as to provide 24 hours delivery service.

As per the reports of review teams, most of the PHCs are in the reach of the community. The transportation is available. The buildings of some PHCs were not good. Most of the PHCs have boundaries. During the visits, it was found that the surrounding environment of the PHCs was not very healthy.

**Others:** During visits it was observed that as a whole, the condition of the building, staff, testing, medicine, facility, sanitation, service availability

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and the behavior of the staff available at the time is not very satisfactory. This was also raised by the community during the FGD. The PHCs were mostly looked after by the Pharmacist and most of the doctors were busy in their private practices.

The observations related with functioning of PHCs can be summarised as:

- Shortfall in all the states except Assam and Himachal
- Few PHCs in Assam, Himachal, and MP started providing 24x7 services
- Orissa, Bihar, MP have a large number of PHCs with one Doctor only
- Lack of lab services, especially in Orissa, Bihar
- Doctors, staff nurses appointed on contract in Assam, Himachal, Orissa, MP

### Janani Suraksha Yojna

#### Assam

As per NFHS III, 22.70% deliveries are Institutional deliveries. In the year 2006-07, there were 1.66 lakhs Institutional deliveries reported, a marginal increase over 2005-06 when the number was 1.49 lakhs. However, number of reported beneficiaries of JSY went up from 0.17 lakhs in 2005-06 to 1.72 lakhs in 2006-07 (Beneficiary included home delivery also).

In all, three districts where the review was conducted it was found that there was no proper system of implementation of the JSY.

The district and block level functionaries have no clarity on the scheme, and as a result there is confusion and many beneficiaries have been found complaining about non-receipt of the money while others complain of delay in receipt of the getting the amount. A critical observation is that the whole purpose of JSY, which is primarily to promote Institutional deliveries is getting diluted as almost all births, whether at home or by trained/untrained TBAs( domiciled deliveries), are being eligible for JSY.

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The District Media Expert of Dhubri district informed the review team that though in the year 2005-2006 there were no JSY beneficiaries, in the subsequent year 2006- till Jan 2007, under the NRHM, there have been a total of 12146 JSY beneficiaries – 2803 (institutional) deliveries and 9343 (home) deliveries.

### Jharkhand

As per NFHS III, only 19.20 percent deliveries are Institutional deliveries. In the year 2006-07, there were 0.57 lakhs Institutional deliveries – almost same as the reported figures of 2005-06 when the number was 0.53 lakhs. The number of reported beneficiaries of JSY went up from 0 in 2005-06 to 0.86 lakhs in 2006-07 (Beneficiaries included home deliveries also).

- 140 institutions in private sector have been accredited for institutional delivery.

### Orissa

As per NFHS III 38.70 percent deliveries are Institutional deliveries. In the year 2006-07, there were 3.58 lakhs Institutional deliveries – a increase of 1.03 lakhs over 2005-06 when the number was 2.55 lakhs. The number of reported beneficiaries of JSY went up from 0.19 lakhs in 2005-06 to 2.27 lakhs in 2006-07 (Beneficiaries included home deliveries also)

- During 2006-07, a total of Rs 2443.00 Lakh was spent on JSY.

### Bihar

As per NFHS III ,22 percent deliveries are Institutional deliveries. As per state NRHM report in the year 2006-07, there were 1.23 lakhs Institutional deliveries which were much less as compared to 2005-06 when the number was 2.37 lakhs. However the number of reported beneficiaries of JSY went up from 0 in 2005-06 to 1.13 lakhs in 2006-07 (Beneficiary included home deliveries also, only 41222 Institutional deliveries).

- During 2006-07, Rs.442.00 Lakhs were spend on JSY.

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The JSY money is directly being given through the CMO office in Saran district. We visited four sub centers in Sadar block, all of them were locked so we could not get information directly from the ANM but on talking with the community members, they knew about JSY scheme as well as about the money available under this scheme. In the Sadar block which review team visited, none of the sub centres were providing the labour room and delivery facilities. On enquiring from the CMO, he explained that the district hospital Chapra was in the same block and most of the sub centers were hardly 6-8 kilometres away from the civil hospital. Therefore, to promote utilization of hospital services, they were deliberately not encouraging deliveries at sub centres.

### Chhattisgarh

As per NFHS III, 15.70 percent deliveries are Institutional deliveries. In the year 2006-07, there were 1.10 lakhs Institutional deliveries – a marginal increase over 2005-06 when the number was 1.03 lakhs. However, the number of reported beneficiaries of JSY went up from 0.25 lakhs in 2005-06 to 0.64 lakhs in 2006-07 (Beneficiaries included home deliveries also).

- During 2006-07, a total of 308.00 Lakh was spend on JSY.

There has been a good publicity of JSY and people do know about it. The Mitanins are also supposed to encourage Institutional deliveries. Institutional deliveries have increased as a result of JSY. All the three districts we surveyed, have reported problems in finance. There are cases of backlogs in all the three districts and the district CMOs have reported problems in getting the money regularly. In family planning also, they are not getting the money. About three lakh rupees is pending. The ANMs have reported that they are not getting the money from the PHC. It is difficult to explain people that why ANMs are not getting the money. The people do not understand this and complain that the ANMs eat up the money and do not give it to them.

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### Himachal Pradesh

As per NFHS III, 45.30 percent deliveries are Institutional deliveries. In the year 2006-07, there were 0.49 lakhs Institutional deliveries – less than the reported figures of 2005-06 when the number was 0.52 lakhs. However the number of reported beneficiaries of JSY went up from 0.01 lakhs in 2005-06 to 0.05 lakhs in 2006-07 (Beneficiaries included home deliveries also, only 1546 Institutional deliveries)

### Madhya Pradesh

As per NFHS III, only 29.70 percent deliveries are Institutional deliveries. In the year 2006-07, there were 9.21 lakhs Institutional deliveries – almost 50 percent more than the reported figures of 2005-06 when the number was 5.99 lakhs. The number of reported beneficiary of JSY went up from 0.68 lakhs in 2005-06 to 3.97 lakhs in 2006-07 (Beneficiaries included home deliveries also) All the three districts we surveyed, have reported problems in finance. There are cases of backlogs in all the three districts and the district CMOs have reported problems in getting the money regularly.

### Uttar Pradesh

As per NFHS III, 22 percent deliveries are Institutional deliveries. In the year 2006-07, there were 17.65 lakhs Institutional deliveries – much less than 2005-06 when the number was 19.22 lakhs. However, number of reported beneficiaries of JSY went up from 0.12 lakhs in 2005-06 to 0.98 lakhs in 2006-07 (Beneficiaries included home deliveries also, only 94483 Institutional deliveries)

- During 2006-07 state has reported an expenditure of Rs. 1917.00 Lakh on JSY

There has been very little publicity of JSY and not many people know about it. Institutional deliveries have increased as a result of JSY. But still, the majority of deliveries are conducted at home. All the three districts we surveyed, have reported problems in finance. There are cases of backlog in all the three districts and the district CMOs have reported problems in

## ANNEXURE

getting the money regularly. The government has now come up with well defined guidelines for the release of money.

The observations related with implementation of JSY can be summarised as:

- In the real sense it is the public face of NRHM
- Increase in Institutional deliveries in all the states, except UP
- More JSY Beneficiaries are home delivered rather than in Institutions, especially in Bihar, Himachal
- Large backlog for payment in some of the states

### Provision of Untied Funds

#### Orissa

In Orissa the untied fund is provided to all the sub centres visited by the team. The funds available have been used for minor repairs, transportation, and purchase of medicines.

#### Chhattisgarh

Variation is reported in the amount of untied funds received. It ranges from 10,000 rupees in Mahasamund to 13,800 rupees in Dhamtari. In Dhamtari, some of the SCs have spent the money on stationery, electricity fittings, chair, table, rack, etc. In Mahasamund, Narra SC has spent the money on medicines, and grill. The ANM in Narra does not have a good relation with the sarpanch; she has taken out Rs 4,000 in one go and used that amount according to her convenience. The ANMs do not have the information if they will be getting the money next year also.

#### Himachal Pradesh

Joint accounts have been opened at subcentre/block levels. In those subcentres where there are no banks, accounts have been opened in the post offices.

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Rs.2, 05,50,000 has been disbursed to subcentres as untied funds. Funds have not been disbursed to some subcentres which have been upgraded to PHCs.

An operational guideline regarding utilisation of this allocation has been circulated.

- Some subcentres do not have a Female Health Worker; in these subcentres, the Male Health Worker is authorised to open the bank account with the Pradhan of the Panchayat.
- Health Sub Centre Grant at the rate of Rs 10000/- per annum is sanctioned for activities approved by PARIKAS or Village Health Committee;
- Untied grant of Rs. 25000 and annual maintenance grant of Rs. 50000 per annum per PHC is received for the Mission Period;
- RKS have been formulated at PHC level to utilise the grant and untied funds properly.

### Madhya Pradesh

Untied fund has been released to all PHCs and sub centres in the month of June 2006. Due to this fund, almost every institution has purchased its furniture, and some have repaired the building. In all, 8134 joint accounts have been opened with this fund.

Untied fund has also been released to CHCs in the month of February 2007 – Rs 20 lakh for each FRU in the first year and another Rs.20 lakh to be given the next year;

In all the villages visited by the review team, PRI members do not know about the untied fund.

### Uttar Pradesh

Variation is reported in the amount of untied fund received. It ranges from 10,000 to 13,800 rupees. The ANMs do not have the information if they will be getting the money next year also. They are also not very sure

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that for what items they can use the money. Now, as per the new guidelines for village level, untied fund will be given to ASHA and Sarpanch, so new accounts will be opened.

The observations related with utilisation of untied funds can be summarised as:

- Reached up to sub centre level in all the states
- Major instrument for empowering ANMs
- Many ANMs not very clear on how to use this fund in all the states
- Places where RKS are not formed – Not given especially at District Hospital

### Strengthening of Sub Centres

#### Assam

The state has 5109 SCs. The NRHM report says only 2637 SCs are located in government buildings and 4726 are functional with one ANM. In 1800 SCs, only two ANMs are posted while 80 SCs are without any ANM. In all, 2827 ANMs have been appointed on contract during 2006-07.

#### Jharkhand

The state has 3958 SCs in position against the requirement of 5057 thus having a shortfall of 1099. The NRHM report says only 1736 SCs are located in government buildings and 3958 are functional with one ANM. None of the sub centres are functioning with two ANMs.

No ANMs has been appointed on contract during 2006-07.

#### Orissa

The state has 5927 Sub Centres (SCs). There is a shortfall of 1356 sub centers. The NRHM report says that only 2542 SCs are located in government building and 5574 are functional with one ANM. In 171 SCs,

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only two ANMs are posted while 353 SCs are without any ANM. In all, 171 ANMs have been appointed on contract during 2006-07.

Most of the sub-centres visited by the review team are managed by a single ANM.

Sub centres mainly provide services like ANC, PNC, Newborn care, conduct immunisation on every Wednesday as per the Government schedule, distribute contraceptives, and oral pills and motivate the community to take family planning measures. The sub centre organise awareness camps on health and sanitation, diet and nutrition, adolescent health care and during the programme, distribute IFA to avoid anaemia, besides assisting in various national and school health programmes.

- In most of the sub centres visited by review team labor room or proper facilities for delivery are not available.
- Medical officer visits sub center once every month, but the ay is not fixed.

### Bihar

To cater for the existing population of roughly 8.6 crores, the state needs 16614 sub centres out of which 8858 are in place with only one ANM. Each Health subcentre, as per IPHS, norms should have 2 ANMs. Total number of required ANMs for all sub centers as per IPHS norms will be 11964 ( $8858+2 \times 1553 = 11964$ ).

The Government has appointed 1091 ANMs on contract.

The review team visited four sub centres in sadar block of Saran district and all of them were locked. All of them were in rented places which were poorly located. On inquiring from local community members, they mentioned that sub centres usually open for half a day for 2-3 days in the week. Rest of the days the ANM visits other villages. Main function of a sub centre is immunisation and ANC/PNC. But no delivery ever takes place in sub centre. Usually medicines are free but ANM charges for the cost of syringe used for immunization. No doctor ever visits the sub centres.

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### Chhattisgarh

The state has 4692 SCs. The state PIP accepts that the gaps in the sub-centre are enormous. The NRHM report says only 1458 SCs are located in government buildings and 3919 are functional with only are ANM. Over 260 sub-centre buildings are under construction, but given the gap of over 2800 sub-centers to be built, this is less than ten percent.

Of the 218 Sub centers in Mahasamund district, 148 are old sub-centres. Of these, 80 are running from an old building, 20 are under construction, 16 have got new permission, the Zila Parishad has agreed to construct 10 sub-centres.

During the process of review, the review team visited two sub centres in Mahasamund and one in Dhamtari district.

In the sub-centres, Narra in Mahasamund has an old building but does not have official electricity connection. ANM lives in the same campus. The space is very limited. All the maintenance is being carried out by the ANM using her own money. On an average, ten deliveries take place every month at a sub center. There is enough stock of medicines available. Immunisation coverage is more than 90 percent. However, ANM shared her frustration for complete lack of any opportunity for further promotion as she has been an ANM for more than 20 years. The other sub-centre Vrindavan did not have a building; it is operated from a rented premise from where Anganwadi is also functioning. There is very limited space because of which no delivery takes place. Even doing ANC and Immunisation becomes very difficult.

The sub centre at Chhati in Dhamtari district was best run. The building has some space, though not adequate for conducting deliveries as well as internal examinations. There is proper boundary wall and open space with small patch for flowers and other plants. On an average, 15-20 deliveries take place every month. The ANM charges money ranging from 200 to 500 rupees in the name of medicines provided by her. She also frequently uses Oxytocin for induction of labour or hurrying with the delivery, which is an

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irrational practice. The ANM said she has not heard of NRHM, while at the very entrance of Sub centre itself, there is a big wall-writing highlighting the Immunisation schedule and logo of NRHM.

### Himachal Pradesh

The state has 2069 SCs. The NRHM report says only 1262 SCs are located in government buildings and 1903 are functional with only one ANM, while 420 SCs are without any ANM. In all, 71 ANMs have been appointed on contract during 2006-07.

### Madhya Pradesh

The state has 8874 SCs. The NRHM report says only 3996 SCs are located in government buildings and 8834 are functional with one ANM, 542 are functional with two ANMs while 603 SCs are without any ANM. 1102 ANMs have been appointed on contract during 2006-07.

From the field visit and interaction with some of the ANMs, it emerged that ANMs are not very clear on the background and concept of NRHM. Some still follow the pre-NRHM protocol. Skill up-gradation is almost negligible. The role of ANMs is limited to immunisation. Many ANMs are not able to devote enough time to Sub Centre because of the large area of coverage. Most of the sub centres visited largely are able to serve only people from the same village where the sub centre is located. Many ANMs are not equipped with technical skills of measuring Blood Pressure, Hemoglobin Test, BCG, Sugar test and even diagnosis of pregnancy during, the early stages.

### Uttar Pradesh

The state has a shortfall of 5823 SCs. The State PIP accepts that the gaps in the sub-centre are enormous. There is a need for around 20,000 ANMs if all the SCs are to be as per IPHS norm and provide services 24x7 hours.

Out of 20521 SCs, only 6581 SCs have their own building and 21925 are functioning with only one ANM. There are 431 SCs without any ANM.

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The ANM training centres are being strengthened and new schools are being opened in the current financial year. In all, 4000 ANMs can be trained every year through these 50 training centres.

Advertisements have been given to appoint 4000 nurses on contract. Proposals have been submitted to Government of India for sanctioning six new nursing colleges.

The PHCs and the sub-centres do not have any facilities for transport, the Panchayat fund is rarely used for this. People prefer going to RMPs, even ANMs and MPWs privately.

The observations related with functioning of sub centres can be summarised as:

- Massive shortfall in all the states
- ANMs are not much aware about NRHM
- At most of the places visited, ANMs do not live at the centre
- Have received untied funds but not sure how to use it, for what purpose, problems with Sarpanch
- Not sufficiently equipped for conducting deliveries

### Knowledge of Responsible staff about NRHM at District and Lower levels

In most of the states visited by review team, staff at the lower level – like PHCs, sub centres, etc., has very limited knowledge about NRHM. It was taken as a source of additional funds only. Very few training programmes were conducted on creating awareness about it. In most of the states the State Programme Management Unit (SPMU) and District Programme Management Unit (DPMU) are set up except in UP where none of these are set up and Jharkhand, where only SPMU has been set up.

## Community Awareness about NRHM

In most of the states, awareness about NRHM is created mainly through Radio and TV spots. Sensitisation programmes on NRHM organised so far have not been able to reach communities in far-flung areas. For those who have heard through radio, it is just another programme. People have no idea about NRHM in general but they have some knowledge about JSY in the form of money given during delivery and ASHA.

The situation was different in Orissa where in Jagatsinghpur and Malkangiri, people were aware about NRHM. All reported that some activities had taken place in their villages and referred to ASHAs, JSY and immunisation service. All reported some differences in the availability of health services and hoped that more would be available. Community was involved during the selection of ASHAs.

The observations related with community awareness can be summarised as:

- Most of the community members ignorant about NRHM except in Orissa
- Some Knowledge about ASHA, and JSY especially in Orissa, Chhattisgarh, Himachal and MP
- Do not find any change since launch of programme especially in UP and Jharkhand

## PRI Involvement

Though PRIs have an integral role to play in the implementation of the NRHM, currently they are merely involved in the selection of ASHAs. In all the places where review team visited, Panchayats do not have much idea of NRHM. Village level health and sanitation committees are mostly non-functional. In many places, joint accounts between ANM and Sarpanch have been opened but there is little collaboration between the ANM and the Sarpanch. Very little formal efforts have been made to sensitise PRI through orientation programmes, except in Orissa and MP. In these states, PRI members were more aware about NRHM than in other states.

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The observations related with PRI involvement can be summarised as:

- Very limited in all the states except MP and ORISSA
- VHSCs are almost non-existent/non functional, except Orissa and MP in Chhattisgarh. Mitanins have created their own VHSCs
- No specific training to PRI members on NRHM except in Orissa
- PRIs have an idea about JSY and ASHA

### Selection and Training of ASHA

#### Assam

In the state of Assam, a total of 26427 ASHAs have to be selected over the mission period. Till April 2007, 25400 ASHAs have been selected. Out of these, only 14030 have undergone training of the first Module.

The ASHA selection process has been politicised with many ASHAs claiming to have to pay for their selection and appointment (Khudimari and Rajapara in Dhubri district). It can be inferred that norms are not being strictly adhered to in terms of ASHA selection.

FGDs of which ASHAs were a part, show clearly that despite having gone through the rounds of orientation/training, they are not aware of their roles and responsibilities towards the community.

ASHAs are not even adequately oriented on the NRHM, nor do they have clear concepts of vital RCH issues. No uniformity of training schedule/duration for the ASHAs. Training for the ASHAs varies from place to place.

#### Jharkhand

In the state of Jharkhand, a total of 18000 ASHAs have to be selected over the mission period. Till April 2007, 14218 ASHAs have been selected out of which 3446 have completed training on first module.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

### Orissa

In the state of Orissa, in all 47592 ASHAs have to be selected over the mission period. Till April 2007, 46246 ASHAs have been selected, out of these only 12729 have undergone the training of first Module.

Selection of ASHAs - In Jagatsinghpur district of Orissa the ANM, Sarpanch and other members of the village health and sanitation committee selected ASHA, keeping view of her financial condition and interest to work for the community development in the village, preferably in age group of 25-45, married/widow/divorced.

ASHAs work in collaboration with the members of PRIs and PHCs and Community. They also maintain good work relationship with the ANMs, PHC Doctors.

ASHAs have not received proper training in two of the districts visited i.e. Malkangiri and Jharsuguda and there is no sufficient back-up support.

### Bihar

At the state level, around 74313 ASHAs have to be selected. Till the month of April 2007, 77844 ASHAs have been selected. From the visit to the field and discussion at village sub centre and PHC level, it was clear that in the selection of ASHA, Community and Gram Sabha have not played any role. In the visited village, ASHA was either selected by the ANM or Village Pardhan. Guidelines for selection of ASHA were not followed at all.

Till the month of April 2007, 42830 ASHAs have been provided orientation training of 7 days. They have not received the second training as well as drug kits. At the field level, review team could meet 4-5 women selected as ASHAs but they have not even received the first orientation training. They had no idea of the type of work they will be involved with or whether they will be receiving any financial remuneration or not. However, they all were hopeful of receiving some financial remuneration in the future thinking that their work will be quite similar to Anganwadi workers work.

## ANNEXURE

In the NRHM PIP for the State, provision has been kept for setting up the ASHA support system but no such system has been put anywhere.

### Chhattisgarh

In Chhattisgarh, the Mitans have been incorporated as ASHAs. ASHA is for a population of 1000. The Mitans programme, which was under the SIP, had a 250 population norm and therefore, there are 60,000 Mitans in Chhattisgarh whereas ASHA allows for only 20,000.

The Mitans Programme was started in November, 2002, and later they were incorporated as ASHA. The villagers know the Mitans in their village; she is there since the last four years. In many places, the Mitans was selected by her relatives without any village meetings like in Brindavan. The Mitans have completed their eighth round of training in most places. She has the drug kit which she gets refilled by the ANM. She gets 50 rupees for gathering people on a vaccination day. They get the money once in three-four months. People go to the Mitans for common illness like fever, pain or itching. Mostly, there is a constant demand of her medicines but in village like Brindavan, the Mitans seems to be from a better off family and people do not approach her much.

In Mahasamund district, the CMO said that maximum number of Mitans are active. Malaria and diarrhea are controlled due to Mitans. All over the state, the epidemics are in control, the Mitans being a major reason. The performance of the Mitans is good. Their IMR was the lowest in Chhattisgarh last year at 36/1000, presently it is at 28/1000. The MMR is 158/lakh. The CMO attributes this to the good vaccination coverage because of the Mitans.

Mitans' presence has increased the immunisation coverage. The pregnant women have also stated accessing ANC. Moreover, any disease outbreak is immediately reported, thus preventing a major epidemic.

The state has released 80% of its fund last year.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

### Himachal Pradesh

In the state of Himachal Pradesh, a total of 7750 ASHAs have to be selected over the mission period. However, as per the state NRHM report, no ASHA has been selected till April 2007.

### Madhya Pradesh

In the state of Madhya Pradesh, a total of 44379 ASHAs have to be selected over the mission period. Till April 2007, 31,690 ASHAs have been selected, out of which 16866 have completed their training on the first module.

For selection of ASHA in many places, no guidelines have been followed. In Gwalior and Tikamgarh districts, most of the ASHAs selected come from powerful and opinion leader families.

ASHAs have been selected very recently and have very little knowledge about their duties / services they have to provide to the community.

The modalities of payment to ASHA are still not clear.

### Uttar Pradesh

UP has to identify 1,23,000 ASHAs over the mission period, out of which 1,19,000 have been selected and till the end of March 2007, 98,000 have received their first round of training.

SIHW is responsible for training. They have already finalised the plan and contents for the second round of training. The second round of training will be for 12 days. This training will include 2nd, 3rd and 4th module of ASHA training as developed by the Government of India. In addition, they are also going to include a one-day training on building interpersonal communication skills and two days on MIS on how to maintain index register for diseases. The training will be organised at block level and Nyay Panchayat level.

## ANNEXURE

The status of the training in our selected districts Shahjahanpur and Varanasi is as follows:

In Shahjahanpur District the total numbers of ASHAs to be selected were 2001 while 1851 have been selected and 1385 trained upto February 2007 in 14 Blocks. As per the information, the training programme is continued for the selected ASHAs.

In Varanasi District, the programme has been implemented in the entire district (8 blocks). Out of which, selection and training of ASHAs has been completed in four blocks only. It is useless to say that after the completion of two years of the NRHM implementation, the selection and training of the ASHAs has not been completed. Therefore, the question of the impact of NRHM can not be thought of.

The survey team discussed with 10-12 ASHAs about their work, training and procedure of the selection during the field visit of the concerned district and also out of the district. The response was not very satisfactory. They were not clear about their work and the selection procedure was not as per the guidelines.

### Backup Support

During the discussion it was found that they have not got any Medical Kit or any backup support. They are helping in the immunisation, antenatal checkup and some what in JSY.

### Financial Matters

ASHA got financial support from different programmes, including *Janani Suraksha Yojna*. However, till a few days back, there was no system for payment to ASHA. How much contribution is to come from which programme was also not clear. Now the Government has come out with a comprehensive GO detailing payment mechanism for ASHA. The mechanism also includes provision of impress money of Rs.2500 to be kept with ASHA. Last Thursday of the month has been designated as Meeting

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

and Payment Day for ASHA. It is hoped that now ASHA will receive her payment regularly.

Joint account of Gram Pradhan and ANM has been opened and Rs. 10,000/- transferred in this account but they are not aware of how to use this amount.

The observations related with selection and training of ASHA can be summarised as:

- Around 90 percent ASHAs selected, except in Jharkhand and Himachal Pradesh
- Guidelines for ASHA selection were mostly ignored, except in Orissa or wherever NGOs were involved in the selection process
- Training quality poor in most of the places. second round not even initiated
- Most of them not aware of their roles and responsibilities
- Support system for ASHA yet to be put in place in almost all the states except Chhattisgarh
- Problems with payment, modalities yet to be worked out in most of the states.

### Involvement of NGOs and Public – Private Partnership

As of now, there is very little systematic involvement of NGOs in the implementation of NRHM. The NGO involvement is Limited to implementation of MNGO and FNGO scheme. Partnership with Non-governmental organisations is sought mostly for special drives for immunisation, Leprosy, Malaria, Blindness Control, etc., HIV/ AIDS control etc but not on a sustained basis. Some NGOs, especially in Orissa and in UP (SIFPSA partners) were involved in the selection of ASHAs in few blocks. At many places in Assam, Orissa, and MP, NGOs were also involved in training of ASHAs.

## ANNEXURE

As a part of public – private partnership in some states like Jharkhand, MP mobile medical units are managed by NGOs. In Bihar, few activities such as running some APHCs, clinical tests, cleanliness at PHCs, ambulance services, etc., have been outsourced to NGOs and others. Orissa and UP are in the process of developing comprehensive guidelines for PPP. In Himachal Pradesh, the government has approved four areas where there could be effective partnership between the public and the private sector:

- Total Ambulance services;
- Non-functional sub centres to be handed over to non-government organisations;
- Diagnostic facilities provided by non-government organisations to be recognised; Medical and Para-medical education to be allotted to Private Universities or Private Institutions;

Gynaecologists in private practice in Chamba, Kullu, Hamirpur and Kangra districts have been identified to perform laparoscopic sterilisation.

The observations related with NGO involvement and PPP can be summarised as:

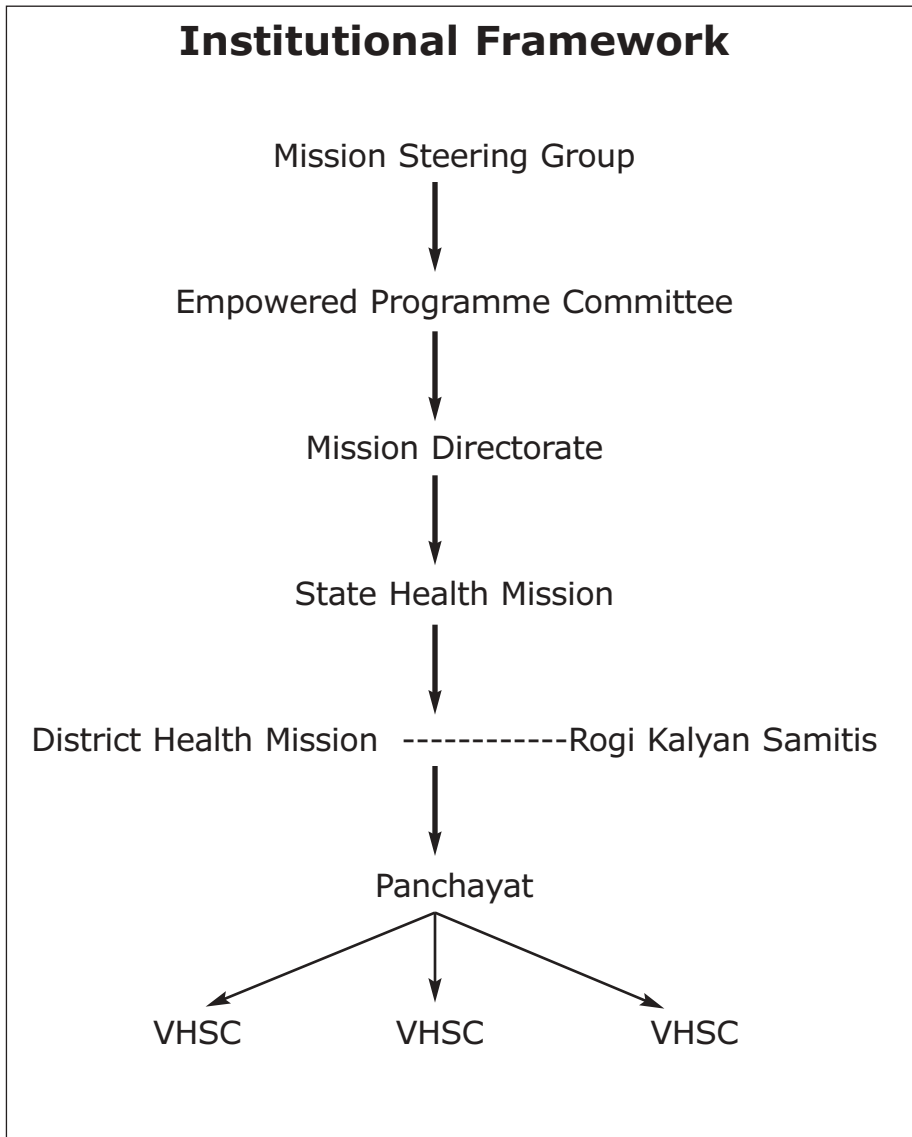
### NGO Involvement

- Very little systematic involvement; Limited To MNGO/FNGO only in MP, Orissa, Chhattisgarh and Himachal Pradesh
- No involvement in UP, Bihar
- In Jharkhand involved for training of SAHIYAs and some research work related with NRHM

### Public-Private Partnership

- Running of Mobile Medical Units in Jharkhand and MP
- Managing Additional PHCs in Bihar
- Provision of Diagnostic facilities in Bihar, Himachal Pradesh
- Orissa and UP in the process of finalising guidelines

## INSTITUTIONAL MECHANISM FOR IMPLEMENTING NRHM



## ANNEXURE

The following Institutional mechanism has been recommended as a part of framework for implementation of NRHM.

**As per this flow chart for setting up of institutional mechanism at the state level following activities were to be under taken.**

1. Set up the State and District Rural Health Mission
2. Merger of Health and Family Welfare Departments
3. Merger of State and District Health and Family Welfare Societies
4. Formation of Rogi Kalyan Samitis
5. Formation of Village Health and Sanitation Committee

Following is the status of achievement in the states selected for review:

### 1. Set up the State and District Rural Health Mission

Assam

State and District rural health mission has been set up.

Bihar

State Rural Health Mission has been set up. There is a merger of State Rural Health Mission and State Health Society. The Mission Director, NRHM also act as the Executive Director for the State Health Society. As per the information available at the State Level, District Rural Health Mission has been set up in all the districts. However, their functioning is still not very streamlined. In the district of Saran, which I visited personally, till date only one meeting of District Rural Health Mission has taken place. The CMO also explains that in this meeting there was hardly any participation from the people's representative either from the MLA side or PRI members.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

### Chhattisgarh

State Rural Health Mission has been set up. However, there is no merger of State Rural Health Mission and State Health Society. There is separate Mission Director, NRHM and Executive Director for the State Health Society. As per the information available at the State Level, District Rural Health Mission has been set up in all the districts. However, their functioning is still not very streamlined. The Chhattisgarh state has an officer of the rank of Joint Secretary as the mission director. There is a state programme manager and there are district programme managers in all the districts. The state programme management unit reports to the mission director and DHS. The role is not very clearly stated out. The mission director says that the positioning of the programme has not been done.

### Himachal Pradesh

As a part of NRHM, State Health Mission has been set up under the Chairmanship of the Chief Minister and District Health Mission under the Chairmanship of Minister In-charge of District. The State Health Society has been set up under the Chairmanship of Principal Secretary (Health); District Health Society has been formed with DM being the Chairperson of the Executive Body. Separate Rogi Kalyan Samitis (RKS) are being set up with all the district hospitals.

### Jharkhand

State Rural Health Mission has been set up.

### Madhya Pradesh

As a part of NRHM, State Health Mission has been set up under the Chairmanship of Chief Minister and District Health Mission under the Chairmanship of Minister In-charge of District. The State Health Society has been set up under the Chairmanship of the Principal Secretary; District Health Society has been formed with the DM being the Chairperson.

## ANNEXURE

### Orissa

State Rural Health Mission has been set up. However, there is no merger of State Rural Health Mission and State Health Society. There is separate Mission Director, NRHM and Executive Director for the State Health Society. As per the information available at the State Level, District Rural Health Mission has been set up in all the districts. However, its functioning is still not very streamlined. The Orissa state has an officer of the rank of Joint Secretary as the Mission Director. There is a state programme manager and there are district programme managers in all the districts. The state programme management unit reports to the Mission Director and DHS. The role is not very clearly stated out.

### Uttar Pradesh

As a part of NRHM, State Health Mission has been set up under the Chairmanship of Chief Minister and District Health Mission under the Chairmanship of Minister In-charge of District. The State Health Society has been set up under the Chairmanship of Chief Secretary; District Health Society has been formed with the DM being the Chairperson of General Body and CMO Chairperson of Executive Body. Separate Rogi Kalyan Samitis (RKS) are being set up with all the district hospitals.

The Mission Director explained that though UP is lagging behind in setting up institutional mechanism for implementation of NRHM, this was because of elections and state's political situation. Now, things will start improving. She mentioned that during the last financial year, the focus was on selection and training of ASHA and operationalising the given a green signal JSY.

To facilitate the release of funds, UP Government has after which all health facilities action till the block level has been shifted to SBI. All these accounts are linked through e-transactions, so there is no delay in payments.

## 2) Merger of Health and Family Welfare Departments

No action has been taken on the merger in the states of Assam, Jharkhand, Orissa, Bihar, Chhattisgarh, Himachal and Madhya Pradesh.

In Uttar Pradesh, though the state government has merged the health and family welfare department, the merger is only in the sense that there is now single Principal Secretary, Health. However, there is a separate directorate for health and family, with full functioning staff including separate secretaries for health and family welfare. The distribution of work between two directors is skewed. Secretary Family Welfare handles the NRHM but mainly the RCH component. All other National Health Programmes like TB, Malaria, etc., fall under the Department of Health. Department of Welfare is responsible for implementation of the programme under NRHM, including upgrading of PHC/CHCs, etc. but the establishment which includes hiring of staff, their posting, transfer, etc., is under the Directorate of Health.

Till date, State Programme Management Unit has not been formed, though cabinet approval has already been received for formation of programme management unit at State Division, District and Block level.

Presently, because of separate directorate, there are lots of problems with finances, since the money available with the directorate of health under various national programmes is not coming under Director, NRHM. Mission Director felt that the Centre has issued ambiguous guidelines for this delegation of financial powers because the guideline states the Mission Director NRHM or Director General Health Services. Therefore, in case of UP, RCH related funds are handled by Mission Director while other National Health Programmes and infrastructure – related funds are handled by Director General, Health. She feels that under the National guidelines, the position of NRHM is not very clear therefore different states are adopting different models. She feels that while the Centre has given such detailed guidelines in relation with programme implementation, why they have come out with such vague guidelines for the institutional mechanism for implementation of NRHM.

### 3) Merger of State and District Health and Family Welfare Societies

Merger of societies is a key component in NRHM. Merger has taken place in all the states under review except Jharkhand and UP, but operationally there are problems. The SPM of Chhattisgarh says that there are problems because no one knows how to actually do it, because every society has their own executive body and legal structures. Merger is not possible just like that though on paper it is shown as a unified society. In Jharkhand, process of merger has been initiated and has been completed in 22 districts but not at the state level. In UP, even the process for merger has not been initiated.

### 4) Formation of Rogi Kalyan Samitis

#### Assam

As per the state report, Assam Rogi kalyan samitis have been formed in all the places, i.e. in district hospital, CHCs and PHCs. As of April 2007, 23 District Hospital RKS, 93 CHC level RKS and 610 PHC level RKS have been formed and registered. However, in all the locations visited by the review team RKS was non-functional, existing only on paper.

#### Bihar

As per the state report, Bihar Rogi kalyan samitis have been formed in all the places, i.e. in district hospital, CHC and PHC. As of April 2007, five District Hospital RKS, nine CHC level RKS and 32 PHC level RKS have been formed and registered.

Rogi Kalyan Samitis have been formed up to the district level. However, most of them are still not registered. As per the DPM of Saran, there is a problem getting registration done with the Registrar of Societies. Now the state health society is trying to facilitate this process. The State Health Society has received money for Rogi Kalyan Samities at the district hospitals but the money has not been released because of non-registration.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

At the time of the visit of review team, no such Samiti (registered or unregistered) has been existing at the PHC of sub centre level.

### Chhattisgarh

As per the state report, Chhattiagarh Rogi kalyan samitis have been formed in all the places, i.e. in district hospitals, CHCs and PHCs. As of April 2007 16 District Hospital RKS, 128 CHC level RKS and 497 PHC level RKS have been formed and registered.

There are representatives from the civil society in the samiti, but this is on the basis of money donated by individuals. In the Jeewandweep samiti, the minister-in-charge is the president of the GBM and the collector is the secretary. In the executive meeting, the collector is the chairman and the CMO is the secretary. The GBM of the Jeewandweep samiti in Mahasamund has not been held in the district because the minister-in-charge has not been able to give time. The Mahasamund CMO says that the people outside the department are not interested in whatever we do. On an average, the Mahasamund district hospital has an income of about 32,000 per month. Last January, the income was Rs.35,000 though OPD, Lab, X-ray. The expenditure is about Rs. 65,000 per month on an average. In January, the expenditure was Rs. 43,000. An amount of Rs. 50,000+ Rs.25,000 has come for the 14 PHCs. In the district hospital, cleanliness has been contracted out. For food, Rs.60 per day is fixed, so the SHGs have taken the responsibility. The post of sweepers is abolished; the government says that this needs to be given under a contract. But there is no money from the government; this money has to be given from Jeewandweep Samiti.

### Himachal Pradesh

Himachal has RKS at District Hospitals level since 1999. Now Rogi kalyan samitis have been formed in all the places, i.e. in district hospitals, CHCs and PHCs. As of April 2007, 12 District Hospital RKS, 12 CHC level RKS and 2 PHC level RKS have been formed and registered.

Promotion of stakeholders committee (RKS) for hospital management.

## ANNEXURE

An RKS at Nurpur has since 1999, earned about Rs. 36.00 lakh, out of which Rs. 28 lakh has been spent on betterment of facilities in the hospital.

### Jharkhand

Rogi Kalyan Samitis have been formed in all the places in Jharkhand i.e. in district hospitals, CHCs and PHCs. As of April 2007, 15 District Hospital RKS, 138 CHC level RKS and 179 PHC level RKS have been formed and registered.

### Madhya Pradesh

Rogi Kalyan Samitis have been formed in all the places, i.e. in district hospitals, CHCs and PHCs. As of April 2007, 48 District Hospital RKS, 267 CHC level RKS and 870 PHC level RKS have been formed and registered.

### Uttar Pradesh

In UP, Rogi Kalyan Samitis have been formed in all the places, at least up to the district hospital level, but most of them are still unregistered.

## 5) Formation of Village Health and Sanitation Committee

### Assam

Though PRIs have an integral role to play in the implementation of the NRHM, currently they are merely involved in the selection of ASHAs. It has been planned to popularise the ASHA through sectoral meetings with Sarpanchs and Gram Sabhas.

## Non-existent Village Health and Sanitation Committees

### Bihar

In all the four villages and sub centres where we visited, Panchayats have no idea of NRHM. Village level health and sanitation committee is non-functional. There is hardly any collaboration between the ANM and the Sarpanch. All the four sub centres which we visited were locked and we

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

could not meet any of the ANM at the sub centre. Sarpanch had no idea about the untied function and whether any such money has been received or not. One of the Sarpanchs was involved with the selection of ASHA, but could not inform about the criteria used for selection except that she is a widow and willing to work. Similarly at the district level, Chairperson of Zila Parishad had no idea about NRHM. She knew about the district health society, but she is not a member of that as some other member of Zila Parishad is a member.

### Chhattisgarh

In all the four villages and sub centres where we visited, Panchayats do not have much idea of NRHM. Village level health and sanitation committee is non-functional. There is hardly any collaboration between the ANM and the Sarpanch. One Sarpanch had no idea about the untied function and whether any such money has been received or not. Involvement of PRI seems to be limited to interaction with ASHA/MITANIN

### Himachal Pradesh

#### Village Level Health, Water, Sanitation Committee – PARIKAS (Parivar Kalyan Salahakar Samiti)

The department of Health and Family Welfare, Himachal Pradesh had notified the formation of PARIKAS at district, block and health sub centre level in 2001. The membership of PARIKAS is derived from department such as Health, SJEE, IPH and Education. It actively seeks involvement and leadership of the representative of PRI. The State Health Mission in its meeting on 20.9.2005 retreated that PARIKAS shall function as village health, water and sanitation committee as envisaged under NRHM. This committee will have inclusion of one member from each feeding village of the sub centre. But, as per CMO Kangara, PARIKAS is not being involved in NRHM.

## ANNEXURE

### Jharkhand

Jharkhand Village health and sanitation committees are formed for basic sanitation facilities in the village.

Not all PRI members were aware about NRHM. They know about the sum of 10,000 rupees which is provided as the untied fund in NRHM, and the joint account placed in the name of ANM and Sarpanch of the village, which will be utilised to address the minor unmet needs for health at the sub centre.

The PRIs are also members of the Village Health and Sanitation Committee and is responsible for the overall supervision of all its activities.

A meeting on the six point programme of the Government is held on the 1st and 16th of every month, fortnightly, which is attended by the ANM, AWW, school teachers, PRIs, SHG leaders, Member of the PDS.

### Madhya Pradesh

In all the places where the review team visited, Panchayats do not have much idea of NRHM. Village level health and sanitation committee is non-functional. There is hardly any collaboration between the ANM and the Sarpanch. One Sarpanch had no idea about the untied fund and whether any such money has been received or not. Involvement of PRI seems to be limited to interaction with ASHA.

- Health committees have been formed
- Membership of both male and female
- No Clarity on the roles of health committee
- Training of health committee members has been done at some places. No separate meetings held for the committee except that a discussion was held with this committee during the Gram Sabha.

## IMPLEMENTATION OF NRHM : AN INITIAL REVIEW

- Health committees are extending support in pulse polio campaign, health camps, exhibition, sanitation and promotion of health messages.
- Financial demands of the committee are met by the Gram Panchayat.
- Health plan has yet to be made.

### Uttar Pradesh

In all the villages and sub centres where survey team visited Panchayats do not have much idea of NRHM. Village level health and sanitation committee is non-functional. There is hardly any collaboration between the ANM and the Sarpanch. One Sarpanch had no idea about the untied fund and whether any such money has been received or not. Involvement of PRI seems to be limited only to interaction with the PHC staff.