CHAPTER: 4
FINDINGS AND SUGGESTIONS

The National Rural Health Mission (NRHM) has been described as one of the largest and most ambitious programmes to revive health care in the world and has many achievements to its credit. It seeks to provide universal access to health care, which is affordable, equitable, and of good quality. It has increased health finance, improved infrastructure for health delivery, established institutional standards, and trained health care staff and has provided technical support. It has facilitated financial management, assisted in computerization of health data, suggested centralized procurement of drugs, equipment and supplies, mandated the formation of village health and hospital committees and community monitoring of services. It has revived and revitalized a neglected public health care delivery system.

The NRHM has injected new hope into the health care delivery system in India. However, it continues to face diverse challenges, which need to be addressed if its goals are to be achieved in the near future. The NRHM has made a significant impact on health care delivery. However, greater political, administrative and financial commitment is required for it to make a substantial impact on health outcomes. The 12th Plan should allocate ring-fenced budgets for specific operations. There is need to develop systems to monitor and audit performance and health indices; this will allow for course corrections.

The health care system has flaws, both at the conceptual and operational levels. However, there is no simple, band-aid solution to the problem. There is a need for continuous monitoring and appraisal, allowing for regular course corrections. Unfortunately, health is a prime example where good politics and good policy diverge. One cannot ignore the economic interests of the health education-hospital-pharmaceutical-insurance industries who directly profit from tertiary specialist care,

indirectly when public health delivery systems are run down and when the social determinants of health are neglected. In our capitalistic world, these interest groups cannot be expected to look beyond their strategy to generate profit. Politicians and governments are also unable to see the ethical issues related to equity and lack the conviction to provide services for the poor. Health, a human right, and universal health care should not remain an aspiration but should become operational in the near future.

Health as a State subject: The location of health in the State list rather than the concurrent list poses major problems for service delivery. This is also compounded by the fact that the NRHM funding is from the Centre while the implementation is by the State governments. Health care delivery cannot be improved to provide a seamless service without the removal of these barriers.

Project mode and problems: The NRHM is currently functioning as a project of the Government of India and is due to end in 2012. Its significant contribution to improving health care infrastructure and service delivery across the country will be frittered away if its funding ceases with the 11th Five Year Plan (FYP). The NRHM should be not only included in the 12th FYP but also be changed from its limited term project mode to a permanent solution to India's health problems.

Its status as a project makes the integration of the NRHM with the State health care systems problematic. The divisions run deep resulting in irrational distribution of human resource and infrastructure. The inertia of the old system and the low morale and discipline of its staff continue to be major challenges. The NRHM has been able to add new infrastructure and personnel; however, its impact on re-inventing and re-invigorating systems seems to be limited, with much more effort being required. There is a need for a more coordinated approach which optimally utilizes resources.

Improving governance: A comparison of data between States and within regions and social groups suggests marked variations in the NRHM process indicators, utilization of funds, improvements in health care delivery, health indices and in community participation. Regions with prior good health indices have shown marked improvements, while those with prior poor indices have recorded much less change.

This is true, despite a greater NRHM focus on and inputs to poor-performance States. Improving governance and stewardship within the NRHM programmes mandates general improvement in the overall governance of States and regions.

Urban health: The NRHM has focused on rural health. Many parts of urban India have similar health care needs and currently have glaring deficiencies. The National Urban Health Mission should be accorded the same status as the NRHM. Both efforts should be coordinated and combined into a National Health Mission.

Expand focus: The major focus of NRHM is on maternal and child health. While this is vital, there is a need to expand the vision to other common general health problems. There is evidence to suggest that other crucial government programmes (e.g. blindness) have taken a back seat.

Social determinants and public health approaches: The goals of the NRHM clearly state the need to impact on the social determinants of health by coordinating efforts to provide clean water, sanitation, nutrition, housing, education and employment. It should, in conjunction with other government programmes, work towards the reduction of poverty, social exclusion and gender discrimination, all of which have a significant impact on health. There is need to increase the synergy and coordination between government programmes (e.g. the Integrated Child Development Scheme, the Mahatma Gandhi National Rural Employment Guarantee Act, etc.) and the NRHM.

Objectives of the programme

The main objectives of the NRHM are:

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 & mainstream AYUSH; and Promotion of healthy life styles.[25][26]

Suggestions For Improving NRHM

1Crunching and Absenteeism of Staff - Now a days opd load is too much in government hospitals but as per that Doctors are not available so ultimately patients has to suffer due to this crunching. It is a common problem to see that doctors are missing or come only for a few hours or few days in a month. Need is for three doctors instead of the two currently at the PHC, so that the load can be handled well. Currently, at times, the wait period for a patient to be seen could go beyond 4 hours at times in OPD. Also, with this, the PHC can operate 24 X 7 , since doctors can do an 8 hour shift each.

SUGGESTION

It is suggested that the entire NRHM attendance moves paperless (biometric attendance be made compulsory). With this, the problem of absenteeism will come to an end. Everywhere vacant post should be fulfilled by the government.

2Mismanagement of medicines- There is a mismatch in the requirement & stocks of medicines. All the PHC's get similar stocks of medicines irrespective of the load in OPD. So, whereas some PHC have more stocks, some have stock outs – More of Forecasting and logistics issue.

Suggestion- Proper forecasting and distribution of medicines as per the OPD load should be there.

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[25] http://www.cag.gov.in/html/reports/civil/2009_8_PA/chap_1.pdf visited on 22 May 2014 at 05:00 PM.

[26] http://www.thehindu.com/todays-paper/tp-opinion/fo-a-new-anrd-improved-nrhm/article2334660.ece visited on 22 May 2014 at 05:30 PM.

3Biomedical waste create infection -Due to this if a person comes in contact of open needles and other waste product of hospitals then he can come in contact of many blood transfusion diseases like - AIDS, Hepatitis B etc.

Suggestion - Biomedical waste disposal has to be given priority to avoid infections in villages. It should be used for recycling.

4Preparing reports and paper work- It takes most of the productive time of the health workers in preparation of these reports and other productive work which is vital they are not able to utilize that time for productive work.

Suggestion With the advent of low cost tablet PC's & low price 3 G enabled phones; it might be worth considering giving these devices to health workers like ASHA's. Also, if these mobiles / tablets have a GPRS connection, it can mean live data updates, thereby, reducing the three month gap between the village data entry and the central review points at Delhi.

5 Electricity – Load shedding in villages: This leads to lack of storage conditions in PHC's & Sub Centers.

Suggestion: India has adequate sunshine for 9-10 months in a year, for rest of the months, the load shedding is less, so it is worth considering having solar panels as an integral part at all the PHC's & Sub Centers for generating electricity needed for storage and other requirements.

6 Poor Quality of Medicines: It is observed that the qualities of medicines are poor, and it is procured by the district Health committee. Poor quality of medicine is a serious issue, as the patients are given medicines for treatment, and if the medicines are not effective, it will lead to mistrust in the entire system, and the poor people will have to move towards private practitioners or quacks and suffer more

SUGGESTION:

Since all the companies in pharmaceuticals have national level operations, it will be good if the national level tie up is done for procurements of medicines at the NRHM rates, and the order, supplies & payments happen locally. With this, we will

be able to get the best rates and also give the best quality of medicines to the needy poor patients. Also, generic medicines should only be allowed to be used under NRHM. This will help to save enormous costs to the government. Also, all the PHC's & sub centers must set up ROP's (re-order points for all the requirements, factoring in the time lag for supplies based on past trends. This will ensure that there are near zero stock outs).

It was observed that the specialists (Gynecologist) in one of the model PHC (Wardha district) comes only for two hours and that too, to direct patients to private practice. This must be avoided at all costs, as this will eventually make ASHA's & ANM's, agents for private clinics for all the wrong reasons & erode the trust in the NRHM

7. Lack of infrastructure , high technology equipments- Now also there is infrastructure problems for many Primary health centers and genral hospitals are not having CT scan and MRI facilities and if these are available then Radiologist are not available.

Suggestions – Government should make arrangement for the buildings to solve the problems of infrastructure and should take a list where these facilities are not available, then make arrangement for these where these are needed.

8Funding problem- For improvement of NRHM proper funding is needed so that it can function in a more proper way.

Suggestion-NRHM should welcome 'tax free' donations from individuals and corporate: This should be publicized and could become a good way to raise funds in a step towards building a financially sustainable healthcare model for rural India.

New Opportunities for improving

Community Radio: This is being experimented in Baramati, and must be looked into. Similar services can be started in villages to drive healthy behaviors. I had visited a

few villages in north, where a simple awareness campaign (pictorial & through songs in local dialect) have reduced the maternal mortality by 93 %.

Toll free based IVR Multilingual helpline: NRHM must initiate this to help reach the right people for the right inputs

m-Health based Jeevandaini scheme : This has been piloted in Wardha district , with good results in institutional deliveries and drastic improvement in MMR. The simple mobile based applications have lead to live data upload and follow up via SMS, leading to good compliance amongst ANM's & ASHA's . This health based model needs to be made an essential part of NRHM . Since 3G & WIMAX is now a reality , the rural health information flow and delivery of few basic services must be done adopting m-Health (mobile health platform).

Mobile Sub centers: Sub centers are built at a cost of Rs.8.5 – 13.5+ Lacs. It might be worth considering to set-up mobile sub centers(Mobile Vans) that can go across to the remotest areas and conduct outreach programmes. So the cost of operating the sub center (rental , electricity etc) gets consumed in the form of fuel expenses for the mobile health center and also, these sub centers can be used as an ambulance in case of medical emergencies .

Digital Training of Health workers: It might be worth considering creating a TV programme on doordarshan modeled exclusively for training ASHA, ANM & for increasing awareness amongst NRHM beneficiaries. Also the same should be made available through mobile phones as 3G is now a reality

Minor surgeries in PHC: Now that that PHC's have facilities for delivery, minor surgeries must be allowed in the PHC. So far, minor surgeries are not allowed in PHC. This is one important decision that can help save a lot for hassles for villagers and bring revenue for the government. The PHC's can enroll patients for minor surgeries, and then get a surgeon on call for a day from a nearby town and complete the minor surgeries at the PHC to function as day care centers .

Incentive to health workers ASHA's ANM's & other Sub center & PHC staff: It is expected that since ASHA's and ANM's are incentivized for institutional deliveries,

referral etc. The incentive might also make them turn to private practitioners over a period of time, as the lure of money will drive them to recommend private gynecologists & give less focus to home visits and counseling, and this might be happening even today as well. It is suggested that the ASHA's & ANM's must be incentivized for counseling, home visits, immunization & preventive checks as a routine part of their job and the incentive must be paid for each home visit (even Rs. 2 to Rs.3 per visit is good enough) .

NRHM Handbook : Since the NRHM programme is the biggest healthcare programme so far, it is imperative that a detailed multi lingual NRHM Handbook, manual or ready reckoner be brought out for all those involved in the programme , covering basic protocols, bio medical waste disposal , do's & don'ts dealt with Frequently asked questions . Also, the digital version must be available on mobiles and internet.

1-3 months rural posting of nurses, pharmacist and doctors must be made mandatory for the courses to fill the resource crunch, and the professionals must be remunerated for these postings along with free accommodation on site at the sub center and PHC.

Awareness & sensitization: Since NRHM is addressing the key areas when it comes to health and hygiene, it is imperative that a chapter on NRHM is added in secondary education (class 6th onwards). This will lead to awareness and sensitization amongst children to adapt to healthy habits

Why programmes succeed or why they fail- Lessons to learn: Let's take a look at the successful programmes like NACO for Aids, National TB control programme & the Pulse Polio programmes. All these programmes have worked well because of the fact that they have proper structure and resources allocated. In the ministry of health & family welfare, the programmes are fantastic announcements, but the human resources required are not properly allocated in the ministry to handle such programmes; only the funds are transferred in the bank for the programme. So the department handling the programme is under resource crunch, they do not even have people to handle the communication, and most of their time goes in reporting. Result – the funds remain un-utilized and are returned back in case of calamity

announcement from the PM's fund or for other reasons and thus programmes fail to leave an impact. Planners must study the success of National TB control programme & NACO and implement the learning's in all the programmes for Health & family welfare.