Evaluation Study of National Rural Health Mission (NRHM) in Karnataka

Department of Health and Family Welfare

Executive Summary

The National Rural Health Mission (NRHM) was introduced in the year 2005, as a flagship programme of the United Progressive Alliance (UPA) government, to rejuvenate the public system of health care in the country. As the initially drafted time frame of NRHM comes to an end, significant challenges remain in translating all the expected outcomes of NRHM into realities. Mainly, the targeted increase in budgetary allocation and the expected decline in IMR and MMR are not met. Decentralised planning, community monitoring and governance and the reduction of regional disparities in health have not been effectively achieved.

Although it is difficult to measure the full scope of NRHM's impact on the status of health care, an evaluation of the current status of NRHM's planning, fund flow and expenditure patterns in relation to its intended goals is crucial for devising future strategies to keep the momentum of growth experienced in the health sector after the advent of NRHM. Thus, the Karnataka Evaluation Authority (KEA)[1] commissioned an evaluation study aimed at thoroughly analyzing NRHM's planning, fund flow and its implementation. Grassroots Research And Advocacy Movement (GRAAM), a public policy research and advocacy organization[2] conducted this evaluation. The evaluation assesses the planning and design of the funds allocation and expenditure under NRHM in Karnataka. Using this assessment, the project focuses on regional disparities and analysing the role of fund allocation, expenditure on physical and human infrastructure and development indicators on the health indicators of the region. Further, the results of this analysis were validated across representative districts of the state.

The first phase of the performance evaluation study of NRHM in Karnataka focussed on review of relevant literature, analysis of a. planning documents including the state PIPs and DHAPs from representative districts, b. the structure and design of fund flows, c. patterns in fund allocation and expenditures, and d. analysis of regional disparities in the state, and conducted correlation tests to relate the trends in various expenditure heads under NRHM with the status of health

indicators at state and district levels.

In the second phase, field validation was carried out to confirm the principal findings of the secondary data analysis of the first phase of the study. It also aimed to understand local NRHM related processes, perspectives and interpretation of NRHM related activities among service providers, including the status of bottom up planning, allocation and expenditures from local perspectives. Further, in this phase, community involvement in public health at the grassroots level was also explored.

[1]The Karnataka Evaluation Authority (KEA), established by the Government of Karnataka (GoK) is a registered society (Registered under the Karnataka Societies Registration Act, 1960), initiated to systematically assess the performance, process of implementation, effectiveness of the delivery systems and impact of policies, programmes and schemes of the government.

[2]GRAAM is an initiative of Swami Vivekananda Youth Movement, working towards advocating policy change based on empirical evidence and research carried out with grassroots perspectives that works towards advocating policy change based on empirical evidence and grassroots perspectives

The major findings of the study are presented below.

About 78% (Rs 651 Crores) of the funds allotted by the Centre went through the State Health Society in 2011[3]. NRHM flexipool[4] is the major component of funds under NRHM (about 44%), followed by RCH flexipool (27%) and infrastructure and maintenance grants (channelled through the treasury route (22%). Funds for Routine Immunization form only 1%-2% of the total funds under NRHM.

Karnataka's rates of fund utilization have considerably increased in the previous years.

However, increased utilization capacities are also a matter of concern, especially because of the critical loopholes in planning and PIP preparation related processes, as seen in the analysis of planning documents (successive PIPs and DHAPs) and field observations. Interactions with field personnel reveal that although health officers have a broad understanding about the overall goals and strategies of NRHM, their perceptions about planning and monitoring were limited, as well as their beliefs in community participation. The capacities of health personnel in

internalizing the bottom-up planning processes envisioned under NRHM, its management and accounting practices and community engagement have to be strengthened at the earliest, to increase the efficiency of the department in translating policy objectives of NRHM into health outcomes.

Planning processes of NRHM in Karnataka do not show long term practical strategies and commitment to reduce regional disparities (other than converting PHCs in North Karnataka to 24 X 7 PHCs). The analysis of expenditures shows that in general, NRHM funds have been transferred considerably to districts with actual needs. However other districts have also been benefitted substantially (and in some cases, more than those districts that are vulnerable). Barring RCH flexipool funds, NRHM flexipool and Routine immunization funds have not targeted the disparities in health indicators. Thus, there are no clear trends of prioritized fund flows to districts identified as vulnerable.

The implementation and expenditure patterns of NRHM are driven by a top-down, stand-alone system with pre-defined priorities, rather than priorities emerging through a bottom-up process. This system of implementation does not provide a practically efficient way to implement need based funding for health institutions. It indirectly affirms the easily implementable, but dangerous 'one size fits all' mode of facility based funding, rather than need based funding patterns.

The study indicates a more complicated problem: higher utilization levels, reduced field presence, lagging health infrastructure and health indicators in districts of Gulbarga and Belgaum divisions, and at the same time, lower utilization levels, ill-equipped PHCs with

[3] Funds under NRHM are channelized through a. the state health society route and b. the treasury route

[4] RCH Flexipool supports all activities and programmes related to Reproductive and Child Health. NRHM Flexipool (or Mission Flexipool) supports additional activities under NRHM (excluding RI and NDCP activities)

comparatively larger shortage of HR in southern districts. In a way this means that regions with proportionately higher ‘low utilization level’ PHCs get more funding than regions with proportionately higher ‘high utilization level’ PHCs. Hence, the bulk of the NRHM flexipool expenditure, due to such facility based funding mechanism is less effective in improving health indicators of the state.

The presence of field based personnel; ANMs and ASHAs has majorly contributed towards increasing awareness levels in the communities and improving RCH related process indicators. Measures have to be taken to provide sufficient confidence, physical and emotional security to these field workers. There is scope to increase the field presence of several other field based personnel (like MHWs, JHA, LHVs) if the clerical and administrative positions at the grassroots level are filled. The field presence of such staff can relieve the work pressure on ANMs and ASHAs and also provide them with a feeling of security due to the simultaneous presence of other experienced field workers in community engagement and related activities.

The reporting and documentation activities of the department take considerable time and effort of the field personnel, especially, the support and field staff of PHCs. This is due to the existence of multiple and overlapping reporting formats, inefficient reuse of existing data, and lack of trained personnel for data entry. Hence, a single, homogenous and well-defined data collection and monitoring system is needed. Such a system would streamline reporting activities and seamlessly merge data requirements for planning, analysis as well as regular monitoring.

Community involvement in management and governance of health institutions is a complex issue and needs considerable thought before future decisions can be taken. The findings of the study show that until a clearer picture emerges, the role of community based institutions as strong monitoring bodies has to be strengthened, but with sufficient checks and balances.

Based on this analysis, the study makes the following recommendations

A. Mandatory capacity building of personnel about NRHM and its activities, Community engagement, Administrative and financial procedures, computer training and other technical issues,

B. Addressing regional disparities through NRHM

    a. For the 6C[5] and high focus districts, focus on the improvement of infrastructure, field presence (specifically ASHAs and ANMs) and ***larger facility based funds*** (like Untied Funds, Maintenance and Corpus Funds).

    b. For other districts, focus on ***demand/need based funding mechanisms*** and optimization of HR based on rotation and shared responsibilities

C. Providing better work environments for ANMs and ASHAs by 1) increasing field presence of other health workers by 2) instilling confidence and providing security, 3) periodic increase in salaries and incentives for ASHAs, 4) recruitment of clerical staff at PHCs,

[5]6C Districts: Bagalkot, Bidar, Bijapur, Gulbarga, Koppal, Raichur (districts recognized by the GoI as lagging in health indicators), Other Vulnerable districts: Bellary, Chamarajanagar, Chitradurga, Davanagere and Kolar (districts recognized by the GoK). In this study, these districts shall be together referred to as vulnerable districts.

D. Making the planning processes of NRHM more meaningful and useful**,**

E. Shifting from facility based funding to need based funding mechanisms,

F. Implementing a single, homogenous and well-defined data collection and monitoring system and

G. Clarifying the role of community based committees like P&MC, ARS and VHSCs (w.r.t governance and monitoring of health institutions). Until this clarity emerges, strengthen the role of community based institutions as effective monitoring bodies.

Conclusions and recommendations

As evident from the literature review, many critical policy suggestions have already been made towards addressing the persistent problems of the health sector. These issues also effect the implementation of NRHM considerably. The urgent need to implement these recommendations is further reiterated from the results of this evaluation.

The study restates the main recommendations stated in the Karnataka State Integrated Health Policy, 2004, viz. devising a synergistic approach towards health through inter-sectoral coordination and meaningful involvement of PRIs, the establishment of planning and monitoring unit for organized health planning and tracking of established process and outcome indicators and the creation of two cadres within the department, namely medical care and ***public health cadres***. Further, the study provides more evidence to the assertion made in the National Health Policy, 2002, that **strategies suggested through any policy or scheme will invariably be contingent on a) capacity of the service providing agencies to absorb the changes, b) the attitude of the service providers and c) the improved standards of governance**.

Together with these long term suggestions, the study explored numerous inter-connected issues like the lack of internalization of objectives, limited prioritization of planning, issues of HR competency and shortage, optimization issues with respect to reporting and documentation, varied fund utilization patterns and institution utility levels, together with issues relating to perceptions, attitudes and beliefs have been discussed. Many such issues need further studies and deeper analysis. However, given the scope of this evaluation, this chapter restricts to six specific and critical issues on which recommendations based on the findings of the study are suggested.

1. Interactions with field personnel as well as community representatives reveals that most officers interviewed had a broad understanding about the overall goals and strategies of NRHM, although their perceptions about planning and monitoring were limited, as well as their beliefs in community participation. This argument is further strengthened by the critical loopholes in the planning

documents reviewed in the first phase of the study (Section 2.3.3, pp. 28, Section 3.1, pp. 32). Further, majority of the personnel expressed the need for capacity building, specifically with respect to the administrative and management aspects of NRHM. In addition, **the job responsibilities of medical officers in PHCs necessitate them to build not just technical skills, but also cultivate hospital management skills, proficiency in community engagement activities and in general, develop *medical leadership*** in order to translate policy objectives into health outcomes among the rural communities of the state.

Hence, trained public health professionals (public health cadre) are necessary for key posts like DHO, THO and MO. In the absence of such trained professionals, **mandatory comprehensive training for all rural health personnel and community representatives about community health issues, rural governance structures, the various aspects of NRHM**, its planning, administrative and financial management guidelines and community involvement is crucial if a holistic approach towards public health has to be realized.

Further, computer training for PHC staff (specifically w.r.t streamlining reporting activities) can help significantly in reducing duplication of work and dependency on untrained staff.

2. There are considerable gaps between the existing planning processes under NRHM in the state vis-à-vis the planning processes envisioned in the NRHM stated in documents like the mission document and NRHM Framework for Implementation. These gaps also prevent the continuous assessment of the efficiency of implementation and expenditure on health related activities, in achieving the long term goals related to health indicators. The main reasons identified for this are:

   o **The operational priorities of implementation of NRHM have been selective** and hence, there is a general lack of importance given to overall preventive health care. This can be seen by the relative importance given to RCH, immunization and NDCP related micro-plan based activities over epidemiological and population based health management interventions.

- Hence, at the district level and below, **planning is largely understood as an integration of such micro-plans**. The need for aggregating (to achieve this form of bottom-up planning) such plans, beginning from the level of PHCs up to the state level, overlooks the heterogeneity of local contexts and requirements; evident in the analysis of DHAPs. Thus **planning processes are reduced to filling up of extensive amount of pre-defined templates**. Broad-based integrated planning is further extenuated by linking these activities with the complex costing framework of the FMR.
- Further, as analysed in the previous sections, there are several critical operational bottlenecks like the acute shortage of staff (specialists, doctors, staff nurses support staff etc.), issues related to the availability of funds and lack of detailed analysis of collected data which result in *planning being not seen as a practically useful priority issue*.
- Hence, similar to other departmental activities, the implementation and expenditure patterns of NRHM too is driven by a top-down, stand-alone system with pre-defined priorities which is no doubt, focussed towards achieving some of its primary objectives (like RCH, for which, the system is comparatively better streamlined, both with respect to HR as well as fund flows), but ignores unique aspects of NRHM like its holistic outlook towards improvement of rural health, decentralised planning and true community involvement.
- Thus, **the prevailing system of implementation does not provide a practically efficient way for implementing need based funding mechanisms** for health institutions. Thus, it indirectly affirms the easier but dangerous ‘one size fits all’ mode of facility based funding which is currently evident. It also leads to decisions that aggravate the existing regional imbalance. The secondary data analysis provides ample signals about the lack of prioritization of issues and regions, even with the specific focus on the 6C districts.

Hence, there is an immediate need to make the planning processes more meaningful for the implementing agencies, and at the same time encouraging them to use these plans at local levels for periodic self-review and performance analysis. To realize this, **planning procedures should capture local heterogeneity of health issues and thus provide**

population based health management interventions. Plans devised based on such strategies would help the realization of true decentralized planning and better targeting of vulnerable districts. To practically achieve this, **a thorough orientation of practically**

operationalizing the planning activities envisioned by NRHM has to be given to DHOs and THOs, followed by the Medical Officers. If the health department feels unskilled to initiate this, the process may initially be triggered with the help of a competent external agency that can internalize the practical field challenges faced by these officers.

3. Secondary data analysis confirms the lack of prioritized planning of fund flows as possible reason for regional disparities in health. It is further evident from this study that the utilization levels in Gulbarga division (and in general in North Karnataka) are higher for PHCs, in comparison with other regions. Thus, the study indicates a more complicated problem:. In a way this means that regions with proportionately higher 'low utilization level' PHCs get more funding than regions with proportionately higher 'high utilization level' PHCs. Hence, **the bulk of the NRHM flexipool expenditure, due to such facility based funds is less effective in improving health indicators of the state**. However, in the perception of department personnel, regional imbalances are mostly linked to lack of infrastructure, which is attributed to historic advantages of southern districts and political will of their public representatives.

While current planning and reporting mechanisms allow for analysis of regional disparities in outcome and process related health indicators, **there is no easy way out for frequent monitoring of disparities in fund allocation, HR and infrastructure allotment to vulnerable areas.** Thus, **regional disparities are constantly recognized, but not addressed**. The lack of structured participation of the state legislature may have also contributed to this

persistent problem[42]. Further, the quantity of funds allotted to each PHC/SC have remained the same since inception. Hence, the study suggests two broad-based strategies[43].

a. For the 6C and other vulnerable districts[44] (with larger proportion of high utilization level PHCs), focus on the improvement of infrastructure, field presence (specifically ASHAs and ANMs) and *larger facility based funds* (like Untied Funds, Maintenance and Corpus Funds).
b. For other districts (with larger proportion of low utilization level PHCs), focus on *demand/need based funding mechanisms* and optimization of HR based on rotation and shared responsibilities.

If the changes suggested above are not feasible in the short run (since they require changes

[42] The analysis of perceptions of public representatives is not presented in the report since it was not in the ToR of the project. However, this analysis is included as an addendum to the report.

[43]Although these strategies may require long term policy changes

[44] 6C Districts: Bagalkot, Bidar, Bijapur, Gulbarga, Koppal, Raichur (districts recognized by the GoI as lagging in health indicators), Other Vulnerable districts: Bellary, Chamarajanagar, Chitradurga, Davanagere and Kolar (districts recognized by the GoK).

at the Centre, in NRHM's planning and expenditure guidelines), alternative financial arrangements at the state level, wherein specific quota of funds is dedicated to public health in the vulnerable districts, to supplement NRHM funds may be explored.

4. The presence of field based personnel; ANMs and ASHAs, has majorly contributed towards increasing awareness levels in the communities and improving RCH related process indicators. Further, of the expenditures under different heads of NRHM, the RCH expenditures are more aligned to address regional disparities in health. Hence, it can be argued that **ANMs and ASHAs should be not only credited for the improvement in RCH related health indicators, but also are critical in continuing the effectiveness of the utilization of RCH funds**.

Field evidence shows that they are also **the most vulnerable groups associated with the service delivery of NRHM**. Hence, immediate measures have to be taken to provide sufficient confidence, physical and emotional security to these field workers who are crucial in guaranteeing delivery of RCH services. Clear job descriptions have to be enforced and periodic increases in financial incentives for these field level workers have to be devised[45].

There is scope to increase the field presence of several other field based personnel (like MHWs, JHA, LHVs) if the clerical and administrative positions at the grassroots level are filled. This not only relieves some of the work pressure on ANMs and ASHAs but also provides them with a feeling of security due to the simultaneous presence of other experienced field workers in community engagement and related activities. Further, this allows for increasing the utilization of Sub-Centres which are increasingly being under-utilized.

5. While the need for shifting from facility based funding mechanisms to need based funding mechanisms has been stressed before, **there are no concrete measures devised to adopt such a switch since this involves considerable amount of analysis and experimentation**.

   The first step in this process could be to make the drug procurement for PHCs need based, for which considerable agreement and information is already available at the taluk level and below. However, the shift towards need based funding patterns (together with planned increases in funds allotted to PHCs) in other funds may require systemic changes in NRHM guidelines; and may not be feasible in the short term.

6. Most individuals interviewed (including community representatives) felt that there have been significant improvements in process indicators (like increased rates of ANC, institutional deliveries etc.) as well as outcome indicators like IMR and MMR. However, there is confusion in actually proving this empirically, due to various limitations in the data available through HMIS due to various technical and HR issues discussed in Section 5.2.2, (pp. 91).

[45] Possibilities of extended responsibilities for ASHAs are explored in studies like "Evaluation of ASHA Progrmme in Karnataka" 2012.

The reporting and documentation activities of the department take considerable time and effort of the field personnel. While intensive collection of data (related to processes and outcomes) is absolutely necessary, especially for the health department, based on the experience in the field, there seems to be a lot of opportunity to minimize duplication of efforts and streamline data collection and analysis methods, thus reducing the demand for repetitive reporting activities, presentation of same data in different formats and duplication of efforts.

A single, homogenous and well-defined data collection and monitoring system is needed. Such a system would streamline reporting activities and seamlessly merge data requirements for planning, analysis as well as regular monitoring. It would help the department to assign more human resources for field activities and at the same time, give indications for planning future activities. **A first step in this direction could be the assimilation of facility based and area based reporting formats into a single more easily understandable, homogenous reporting method**. The Planning, Monitoring and Evaluation wing of the department can initiate this process.

7. The issue of community representatives' interference has frequently come up during the second phase of the study. This is a complex issue and needs considerable thought before future decisions can be taken. The analysis in sections 4.4.3, pp. 78, and 5.2.2pp. 91, discuss this issue at length. From this study, it is clear that

    a. **the existing arrangements for community bodies to engage with public health institutions is inadequate to foster a stable relationship between the health personnel and the community representatives**.
    b. there is no clarity and common understanding of the role of community representatives in the governance of health institutions.
    c. as much as the trouble endured by ANMs and ASHAs from the community representatives is true, so is the unwillingness of the health department personnel to truly involve community representatives in their activities.

To arrive at the agreed set of roles and responsibilities of community groups towards health institutions, **activities of health institutions that should be primarily driven through community monitoring and those that are not have to be identified**. Monitoring processes devised through this mechanism should be linked to performance assessment of health institutions. Department personnel and community representatives have to be sensitized and trained with these monitoring mechanisms. Thus, looking at a) the levels of acceptance of the shared roles and responsibilities between MOs, ANMs, ASHAs and respective community based groups and b) the preparedness and willingness of communities to take up these roles and responsibilities at the PHC SC and VHSC levels, **the role matrix for community groups' participation within the health system should be developed**.

At the same time, **public health policy has to focus on developing long term strategies that nurture stable relationships between health personnel and the community bodies involved**, in order to create a dependable and accountable community participation mechanism.

Until a clearer picture emerges, both in the form of policy as well as agreed common understanding between department personnel and the community representatives, **the role of community based institutions as *effective monitoring bodies* has to be strengthened**, rather than governing bodies.

The recommendations from the study, together with suggested changes at different levels and possible impacts are summarized in the following table.

Summary of recommendations

Key Issues	Recommendations	Levels where changes are required	Possible impacts
Limited perceptions about roles and leadership in planning, monitoring and community participation. Lack of administrative and management skills among MOs.	**1. Mandatory capacity building of personnel**		
	NRHM and its activities, Community engagement, Administrative and financial procedures, computer training and other technical issues	State and District levels, within the health department.	Better understanding of duties, increase in efficiency and output
	2. Make planning processes more meaningful and useful		
	Prioritize epidemiological and population based health management interventions	Training and sensitization at state, district and taluk levels, strengthening district level planning processes	Realization of true decentralized planning and better targeting of vulnerable districts.
	Capture activities that address the heterogeneity of local health contexts		
Facility based approach, rather than need based approach is adopted for funding health institutions. Hence, larger proportion of funds allotted to districts with more "low utilization PHCs".	**3. Addressing regional disparities through NRHM**.		
	For the 6C and other vulnerable districts, focus on the improvement of infrastructure, field presence (specifically ASHAs and ANMs) and ***larger facility based funds***. If not feasible in the short run, supplement NRHM funds for these districts through special quotas at the state level.	Policy change in NRHM (at the centre), Recruitment strategies at the state and district levels, in the health department, Data collection processes w.r.t to comparative needs and demands at the district and taluk levels	Better targeting of expenditure, addressing regional imbalance
	For other districts, focus on ***demand/need based funding mechanisms*** and optimization of HR based on rotation and shared responsibilities		

Key Issues	Recommendation	Levels where changes are required	Possible impacts
Grave cases of aggravation of ANMs and ASHAs (by Grama Panchayath Presidents and members) reported ANMs and ASHAs have contributed significantly in the success of NRHM. Other field staff in PHCs restricted to admin work at PHCs due to lack of staff.	**4. Providing better work environments for ANMs and ASHAs, increasing field presence of other health workers**		
	Instilling confidence and providing security	Sensitization at the district, taluk, PHC and village levels (PRIs and health department)	Increasing the reach and effectiveness of community health initiatives of NRHM
	Periodic increase in salaries and incentives	Policy change in NRHM (Centre, State)	
	Recruitment of clerical staff at PHCs	Health department and state government	
Facility based approach, rather than need based approach is adopted for funding health institutions. Lack of readily useable data to implement need based funding mechanisms immediately	**5. Shift from facility based funding to need based funding mechanisms**		
	Drug procurement to health institutions based on need/demand (sufficient data and demand from MOs and THOs already exist)	Policy change in NRHM (Centre, State), data collection processes at district and taluk levels	Addressing local needs, increasing effectiveness of expenditures
A lot of resources consumed for collection of data. Confusion exists on reliability and usability of data In many cases, data collected for a particular report is not reused for other reports. Data collected not analysed, used	**6. Implement a single, homogenous and well-defined data collection and monitoring system**		
	Assimilation of facility based and area based reporting formats	Decision on how collected data can be used/reused at state and district levels, data collection processes at district, taluk & PHC levels	Streamlining data gathering and analysis, reducing time spent on reporting at field level
Key Issues	**Recommendation**	**Levels where changes are required**	**Possible impacts**

Community's role in health not clear. Existing structures inadequate for long term empowerment of community members bodies	**7. Clarify the role of community based committees like P&MC, ARS and VHSCs (w.r.t governance and monitoring of health institutions)**		
	Strengthen the role of community based institutions as effective monitoring bodies, rather than governing bodies of the health institutions.	Health department, PRIs and community representatives	Meaningful community engagement