In Defence of the National Rural Health Mission

AMARJEET SINHA

The National Rural Health Mission provides a large canvas and platform for health action, but Shyam Ashtekar (EPW, 13 September 2008) misses many issues and does not make his critique from the right perspective. During the short period of its existence there is ample evidence to show that the mission has been moving in the right direction, crafting a credible public system of health delivery starting from the village and going up to the district level.

I have carefully read Shyam Ashtekar's article titled "The National Rural Health Mission: A Stocktaking" (EPW, 13 September 2008) and would like to submit that the article misses many issues and does not seem to place them in the right perspective. This response is not meant so much to challenge the wisdom of Shyam Ashtekar. He has been guiding the National Rural Health Mission's (NRHM) Accredited Social Health Activist (ASHA) mentoring group and the mission would like to place on record the learning from his insights. We value his views. As someone associated with the design and implementation of NRHM, I thought a few clarifications on some of the "perceptions" would be in order. The NRHM has deemed it fit to request the most independent minded non-governmental organisations (NGOs) to create a framework for community monitoring by organising public hearings and to help the mission in making public systems accountable. The mission has nothing to hide and would like transparency and accountability to community organisations to be a part of all its activities.

Home-grown Idea

The assumption in the article is that the NRHM is driven by external funding agencies. He does not seem to be aware that the NRHM is entirely a home-grown idea which has developed with contributions from the best of public health and public administration experts. The prime minister launched the mission in April 2005 and a number of task forces went into developing clear focus on a range of healthcare issues. These task forces had representation of public health experts, civil society organisations, academics, etc. One of these task forces worked on developing the Framework for Implementation of the NRHM which was approved by the union cabinet in July 2006. The detailed framework is a very strong commitment towards crafting credible public systems by following five key approaches, namely: (a) communitisation; (b) adequate and flexible financing; (c) monitoring against Indian Public Health Standards; (d) innovations in human resource management; and (e) building capacity at all levels for decentralised health action. The thrust of NRHM is public systems and its accessibility, affordability and accountability. Unlike many other programmes in the health sector in the past, the NRHM is about crafting a credible public system of health delivery at all levels starting from the village and going right up to the district level. All programmes (except HIV/AIDS, cancer and mental health) were brought under the umbrella of the NRHM.

Very categorically NRHM committed itself to communitisation under the umbrella of panchayati raj institutions (PRIs). Accordingly, Village Health and Sanitation Committees were to be set up, joint accounts of auxiliary nurse-midwife (ANM) and sarpanch were to be opened at the health sub-centre and block levels and district level health missions had to be constituted involving PRIs. Facility specific *Rogi Kalyan Samitis* (patient welfare committees) had to be established in primary health centres (PHCs), community health centres (CHCs), sub-district and district hospitals. The Village Health and Sanitation Committees and the thrust on organising the Village Health and Nutrition Day every month at the village Integrated Child Development Services (ICDS) centre are intended to promote greater convergence among sectors that determine health outcomes like water, sanitation, education, health and nutrition. Initiatives in nutrition have been funded in West Bengal, Andhra Pradesh, Gujarat, Madhya Pradesh, Orissa, Bihar, etc. The NRHM provided the flexibility to the states to design their own interventions for outreach of services. From the gram panchayat headquarter level clinics at sub-centres in West Bengal to the *Muskaan* programme at the ICDS centre in Bihar, the *Mamta Abhiyaan* in Gujarat, the boat clinics and mobile medical units in Assam, are an affirmation of flexibility available to the states.

Amarjeet Sinha (*amarjeetsinha@hotmail.com*) is a civil servant and is currently with the Ministry of Health and Family Welfare, New Delhi.

The interventions made in the last three years are a testimony to the flexibility of the programme. From cellphones to ANMs to interventions for sickle-cell anaemia, flurosis, school health programmes, emergency medical transport systems are all an affirmation of the great diversity of interventions that states have undertaken. I can say with full confidence that no state government would agree with Ashtekar's comments that "though flexibility is its key word, the NRHM's design and budgeting leaves little creative freedom for states". The record of proceedings and the programme implementation plans of the states are all available on the web site of the Ministry of Health and Family Welfare (www.mohfw.nic.in) for anyone to look at.

Ashtekar makes a comment that untied funds are "verily a problem rather than a solution". On the one hand, Ashtekar would like flexibility in the system. On the other hand, he is not able to understand systems of untied funds contributing to local health action. If ANMs in the country are able to procure their blood pressure (BP) equipment, stethoscope, weighing machine, examination table, curtains, etc, from untied resources as per need, is it not an example of flexibility? The guidelines for untied funds are well articulated and are available on the web site of the ministry for anyone to see. It permits any Village Health and Sanitation Committee, Sub-Centre Committee, Rogi Kalyan Samitis of PHCs, CHCs, sub-district and district hospitals to undertake any intervention that is likely to provide to the public health service guarantee for local people. Hospitals and health centres have been transformed in many parts of the country with the untied resources as it permitted provision under community institution supervision, as per felt need. In Tamil Nadu private sector deliveries have come down as the well equipped PHCs provide quality of services better than many private institutions. I concede that there is a long way to go in improving the quality of services but it is going to take a little time. It is true that in many parts of the country doctors in PHCs and CHCs still do not have the confidence to spend. We will have to build that confidence under the scrutiny of public institutions like the Rogi Kalyan Samitis. We should not go back on decentralisation if we are keen on flexibility and local action.

Involving Local Institutions

Ashtekar has rightly raised the issue of involvement of the PRIs. In spite of our best efforts we concede that the involvement needs to be further stepped up as NRHM is committed to working under the umbrella of PRIs. At the same time, the NRHM has also provided for other village level organisations like self-help groups (SHGs), women's groups, *mahila samakhya* groups, water and sanitation groups to be represented on the Health and Sanitation Committees as the intention is to ensure that all those who have the motivation are given the authority as well. The Rogi Kalyan Samitis also have representation of civil society besides the PRIs for the health facilities. Alongside the involvement of the PRIs, through the institution of the State Health Mission under the chief minister, the NRHM has tried to put health as a priority for the political system. In state after state, chief ministers have been chairing State Health Mission meetings and providing very useful leadership for change and development.

As somebody who has attended a large number of such meetings at the state level, a statement by Shyam Ashtekar that NRHM is yet to catch the attention of the political community seems strange. We do concede that a lot more work on building capacities at district and below sub-district level is required. The central government has conducted a large number of workshops on planning and implementation for state level teams. It has also facilitated visits to states which have done well on particular themes by all other states for them to emulate the good practices. State teams have gone to Chhattisgarh to look at the *Mitanin* programme and community processes, to Tamil Nadu to look at their procurement and logistic systems under the Tamil Nadu Medical Supplies Corporation (TNMSC), to Gujarat to look at their outstanding infrastructure development programmes. The NRHM is about learning from each other and today every state is trying to emulate a good practice of another state. Andhra Pradesh started a partnership for emergency medical transport with the toll free 108 number and with well equipped ambulances and paramedic staff. Already Gujarat, Tamil Nadu, Rajasthan, Assam, Goa and Uttarakhand have followed suit and many other states are in the process of doing so in a very short time. The case with nutrition resource centres of Madhya Pradesh and their extension to states like Orissa, Gujarat and Bihar is similar.

We concede that the District Health Action Plans prepared by most of the districts of the country could have been more participative. Being the first exercise at large-scale decentralisation, some states felt more comfortable in involving consultants with technical planning skills in the process while many others chose to do it themselves. In many states the planning process involved the panchayats and some excellent local problems and issues were flagged in the process. Some consultant-driven plans like the ones in Jammu and Kashmir brought out the key issues of districts very clearly. They needed to be far more consultative but one has to realise that the ideal situation does not exist in many places. By bringing in technical skills through consultants, states were able to kickstart the process of decentralised planning. We hope that this process will gain in strength over the years. It is mandatory for these plans to be approved by the District Planning Committee to ensure full convergence under the umbrella of the PRIs. Decentralised planning will take a little time in deepening its community ownership and in giving confidence to local institutions to raise their key concerns.

Expanding Trained Cadres

Ashtekar seems to be of the view that a well-trained ASHA is a substitute for ANM, nurses, doctors and other paramedics. The NRHM has managed to bring in an

additional 2,500 specialists, 10,000 doctors (including ayurveda, yoga, unani, siddha and homeopathy (AYUSH) doctors) and over 40,000 ANMs and staff nurses into the health system. Considering the size that existed before NRHM, it is not a small number. In states like Assam, the increased human resource has started providing healthcare services where nothing existed before. Bihar has recruited ANMs and nurses after many, many years. It is true that it is far short of the requirement that we have and it will take us a few years to provide ANMs and nurses that we need. There are excellent examples like West Bengal where local communities have selected a local resident woman to undergo the 18-month ANM training programme. The NRHM has added over 5,00,000 ASHAs who are at various stages of their training. More than half of them have been provided their drug kits. The NRHM saw ASHA as a health activist who connects households to health facilities. Very clearly it was felt that for ASHA to become a community health worker and then a full-fledged health worker may take a few years. We do not buy the philosophy that remote areas do not need more nurses and doctors and that community workers is all that is needed. Even with the best of the community workers, there is a case for expanding well-trained cadres of nurses and ANMs in the system. The NRHM has emphasised these aspects alongside efforts to develop ASHAs into community health workers and thereafter in some cases even into a health worker. The process will take sometime as we do not want to inflict an untrained worker on the lives of poor households simply because they live in remote areas. We have encouraged higher payments in remote areas to attract health workers like in Uttarakhand, Orissa, Rajasthan, Andamans, Lakshadweep, etc.

The author is right in pointing out that human resources is the key issue. The NRHM's top most priority has been on securing resident health workers in rural areas and the addition of doctors, nurses and paramedics made under the programme is a testimony to this thrust. Contract and local criteria have been emphasised to ensure that resident health workers are available to the community. Strangely, Ashtekar seems very dismissive of doctors, nurses and paramedics and their willingness to live in rural areas. The NRHM has tried to strengthen the block level hospitals to provide round the clock hospitalised care. It has also tried to establish 24 × 7 PHCs with three staff nurses to enable round the clock provision for deliveries and for attending to emergencies. By co-locating the AYUSH doctor in over 4,000 PHCs, CHCs, the NRHM has also made an effort to involve the Indian systems of medicine not only for providing a choice to households but also for making a trained professional available who manages even the national health programmes

after adequate training. States like Gujarat and now Orissa have recruited a large number of ayurveda doctors and propose to use them for the management of national health programmes as well. It is only on account of the thrust to add resident human resources that the number of 24 × 7 healthcare institutions has risen many times. The names of all such institutions are being placed on the web site of the Ministry of Health and Family Welfare for anyone to visit the field and hold us responsible.

The issue of salaries of doctors has been rightly raised in Ashtekar's article. We would like to inform him that NRHM processes have led to a demand for better service conditions in many states. New agreements have been concluded in Kerala and Orissa which provide better service condition for doctors. This has been on account of the pressure put by NRHM's higher contractual salaries for doctors and specialists. The NRHM has also encouraged large-scale provision for difficult area allowances, tribal area allowances, PG allowances, etc. Evening out patient departments (OPDs) have been started in states like Assam and Kerala and doctors are compensated for this additional duty. Performance based payments have also been introduced in many states to ensure that the take home package of doctors and specialists are satisfactory. Many states have devised new ways of attracting doctors to rural areas by providing them an enabling environment to work in. There are still large governance issues which need to be resolved. The NRHM, in partnership with the states, is providing a platform which allows for it.

Funds and Accounting

It is strange that Ashtekar identifies transfer of funds to the State Health Societies as not a very accountable system and largely driven by external agencies. He does not seem to realise that this has been resorted to as the transfer through treasuries have in the past led to delayed and inadequate funds for activities. As somebody associated with the design of Sarva Shiksha Abhiyan (SSA) as well, the government first went in for the treasury route for the fund transfer to the states for the programme. It had to be given up within a year on account of delayed releases for the activities in the field. The State Health Societies are subject to the same set of audit and NRHM in fact provides for Comptroller and Auditor General's (CAG) audit as well. Currently, the CAGs performance audit of NRHM is also going on in all the states. The State Health Society route of funding has nothing to do with external agencies. Both the SSA and NRHM are completely home-grown and not influenced by external agencies, whose fear and apprehension seems to inform Ashtekar's article. If the treasury system could ensure transfer of funds to each and every level of decentralised programme implementation in time, all state governments will be very happy to move to that account. The NRHM will be very happy to make that shift if it works effectively.

Faulty Assumptions

Ashtekar laments the decline of the *dai* system or its inadequate involvement under the NRHM. We would like to clarify that NRHM allows for training and skill development of registered medical practitioners/traditional medical attendants/dais as well, wherever they have basic literacy and are willing to do long-term programmes that help them to improve their skills. This has been provided for in the framework for implementation and states are being encouraged to undertake this as well. The role conflicts of anganwadi workers, ASHAs and dais needs to be viewed differently as any change always leads to resistance.

Ashtekar's lament is that the male multi purpose worker (MPW) is not a part of NRHM. I would like to clarify that the male worker is very much a part of NRHM. The states have to provide for a male worker and currently not even 50% of health subcentres have a male worker. The government of India under NRHM has been putting pressure on state governments to fill up the existing vacancies of MPW (male) before they are entitled to the second ANM. This pressure is being put to ensure the availability of three persons at the subcentre, namely, two ANMs and one male MPW. The intent of the mission is not to substitute and that is why existing posts of MPW (male) had to be filled up by state governments. If we wish to reach 2% to 3% gross domestic product public expenditure on health it cannot come by substitution; it will only come by supplementation. I am amazed how lack of facts and figures can at times lead to faulty conclusions.

As has been mentioned earlier, the framework for implementation of the NRHM was approved only in July 2006. It provided a large canvas and platform for health action. It is not even two years since the framework for implementation of the NRHM was approved and during this period there is evidence from a large number of states of improved outpatient cases, institutional deliveries, immunisation, drug availability, diagnostic service, ambulance services, etc. Public health is a marathon and not a sprint and Ashtekar will agree with us that it will take a little time. We are seeking partnerships with the NGO sector wherever required to build on the public sector health resources. These partnerships are for a range of services from diagnostics to human resources to institutional deliveries, etc. We have NGOs who have taken the responsibility of running PHCs in very remote tribal areas. We have a large number of innovations going around in the states, the details of which are all available on the web site of the Ministry of Health and Family Welfare. The thrust on human resources and the flexible financing is providing the rare opportunity to seek service deliveries at all levels of the health system. We are confident that the health indicators of our country will not be the same if we continue to relentlessly pursue the strategies that we have adopted in the NRHM in partnership with the states. The NRHM respects health as a state subject and provides the states the opportunity to determine their course of action. The large number of innovations reflects the confidence of the states in doing what is a priority. I only wish Ashtekar's piece was better informed with facts and figures and had been based on a wider travel across the country to see what is happening in the field. We accept all his criticism in humility. We would like to assure readers that three years later he will realise that his assessments were far from the real picture.