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Evaluation of National Rural Health Mission in Bangalore Rural District

KEYWORDS: NRHM, Primary Health Care, Community Health Care, ASHA, ANM

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ABSTRACT *The National Rural Health Mission (NRHM) was introduced in the year 2005. It is a flagship programme of the United Progressive Alliance (UPA) government, to revitalize the public system of health care in the country. The thrust of this mission was to establish a fully functional, community owned, decentralized 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 gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.*

This study assesses the performance of NRHM in Bangalore Rural District. Since NRHM primarily represents architectural improvements in the public health system in the rural areas, we review the performance of the Mission at different levels starting from the bottom. Qualitative information will be collected in a subset of such institutions, using open ended semi-structured questionnaires. These questionnaires were devised to capture qualitative information regarding planning, implementation and expenditure processes and community involvement related issues. For this purpose, individual personnel within the health department will be interviewed. The participants of these interviews are: District Health Officers (DHOs)/District Programme Management Officers (DPMOs, Taluk Health Officers (THOs), Medical Officers (MOs), Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activists (ASHAs) and VHSC representatives. On the basis of field survey, the study provides necessary feed back to implementing agencies about the implementation of scheme and bottlenecks experienced in achieving the objectives of the scheme.

Introduction

The National Rural Health Mission (NRHM) was introduced in the year 2005. It is a flagship programme of the United Progressive Alliance (UPA) government, to revitalize the public system of health care in the country. The thrust of this mission is on establishing a fully functional, community owned, decentralized 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 gender equality.

National Rural Health Mission was first implemented in Karnataka in 2005. But the full fledged activities began in full swing in 2007-08. In Karnataka, the implementation plan for NRHM has been developed by integrating different strategies suggested by the state health policy as well as core strategies of NRHM. The district health action plans from all the districts of the state are integrated to form the state Program Implementation Plan (PIP) with a focus on the backward districts and high focused districts. The program implementation plan mainly gives an overview of the present health status, situational analysis of the infrastructural facilities of the state and the plan of implementation for the current year.

It highlights the strategies and activities to be undertaken by different components of the program in detail so as to meet the goals and objectives of the program. As evident in the next sections, the mission has been able to improve the health status of the state in terms of the health indicators such as decreased MMR, IMR, increased number of institutional deliveries etc.

Objectives of NRHM[1]

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR).
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

Objective of the Evaluation Study

The principal activity under this objective was to conduct a systematic evaluation of the performance of the NRHM in Bangalore Rural District relying on empirical analysis of the primary and secondary data; detailed interviews of health functionaries at the village, block and the district levels.

2. Methodology

Since NRHM primarily represents architectural improvements in the public health system in the rural areas, we review the performance of the Mission at different levels starting from the bottom. For each of category of participants, separate semi-structured questionnaires were prepared. Since NRHM primarily represents architectural improvements in the public health system in the rural areas, we review the performance of the Mission at different levels starting from the bottom. Thus, we have the major components of NRHM as:

a) Village level – 20 ASHAs
b) Sub-centre level – 10 ANMs (Sub centres)
c) PHC level – 4 PHCs
d) CHC level – 2 CHCs

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In order to collect the necessary data and information, we utilized a set of questionnaires for ASHAs, ANMs, and Medical Officers in Charge in PHCs and CHCs. Qualitative information was collected in a subset of such institutions, using open ended semi-structured questionnaires. These questionnaires were devised to capture qualitative information regarding planning, implementation and expenditure processes and community involvement related issues. For this purpose, individual personnel within the health department were interviewed. The participants of these interviews were: District Health Officers (DHOs)/ District Programme Management Officers (DPMOs, Taluk Health Officers (THOs), Medical Officers (MOs), Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activists (ASHAs) and VHSC representatives. The following sections provide the analysis of quantitative information collected during the field visits.

Findings of Field Analysis

Functioning of Community Health Care Centres (CHCs)

Both the CHCs have own building and they have necessary equipment for delivery, pharmacy and availability of the medicines. But medicines are available only to some extent. When we come to availability of emergency obstetric care, emergency care for sick children, safe abortion services, etc. we find the situation is awful in both the CHCs. Both the CHCs are having separate wards for male and female. In case of Vijayapura there are 10 wards each for male and female where as in case of Thyamgondlu 2 wards exist. Vijayapura CHC has equipped labour room where as Thyamgondlu doesn't have and also it doesn't have minor OT. In Both the CHCs electricity supply is there for 6-8 hrs only and in both the CHCs generator is not functioning. Very important point to note that both the CHCs are not connected with any Blood Banks.

Availability of specialists/doctors comprising of surgeons, gynaecologists, paediatricians, and even physicians is poor in both the CHCs. The following table shows human resource availability in both the CHCs.

Functioning of Primary Health Care Centres (PHCs)

In order to provide optimal level of quality health care, Primary Health Centre is universally recognized the most effective intervention to achieve significant improvements in health status of population in the locality. For the purposes 4 PHCs have been surveyed in our sampled district under the sampling criteria of 2 PHCs under each of selected CHCs in the district.

All the 4 PHCs surveyed were reported to be functioning in own buildings. All the 4 PHCs have drinking water facility but Dabaspet and Manne PHC has only 2-4 hrs of water availability. In all the 4 PHCs pharmacy is available but adequate medicines are not available. However, all the PHCs have OPD rooms but none of the PHCs has minor OT or general OT. In all the PHCs only 6 hrs of electricity is available and none of the PHCs had functioning generator. Only 2 PHCs has functional vehicles. None of the PHCs are linked with blood banks. The following table shows human resource shortage in all the four PHCs.

Functioning of Sub-Centres and ANMs

Sub-Centre (SC) is a bridge between rural community and public primary health care system. A sub centre is responsible for providing all primary health care and makes the services more responsive and sensitive for the rural community. This section provides information on the sub-centers (SCs) and ANMs based on our sample survey. It can be seen that on an average there is one ANM per SC. The number of villages covered per ANM is in the range of 5 to 8. Quality of healthcare at SC therefore obviously suffers. Number of ASHAs per ANM also varies substantially in these SCs. The average number of rooms in the SCs also varies considerably from 1 to 4. Only 30% of SCs have their own buildings. In terms of the physical infrastructure, about 50% SCs did not have delivery tables, 40% SCs did not have medical equipments, 30% SCs did not have electricity connection, 50% SCs did not have water supply for 24 hrs per day, and only 5% SCs had a two wheeler. NRHM funds have not succeeded so far to remove this deficiency of physical infrastructure prevailing at SCs.

70% of ANMs are involved in the selection of ASHA with whom they have to work closely. However, 60% ANMs felt that ASHAs had reduced their work load. Almost all ANMs received the NRHM un-tied grant of Rs.10,000/- per year. All ANMs had joint bank account with Sarpanch of the Panchayat. 80% ANMs used the fund for repairs and renovations; 10% for buying medicines; 10% for electricity supply. In short, the funds were used for overcoming the infrastructural shortcomings wherever they were used. However, utilization of the NRHM fund by the ANM also ran into problems reported by 30% ANMs. This happened largely because of the joint account with Sarpanch, where the NRHM funds were made available. The Sarpanch used to demand his commission for signing the check that would be in the range of 20% to 50% of the amount. As a result, some ANMs would not spend the money and others may not be able to properly spend the money. However, 80% ANMs felt that the funds given under NRHM were not adequate, since the physical infrastructure continued to be in the bad shape as found above.

The ANMs get their drug kits refilled as reported to us is regularly. 60% get it weekly; 30% fortnightly; 10% rarely. Still the refill of drug kits still remains a problem and AYUSH medicines are largely missing. No ANMs conducted deliveries and deliveries were referred to either PHC or CHC. At the SC level, NRHM has started making some difference particularly by providing some discretionary fund for improving the infrastructure and getting some equipment, but there is still a huge gap in these matters before quality of the healthcare improves significantly. Problems encountered in utilization of this fund by ANMs need to be particularly addressed quickly to achieve better progress.

FINDINGS OF Household Survey

An important objective of this study is to assess the availability, adequacy and utilization of health services in the rural areas, the role played by ASHAs, AYUSH in creating awareness of health, nutrition, sanitation and hygiene among the rural population and to identify the limitation and mechanism in the implementation of the NRHM.

Thereby, selection of villages was to facilitate purposive selection 40 households with the objective criterion of selection of at least households having respondents under pregnant women, lactating women with new born children of less than one year. The household schedule comprised main sections including socio-economic characteristics of members of the household, details about utilization of ANC by the pregnant women, utilization of the delivery and post-natal care for children aged 0-5 years. Further, we gathered information about awareness about NRHM, ASHA, existence of VHSC, etc. and also client's satisfaction with the health services.

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Knowledge about ASHA, NRHM, AND VHSC

Data collected through field surveys indicate the extent of respondent's knowledge regarding NRHM, ASHA, and VHSC. The data shows that only 30.3% of people heard about ASHA and 54.5% of people have heard about NRHM. 44.4% of respondents have heard about NRHM through news papers followed by ASHAs/ANMs. 36% of the respondents said that ASHA visits weekly, 33% households said bi-weekly in the respective village. 31% of the households reported that ASHAs will not visit their village. On an average only 30% ASHAs having kits and in 27% cases they provide common medicines to people as reported by the surveyed people. Even though VHSCs are one of the important components of NRHM, 93% of the respondents told that VHSCs does not exist in their village. 75.8% of the households replied that no health camps were conducted in the village. Only 42.4% people have told about improvement after launching of NRHM. 42.4% of the respondents said that they have seen some improvement in health facilities and infrastructure after launching of NRHM. After introducing this scheme there are improvements in availability of medicine and the quality of the treatment.

Functioning of Accredited Social Health Activists (ASHAs)

Our survey provides information on different aspects of ASHA's background, selection, training, and interface with community and rewards. To analyse the functioning of ASHAs we interviewed 20 ASHAs. Out of these, 70% of the ASHAs have been joined in the year 2009 and 80% of the ASHAs are staying in the serving village.

About the selection procedure, 55% ASHA said, there were Focused Group Discussions (FGDs) conducted before selection and candidates were shortlisted. 40 % said, Gram Sabha meeting was held during the selection process. 45% ASHA worked as community based workers earlier. Almost all of them received training after joining. Almost 95% ASHAs received some formal training for 10 to 31 days during the first year of their work. Almost all ASHAs felt that the training was very useful in solving doubts and in refilling supplies. About 90% ASHAs received some compensation of Rs 500 for attending the training. About 95% ASHAs have receive drug kits. Medicines for fever, and pain killers, etc were the part of the drug kits for 20% ASHAs. More than 90% ASHAs interviewed informed us about their active involvement in creating awareness in the community on health, hygiene and nutrition; mobilizing community to utilize healthcare services such as ANC, PNC, Immunization; sanitation, counselling women on birth preparedness and safe delivery; new born care, breast feeding and complementary feeding, infant immunization, use of contraceptives and family planning measures, escorting pregnant women and sick children to the nearest HF and informing SC/PHC/CHC about births and deaths in the village. However, 35% ASHAs did not participate in promoting construction of household toilets. The preferred destination of ASHA escorting a pregnant woman was a sub centre. There is a marked variation in the reported average amount received for accompanying a pregnant woman to a HF by ASHA. It varied from Rs100 to 400. About 90% ASHAs complained about the money being inadequate since they had to spend extra money out of their pocket. Only 15% ASHAs received performance based incentives. About 75% ASHAs received proper support from the ANM or AWW (Anganwadi Worker) for refilling the drug kits, on the job training, guidance regarding use of various medicines, doses and side effects of contraceptive pills, and danger signs of pregnancy and labor pain. Only 60% ASHAs were actively involved with PRIs and VHSCs. Almost 75% ASHA felt that institutional deliveries have increased after NRHM that shows positive mindset and optimistic attitude of ASHAs.

Conclusion

Field level experiences from in-depth discussions with the state health officials provided an insight into the policy environment for implementation of the NRHM programme. Though the program got picked up quite late but seems to be progressing quite well. Some important suggestions are:

Serious shortage of medical doctors and specialists and paramedical staff, especially staff nurses and lab technicians, was extended as a serious reason for not getting good results despite no financial constraints under NRHM. It was clearly expressed that postings and availability of qualified doctors in rural areas would not be possible because of almost nil social facilities like educational infrastructure for their children, irregular supply of electricity as well as potable water, safety of females in some of the rural tracts in most of the states, unhygienic and insanitation conditions not only in rural neighbourhood or villages but also in the vicinity of health facilities.

Because of lack of properly equipped laboratories it becomes difficult to diagnose even minor ailments and thus most of the patients get referred to higher level secondary and tertiary health facilities, which unnecessarily get crowded and hampers effective delivery of health care.

ASHA scheme seems to working quite effectively as we find that almost all the deliveries get registered under JSY scheme and have enhanced institutional deliveries, which in turn would reduce infant and maternal mortality and morbidity. However, these incentives irrespective of the birth order may have some pro-natalistic effects.. Involvement of ASHAs in organizing family planning camps, routine immunizations, DOTS distribution, etc. seems to have gone up.

Training of the grass root health functionaries like ASHA, need to be taken up seriously.

Effective ambulance system at PHC and SC level for movements of patients referred to health facilities and also for emergency services at the doorsteps would definitely help in rendering the delivery of health care at doorsteps in rural areas. Improvement in the Ambulance System, especially at the CHC and PHC level along with the up gradation as per the IPHS standards need to be taken up seriously.

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