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An SVYM Initiative

Performance Evaluation Study of NRHM in Karnataka

Final Report

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Abbreviations

ANC	Ante-natal care
ANM	Auxiliary Nurse Midwife
ANMTC	ANM Training Centre
ARS	Arogya Raksha Samithi (Rogi Kalyan Samithi)
ARSH	Adolescent Reproductive and Sexual Health
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, Homeopathy
CAG	Comptroller and Auditor General of India
CHC	Community Health Centre
DHAP	District Health Action Plan
DHO	District Health Officer
DPMO	District Programme Management Officer
FBNC	Facility Based Newborn Care
FMG	Financial Management Group
FMR	Financial Management Report
FRU	First Referral Unit
FMW	Female Health Worker
GDP	Gross Domestic Product
GoI	Government of India
GoK	Government of Karnataka
HBNC	Home Based Newborn Care
HDI	Human Development Index
HI	Health Inspector
HMIS	Health Management Information System
HR	Human Resources
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
JHA	Junior Health Assistant
JSY	Janani Suraksha Yojana
KHSDRP	Karnataka Health System Development and Reforms Project
LHV	Lady Health Visitor
MCTS	Mother and Child Tracking System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MO	Medical Officer
MMU	Mobile Medical Unit
NCMH	National Commission on Macroeconomics and Health
NDCP	National Disease Control Programmes
NHSRC	National Health System Resource Centre
NRHM	National Rural Health Mission
NPCC	National Program Coordination Committee
OPD	Out Patient Department
P&MC	Planning and Monitoring Committee
PA	Prasuti Araike
PHC	Public Health Centre
PIP	Program Implementation Plan
P&MC	Planning and Monitoring Committee
PNC	Postnatal care
PPP	Public Private Partnership
PRI	Panchayathi Raj Institution
RCH	Reproductive and Child Health
RHS	Rural Health Statistics
RI	Routine Immunization
RKS	Rogi Kalyana Samithi
RoP	Record of Proceedings
SC	Sub-Centre
SHS	State Health Society
SHSRC	State Health System Resource Centre
SMS	Short Message Service
SRS	Sample Registration Survey
THO	Taluk Health Officer
TLH	Taluk Level Hospital
UNICEF	United Nations Children's Fund
VHSC	Village Health and Sanitation Committee

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 analysing 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

- Mandatory capacity building of personnel about NRHM and its activities, Community engagement, Administrative and financial procedures, computer training and other technical issues,
- 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
- Providing better work environments for ANMs and ASHAs by 1) increasing field

[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.

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,

- Making the planning processes of NRHM more meaningful and useful,
- Shifting from facility based funding to need based funding mechanisms,
- Implementing a single, homogenous and well-defined data collection and monitoring system and
- 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