Common Review Mission of NRHM in Madhya Pradesh (November 2007)

Executive summary

The implementation of NRHM in M.P. has brought in major additional resources, management changes and programmatic additions for the Public health system in the state. These changes are being combined with certain innovative schemes designed within the state. Positive changes may be observed regarding certain programmatic components (such as increase in institutional deliveries under JSY), model institutions (such as CHCs in Dhanwantari blocks) and piloting of innovative schemes (such as Janani Express Yojana in Bhopal). However comprehensive strengthening of Public health institutions at all levels is still in the process. In several institutions observed, while institutional deliveries have definitely increased related to the cash incentives, there does not seem to be concomitant increase in utilization of other medical services, and quality of both delivery and other types of care requires significant improvement. While institutions are not always adequately equipped to deal with the increased inflow of delivery cases, there are also deeper questions related to the effectiveness of present JSY and the tendency to treat this as a kind of vertical programme, as if institutional deliveries were the end in itself. Overlaps and competition between ASHA, ANM, AWW and Dais related to JSY incentives need to be addressed, along with checking irregularities in payment of these incentives in some cases. Availability of medicines to patients remains an area of dissatisfaction, despite some improvements. The Rogi Kalyan Samiti in one District hospital which was analysed showed a heavy reliance on user fees as a source of income, and the major chunk of RKS expenditures on routine heads like salaries and medicines, which should be largely met through Departmental funds. A state level analysis of RKS data showed large financial fluctuations and significant divergences between income and expenditure in several years; large scale non-reporting or inadequate reporting from RKS institutions to state level, with RKS from one-third of districts not reporting at all; an unacceptably large 'others' category in reporting both total incomes and expenditures; and over one-third of RKS income coming from user fees which is regarded as a regressive form of financing. These findings suggest the need to move towards a different model of RKS in M.P. given the availability of untied funds under NRHM. Several positive management mechanisms, including financial management are being operationalised in the state. There is an elaborate system for development of PIPs at various levels which are effectively collated at the state level. The system of concurrent audit is unique and very effective in ensuring timely reports, and is worth replicating by other states. Certain other methods such as regular appraisal of Dhanwantari blocks at the highest level, innovations related to HMIS and communication practices (facilitating transport of women for delivery care in Bhopal) deserve commendation. Selection of ASHAs remains incomplete due to non-availability of women meeting the educational criteria, hence this criterion needs to be relaxed while appropriate training material for less educated ASHAs may be utilized. Regarding MNGOs, current selection may need to be re-examined in some cases, and coordination with the district health system needs to be much more systematic. While there are a few positive examples, overall NGOs and CBOs are not adequately involved in NRHM and need to be actively involved across the state in activities like ASHA training and mentoring, Community monitoring, and capacity building of Village health committees. The recent revealing of large scale unaccounted funds with a very senior Health department official leading to his suspension, and other complaints are a matter of concern, especially given the increasing flow of programmatic and untied funds under NRHM. These need to be addressed by greater delegation and decentralization of financial powers along with more effective financial monitoring, and full transparency subjecting major financial transactions to public scrutiny. Given the trend towards partnerships with the private sector, such

collaborations need to be carefully monitored, and a precondition for such partnerships would be the legal and operational regulation of the private medical sector in the state.

To summarise, with the impetus of NRHM, a phase of change has been initiated in the public health system in Madhya Pradesh. Wherever dynamic, innovative leadership has been provided, and where competent civil society organizations have been effectively involved, improvements are visible. However there is a contrast between certain high-profile programmes and model institutions on one hand, and the need for comprehensive public health systems and the objective to strengthen myriad 'ordinary', less high profile, hitherto weak health care facilities on the other hand. Hence the challenge is to generalize, accelerate and make sustainable the momentum of change, reaching out to the health institutions and populations in the most marginalized and neglected areas, and making the public health system comprehensively effective and accountable everywhere. The expectations of people across the state regarding health services are being logically raised, and the transformation of the Public health system at all levels must now rise to the challenge and meet this justified popular expectation.

Introduction:

NRHM Common Review Mission, 14-20 November 2007 for the State of Madhya Pradesh (MP) was conducted by the following persons:

Mr. Praveer Krishn, Joint Secretary, Ministry of Health and Family Welfare, Government of India
Mr. Sushil Kumar Lohani, NRHM Mission Director, Orissa
Dr. Abhay Shukla, Senior programme coordinator, SATHI-CEHAT, Pune
Ms. Shruti Pandey, Senior Consultant, NHSRC

At Bhopal, the team interacted with the Principal Secretary, all the Directors, concerned Programme Officers like Joint Directors, Deputy Directors, SPMU members as well as all the consultants of NRHM/RCH. A detailed presentation was made on the progress made on the various activities under NRHM so far.

The team thereafter selected two districts, Barwani and Jabalpur, for detailed field appraisal through visits to the health establishments and offices in these districts. The team also met with civil society in villages and through NGOs, to get a well-rounded picture of progress made.

The groups which were formed to visit the districts were consisting of members from the GoI team as well as from GOMP.

<u>JABALPUR TEAM :</u>

Mr. Praveer Krishn,
Ms. Shruti Pandey,
Dr. A.K. Agnihotri, Regional Director (GoI)
Mr. Ram Veer Singh Sikharwar, Consultant, Urban Health, MP

BARWANI TEAM:

Mr. Sushil Kumar Lohani,
Dr. Abhay Shukla,
Dr. Hemant Sinha, Deputy Director, Family Welfare, MP
Ms. Kavita Chauhan, Consultant, ARSH, MP
Mr. Sanjay Nema, Consultant, Civil, MP

In Jabalpur, the following places were visited by the team:

Office of Collector, Jabalpur
District Victoria hospital
Lady Elgin Hospital
Civil Hospital, Tehsil Sinhora
Community Health Center, Patan
Community Health Center, Majhauli
Primary Health Center, Chargaon
Sub Health Center, Nunsar, Block Patan
Sub Health Center, Bijori
Village Gosalpur, Tehsil Sinhora

In Barwani District the following health institutions/ places were visited by the team:

CMHO office and DPM office
District Hospital, Barwani
CHC, Thikri
CHC, Pati
CHC, Niwali
PHC, Anjad
Sub Health Centre, Sawariyapani
Village Sawariyapani (Pati Block)

A. Observations regarding District Barwani

I. Utilisation of public health facilities and quality of care

The following category of health institutions are existing in the district :

District Hospital - 1
Civil Hospital - 1
CHC - 5
PHC - 31

District Hq. Hospital, Civil Hospital and 2 CHCs have been declared as CEmONC. Rest 3 CHCs and certain PHCs have been declared as BEmONC. Blood bank or blood storage unit was found to be available only at DHH. Also, 2 anaesthetists were available at DHH

only. No other specialists were available at any of the CHC CEmONCs. As a consequence Caeserian operations are being performed only at District Hq. Hospital. As per the information provided, 786 institutional deliveries were conducted in the month of April 2006 against 1636 deliveries conducted the the month of October in the district, more than 100% increase in 1.5 years. The achievements under family planning operations have also shown 50% increase in the last one year.

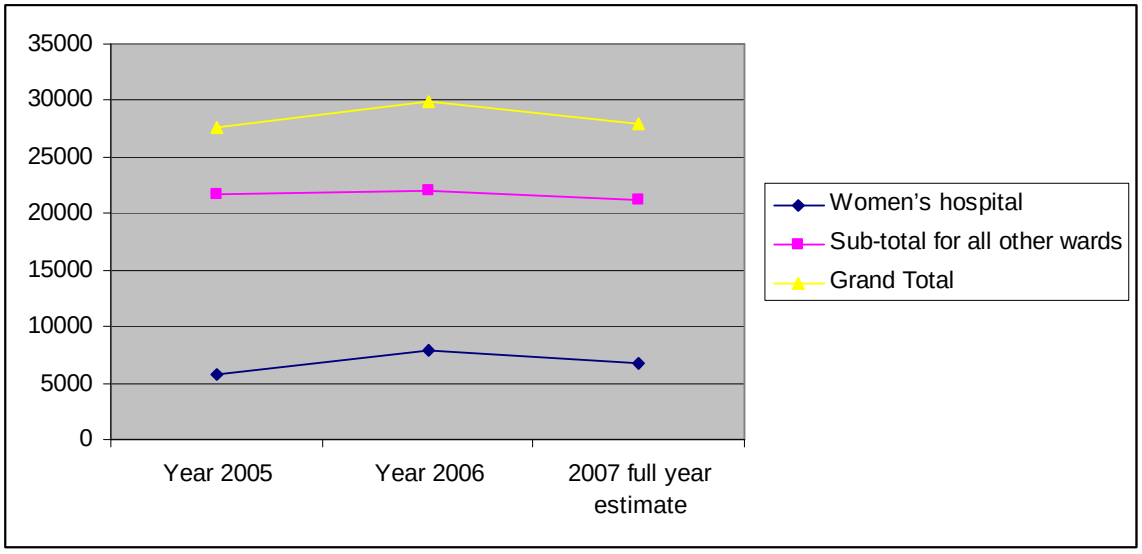
Some of the observations with regard to the institutions visited are as follows:

Barwani district hospital

Barwani district hospital is a large and long established hospital, with a total capacity of 262 beds. Being the main indoor establishment for the district headquarters and most of the rural population in this adivasi district, this public hospital has a high degree of utilisation and historically has been playing an important role in providing health services especially to the poor and adivasi people. However in the context of NRHM, we needed to see whether the various forms of strengthening under the Mission have significantly increased utilisation of this hospital.

We could obtain data for inpatients admitted in Barwani district hospital for the years 2005 and 2006; for 2007 we received data uptil 15 November. These admission figures for various major wards are given below. In order to compare the figures of 2007 with previous years, we have also made an extrapolation for 12 months assuming the same average rates of admission in the remaining one and half months.

Ward	Year 2005	Year 2006	Year 2007 upto 15 Nov.	Extrapolated for 2007 full year
Women's hospital	**5825**	**7831**	**5887**	**6729**
T.B. & isolation	3065	1934	2376	2716
Female medical	3645	3859	3633	4152
Male medical	3452	3901	3053	3490
Female surgical + orthopaedic	3221	3461	2102	2403
Male surgical	2603	2996	2349	2685
Paediatric	4739	4853	4313	4930
Ophthalmic	997	991	742	848
Sub-total for wards besides women's hospital	**21722**	**21995**	**18568**	**21224**
Grand Total	**27547**	**29826**	**24455**	**27953**



Over the last two years there is some increase in the number of women receiving care in the Women's hospital – primarily related to the increase in number of deliveries being attended to. However, the attendance in all other major wards of the hospital remains at largely the same level over these three years. Thus it seems that related to JSY and the increased stress on institutional deliveries, there is some increase in utilization of delivery care, but overall utilization of the Barwani District hospital has not substantially changed over this period. In the meanwhile some small private nursing homes have started in Barwani. It needs to be examined as to *why increased funds and management inputs related to NRHM have not made much impact on utilisation* of this generally well-attended public hospital.

Issues regarding availability of medicines and quality of care

As mentioned, one of the team members with medical background met some patients and their relatives in Barwani district hospital. The first patient, in the male surgical ward, was an elderly man who had come with urinary obstruction, which had been relieved by catheterization. He was a BPL patient, but the relatives had to purchase a rather expensive antibiotic from the medical store. When it was enquired as to why the antibiotic was not being given from the hospital itself, it was informed that the concerned surgeon used to prescribe some specific, advanced antibiotics which were not available in the the hospital supply. It was also a matter of concern that the patients son told the team member that he had to pay Rs. 200 to the surgeon and assistant for catheterization. When the surgeon was asked about this, he did not deny having charged the patient, but claimed that this was done at his residence, which did not seem convincing since a procedure like catheterization would normally be done in a hospital setup.

In the pediatric ward, the team member talked with the parents of three child patients. Of these, two showed intravenous saline bottles which they had to purchase from the medical store. One of the children who had come for treatment of diarrhea was taking oral feeds but the parents had not been advised or informed about ORS in any form.

Another child who also had diarrhea was being given continuous intravenous infusion even though he was taking oral feeds and was not dehydrated, he could preferably be given rehydration by the oral route.

These observations point to the fact that availability of medicines to patients in the Hospital does not seem adequate, and even basic items like intravenous fluids have to be purchased by some patients. Care for children with diarrhea was found to be not very rational, and the instance of excess charging for performing a procedure points towards issues of deeper concern.

CHC Niwali

We visited the labor room and inspected the delivery register which showed total of 120 deliveries conducted till 16th of Nov'2007 during the month. Hence, on an average 7-8 deliveries per day. However no patient relating to pregnancy or child birth was found be present during our visit. On enquiry, the staff nurse informed us that no delivery had taken place on that day and on the previous day only one delivery had taken place. Seeing the condition of labour room, it was difficult to believe that so many deliveries would have been taking place there every day. It was also noticed that either ASHA or any other link worker had accompanied the pregnant lady in all the cases. Also, it was reported that 171 deliveries had taken place in the previous month.

We also interacted with some civil society members and NGOs who disputed the claims made by the medical officers regarding such increase in institutional deliveries. One of them claimed that he had been to many villages and interacted with many beneficiaries whose names figure in the list of Institutional Delivery Register of the PHC. He alleged that there is strong connivance of the field functionaries with the CHC functionaries and the fund is being siphoned off in a very systematic fashion by showing home deliveries as institutional deliveries. Our observations also indicated towards this. I advised the CMHO & DPM to conduct few test checks to confirm this. It was also learnt that the JSY payment to the beneficiaries for last two months have not been made due to non-availability of fund with them.

No 'Janani Express' was found to be functional there. A new building has recently been constructed for the hospital but not inaugurated and the hospital is functioning in an old dilapidated structure. The labor room was also in a very bad shape. Though the hospital has been declared as a BemoC, the medical officer was not very conversant with the concept of BemOC.

Also, Though RKS was supposed to be functioning there, no proper accounts was being maintained with regard to income and expenditure. The medical officer could not show the cash books and other documents in updated form. The delegation of powers to the block MOs appears to not have been done.One DEO (Data entry operator) has been provided in the PHC under NRHM but she is underutilized due to lack of job clarity. Medical officer should have utilized her in compilation of various informations.

On the way to the block we also came across a mobile medical unit. There was a team of doctors and other paramedical staff distributing medicine in the market area. A monthly tour programme was also available. We were told that such mobile vans are available in every blocks. There is a need to carry out a cost benefit analysis to fully understand the utility of such facilities. Such facilities would be more useful if camps are conducted in the remote and interior areas where people are deprived of any health services and not on the road side villages.

CHC Pati

The CHC at Pati is a CEmONC with a sanctioned capacity of 30 beds. However the number of actually functioning beds appeared much smaller, with less than 10 beds actually occupied. The utilisation figures available are as follows:

	2005-06	**2006-07**	**2007-08 till Oct.**	**2007-8 extrapolated**
OPD attendance	50375	48436	37049	44459
IPD	1634	1566	1538	1846

Outpatient attendance has not changed substantially over this period, inpatients have increased somewhat (from 1634 to 1846 in 2 years) but this increase may be entirely explained by the increase in deliveries over the same period (from 218 to 457) as seen in the table below.

	2005-06 (Oct. 05 to Mar. 06)	**2005-06 extrapolated**	**2006-07**	**2007-08 till Oct.**	**2007-8 extrapolated**
Deliveries	109	218	337	381	457
Cesareans	0		0	0	

Hence we see the same trend here as regards Barwani district hospital – that there is a significant increase in deliveries, but ***aside from deliveries, the overall utilization of the CHC does not appear to have increased despite NRHM inputs.*** The fact that not a single cesarean operation has taken place over a three year period in a CEmONC facility also needs explanation. We see a similar complete absence of cesarean operations in CHC Niwali, CHC Thikri and PHC Anjad.

The CHC is functioning in an old building. There were 3 delivery patients on the day of our visit. All the beds were lying in the verandah outside the ward. We were told that this has been done due to frequent power cuts and mosquitos inside the room. Some villagers met us and complained about the demand of illegal gratification by the staff which could not be substantiated. Though the medical officer informed us about the functioning of RKS, no documents could be shown to us regarding conduct of meetings, collection of

user fee etc. A newly constructed OT was also available which is utilized during family planning camps etc. However no routine operations are performed due to absence of a resident surgeon or anaesthetist. Similarly, unused equipment for neonatal UV irradiation was found carefully kept under wraps.

There were complaints regarding non-availability of medicines, and that OPD patients are given medicines for only two days at the time of a visit, requiring them to travel back frequently for follow up. It was complained that certain of the CHC doctors induce certain patients to visit their private clinics where they charge the patients. There were also complaints that the ambulance (which has a driver on contract basis) is often not available for patients when required, and even BPL patients have to pay for ambulance services.

No Janani express was found to be functional here due to non-availability of suitable vehicle.

Concerning functioning of JSY, some representatives of a locally active organisation showed us written complaints which they had submitted regarding lack of full payment to JSY beneficiaries, and complaints that instead of ASHA receiving the incentive amount, this had been taken by the local Health department staff. It was alleged by them that there was no satisfactory reply to these complaints from the authorities, and at the time of our visit the Medical officer did not seem to be in a position to respond to these complaints.

Discussion with ASHAs in Pati block

ASHA training in the block is being conducted with the help of a locally active NGO, SATHI who are utilizing pictorial training materials for better appreciation of concepts. This can be replicated elsewhere in the state, especially for less educated ASHAs. We interacted with a group of around 30 ASHAs and about 30-40 villagers at village Sawariyapani in Pati block. The ASHAs appeared to be enthusiastic, motivated and well informed. They were from very interior pockets of the block and complained about difficulty in conducting immunisation etc. due to long absence of ANMs from head quarters and their irregular visits to the tribal hamlets. The ANM centre available in the village had a good building but neither ANM nor MPW were available, as learnt ANM was not staying there.

CHC Thikri

This is one among the 50 Dhanwantari block institutions selected in the state, also declared as a BemoC. The functioning of the institution, the upkeep & cleaniness, motivation level of the MO and other staff, functioning of JSY, RKS & Janani express was in sharp contrast to the other institutions in the district. Regular reviews at state level as well as highly motivated and commited staff, able leadership of MO had made all the difference.

The RKS was active. MO had utilized the fund for purchase of emergency medicines, white wash of the building etc. However, MO expressed inconvenience due to non delegation of powers as well as non- familiarity with the procurement procedures. Also, it was noticed that the RKS is mostly non-participatory, meeting not being held regularly as well as there is no involvement of stakeholders in its functioning. State, who was the pioneer in introducing the concept 10-12 years back has to reorganize and reconstitute them as per the changing needs.

Janani express was functioning well. Average delivery in the institution has shown sharp increase from 45 per month to 90 in last one a half year.

II. Rogi Kalyan Samitis

Rogi Kalyan Samitis have been officially developed as facility based institutions to improve management of health services, which have originated from the state of M.P. since 1995. This institution has been presented as a model for decentralized management of public health services, with greater autonomy of decision making and availability of some flexible funds. At the same time, questions have been raised about the form in which RKS have evolved in M.P., particularly the trend of using funds collected from user fees to partially replace public funding, and regarding the pattern of utilising these funds. An examination of RKS in the facilities visited presents a mixed picture, with certain improvements having been made possible with the untied funds available with RKS, but also a concern regarding the use of RKS funds for core expenditures of the facility such as regular salaries, as well as constraints perceived by medical officers regarding the use of RKS funds. The major dependence of RKS on user fees as its source of finance till recently is another matter of concern, since this may imply some barrier to accessing health care for those with limited resources but without BPL cards, which has been acknowledged to include a sizeable section of the population. Another issue is the very limited participatory nature of the RKS executive body, which remains firmly under control of the authorities with some involvement of political representatives, but with only nominal participation from NGOs and community organisations. Further, the strikingly irregular and inadequate reporting from RKS to the State health department reflects an insufficient public stewardship of these institutions working on a large scale and influencing the management of Public health institutions across the state.

RKS - Barwani district hospital

Sources of income for RKS Barwani District Hospital

Source of income	**2005-06**	**2006-07**	**2007-08 uptil Oct. 07**
Inpatients fees	282040	314566	219980
OPD fees	331109	294670	187096
Laboratory fees	103155	150060	84470
Blood bank fees	107950	259625	214550
NICU fees	76700	85150	69850

RKS ambulance	58218	76595	23860
Official ambulance	85019	0	0
Private ward fees	225850	343650	189750
Subtotal fees	**1270041**	**1524316**	**989556**
Shops rent	178300	85100	71000
Shops premium	26000	40000	5020500
Auctions and contracts	6528	834474	11700
Subtotal property related income	**210828**	**959574**	**5103200**
Total (incl. other items)	**1715817**	**2709036**	**6199289**

We see that user fees from wards, OPDs, blood bank and laboratory services as well as ambulance services formed the main chunk of income for the RKS in 2005-06 and 2006-07. The present year (2007-08) is exceptional because 'premium' (a euphemism for 'pagdi') has been charged on a very large scale from shopkeepers to whom shops on hospital land have been rented out. There is no direct mention of RKS receiving funds through NRHM or from any other official source.

It needs to be considered whether such a large dependence on user fees is appropriate, and whether it might form a barrier to using services for the 'marginal poor' and the 'poor without BPL cards'. One of the team members visited the male surgical and pediatric wards in the hospital and randomly talked to some patients and their relatives. Of the five patients talked to, one surgery patient was BPL but had not brought the card and hence was having to pay for services. One other patient was an adivasi and obviously poor, but had not received a BPL card and was paying for services for his child. If these kind of situations are commonplace, then there are significant 'targeting errors' in the system, because of which comparatively poor people are being made to pay because they have not received or have not come with a BPL card. It may be kept in mind that there are no standard guidelines across the state on how much should be the maximum level of user fees for various services. In such a situation, RKS reliance on user fees on a large scale, including for life saving services like the blood bank and the RKS ambulance, could lead to an important barrier for such marginal poor patients. Instead of this, there needs to be greater infusion of NRHM and other untied funds which could ensure autonomy of the hospital but would avoid charging of major user fees.

Expenditures of RKS Barwani District Hospital

Expenditure head - 2006-07	Amount	Percentage of total expenditure
Medicines and oxygen	636671	23.09
RKS employees	615405	22.32

honorarium		
Construction and maintenance	502945	18.24
Mattresses and sheets	230378	8.36
Equipment purchase and repair	185726	6.74
Electrical fittings	127711	4.63
RKS ambulance	97543	3.54
Diesel generator	57721	2.09
Printing of forms	50658	1.84
Miscellaneous hospital exp.	252274	9.15
Total	**2757032**	**100**

We were able to get expenditure data for the full year for only the year 2006-07, which data is analysed here. We find that ***almost half of the expenditure is made on just two items which are basic, regular hospital expenses – medicines and salaries***. If we look at the type of salaries being met through RKS funds, we find an astonishingly high number of **42 regular employees being paid regular salaries from RKS funds!** These 42 employees included staff nurses, laboratory technicians and other employees whose work is of an entirely regular nature. In effect RKS funds seem to be replacing Health department funding, rather than supplementing it. If basic, regular items such as medicines and routine salaries are being substantially (not occasionally) paid from RKS, which is in turn significantly financed through user fees, then this amounts to semi-privatisation of the institution rather than a supplementary form of income to give some local and flexible spending autonomy. In contrast to this, the Hospital Development Committee model, where state funds are made available to the committee for some flexible use, needs to be considered.

B. Observations regarding District Jabalpur

I. General observations

The State of MP is certainly showing the positive results of the mission mode of NRHM. The Central Government's pumping in of resources as well as the high-pitched emphasis on strengthening of health systems have begun to show visible and impressive results. The significant increase in numbers of people approaching the government health services mainly for deliveries shows that the confidence in government health services has risen which is certainly one of the best indicators of the difference that has been made. Conversely, the doctors also displayed a very high sense of ownership and confidence. The high level of motivation and enthusiasm at the leadership level in district health and administrative officers that we witnessed at a few places in Bhopal and Jabalpur, even if it was of exceptional nature, showed the quick and critical difference

that levels of personal motivation of the leadership can make in systems that have resisted change for decades.

Particularly on institutional deliveries there has been a phenomenal increase in the numbers of women who are approaching the institutions for deliveries. In Jabalpur district while there had been 13,000 institutional deliveries last year, this year by now there have already been 15,000 deliveries. In the Patan CHC, last year there were 1300 institutional deliveries, but this year already 2000 institutional deliveries have been conducted there. In the Civil Hospital at Sinhora, the institutional deliveries have gone up from 585 in 2005-06 to 742 in 2006-07 and already 1200 in 2007-08.

There are however two caveats to these observations:
One, there is overemphasis on JSY and institutional deliveries and that is being taken to be an end by itself, thus not even addressing maternal health in its totality (since institutional delivery by itself is not equivalent to maternal health), while other areas of health concerns seem to lag behind wrongly as secondary concerns.

Two, the present change, where it is highly visible, is led and driven by personal leadership of a few individuals at the helm of affairs who have passionately taken it on themselves to steer it; the systems have yet to take over the process of bringing about the change and till that happens, the sustainability of change is uncertain, even as the leadership that has been created is undoubtedly highly inspiring and touching.

II. Observations on Janani Suraksha Yojana:

- At the policy level, the apparent success of JSY notwithstanding, it is still open to scrutiny if the quantum of resources pumped into JSY for incentivising institutional deliveries is proportionate to the gains made in its ultimate objective, i.e., decreasing maternal mortality and morbidity. It is clear that at the best places, institutions are not adequately ready for handling the sharp increase in number of women approaching the institutions for deliveries. Neither the staff nor the infrastructure is sufficiently equipped to handle the sheer numbers. The quality of services and care is something that is therefore a huge casualty and is not being attended to at all in the current scenario. There are also inevitable experiences of corrupt practices like illegal demands for money, or showing home births as institutional births and dividing the cash incentives between the perpetrators of this fraud, that have not been looked into. Clearly the women are coming to the institutions chiefly for the lure of cash incentive and many of them go back with negative experiences of services and treatment they receive (as was revealed in meetings with women in village Gosalpur in Sinhora, Jabalpur). In such state of affairs, the government ought to keep the JSY under constant and close scrutiny to determine if the resources used only for motivating pregnant women to approach the institutions for deliveries are yielding proportional results or they can instead be used for larger purposes of building/ replenishment of infrastructure, drug supplies and staffing which would adequately prepare the institutions to render services of certain quality and which in turn and by itself would be enough to

attract the people, including but not limited to pregnant women, to the institutions since in any case they have been craving for free of cost services and in most rural places none are available except the government run services.

- At implementation level, some observations are: A new guideline was issued on 5.2.2007 by the Madhya Pradesh Government by which the cash incentive of Rs. 350 for bringing a woman to the institution for delivery is now to be given to not just the ASHAs but to whoever brings the woman to the institution including the Anganwadi Worker (AWW) or Dai. This has created a situation where the ASHA's cash incentives are now being shared with two other powerful contenders, the Dais and the AWW, who have more influence in the villages. This needs to be looked into. The ASHA we met at village Nunsar, Patan Block, Jabalpur, said that since July 2008 she had received her cash incentive for only 4 deliveries (which was confirmed by the BMO in CHC, Patan) while she had motivated 18 women for institutional deliveries in this period. She was not paid the cash incentive simply because 14 of those women were accompanied by the Dai or AWW at the time of delivery. The ASHA seemed to be considerably demotivated by this.

- Apart from taking a policy decision on this issue, it also highlights the related issue of overlap between and lack of clarity of the roles and responsibilities of ASHAs and AWWs. The government should address this.

- Some ASHAs also brought it to our notice that in Madhya Pradesh since a flat amount of Rs. 250 has been earmarked across the board for transportation of the woman to the institution, this money is being deducted from ASHA's share at a flat rate and across board, even if the transport is not being provided in individual cases. This also makes a dent in the cash incentive earned by ASHA as earlier she could save some money from this in most cases, especially when the distance to the institution was short.

- A few ASHAs also complained about illegal demands of money for handing them the cheques (one ASHA we met told us that the nurses would demand Rs. 100 and even the reduced payments are delayed and are released after much delay). Even though the State Government has made it compulsory to issue account payee cheques and not disburse cash payment under JSY, the kickbacks continue to be demanded from ASHAs, which raises the issue of accountability that cannot be wished away especially since a huge amount of public money is involved.

- There was an observation at the state level that JSY is taking up a large portion of the NRHM fund flow for the state, since these are large scale continuous expenditures which have to be met immediately (in response to beneficiaries coming for deliveries) unlike other planned expenditures. It was shared that with continuous escalation in numbers of beneficiaries, the issue of managing fund flow for JSY may become a problem.

III. Observations on quality of care

Quality of care is an issue important enough to be flagged independently as also in addition to the earlier observations herein on the quality of care being neglected within the JSY scheme. We felt that while the increase in patient case load and institutional deliveries is certainly noteworthy, there has not been commensurate emphasis or attention on the quality of care in the institutions. We met women in the village of Gosalpur in Sinhora Tehsil in Jabalpur district who candidly spoke of several instances of the neglect of quality of care which seems to be symptomatic of the state of affairs there. In particular, they spoke of issues like: lack of hygiene and cleanliness and use of the same syringes for injecting several women at the same time, not protecting the dignity/ privacy of women who are made to lie in a row in public view before conducting sterilizations. Related issues like rude behaviour of the service providers, outright denial of services to effective denial due to absence of the doctors and nurses who indulge in private practice, demands for money for providing medicines, instructions to get own syringes/ medicines. When asked specifically if the patients are counseled or informed of the line of treatment and the available options etc. it was clear that the values of patient autonomy, informed consent are totally missing, while dignity, privacy etc. are flouted with impunity. The ASHA of this village told us that women are regularly being discharged within 2-3 hours after delivery, thus making post-natal care a dispensable part of services. That there is absolutely no means of registering a complaint or even lodging protest makes it worse. On one hand, this by itself takes away the gains made by increase in number of patients approaching the institutions. On the other hand, this callousness would be actually counter-productive as people who do come to the institutions and are then treated callously would be discouraged in future to approach the institutions again and would also discourage others in the community to do so. It is also important to understand that quality of care must be interwoven into every initiative of the NRHM at every stage as a non-negotiable.

In addition to the above, following are a few particular observations on some of the institutions visited. These may not be symptomatic of the general picture across the entire State or even district, yet we feel that they need to be mentioned as they show when and how the maladies develop in the systems or why some institutions remain resistant to change:

In ‘Civil Hospital’, Sinhora, Jabalpur District, a huge building for 100 (later reduced to 60) beds hospital is lying fully constructed for at least but which has not been made functional for reasons that did not seem very convincing to us. Thus, services are being offered on a much smaller scale of ‘civil dispensary’. The vacancies in staff have accordingly not been filled. The entire place looked extremely run down with neglect and in extremely poor hygienic conditions – an overflowing sewer just outside the labour room led us inside the labour room which had a totally filthy bed. The doctors we met spoke of pilferage of equipment and medicines, law and order problems, political interference and non-performance by contract employees recruited through favouristism, that impeded their work. There are no staff quarters though their construction was sanctioned quite some time back. Also there is no power back-up – the generator does not

work and there is only one inverter in labour room & OT. Even the staff that are posted here are attached to other institutions and hence cannot be available here. There is no supervision by the Civil Surgeon under whom this hospital is placed. There is frequent absenteeism by doctors who have private practices. Ward security was an issue highlighted by all the staff we met – misbehaviour and drunkenness of patients' attendants, gambling just outside the hospital gate were some instances that were mentioned while there is not police protection. The RKS is dysfunctional here through there is money in the account (about Rs. 1.5 lacs); no RKS meeting are held and no money from RKS find is being used.

C. State level scenario regarding Rogi Kalyan Samitis

As noted above, Rogi Kalyan Samitis (RKS) have been developed as a significant model for flexible and autonomous management of Health care institutions in M.P. These have been upscaled from initial positive experience in Indore in the mid 1990s, to cover institutions at various levels across the state. Here we look at the officially available data compiled at state level regarding total RKS incomes and expenditures.

Income & Expenditure of Rogi Kalyan Samitis in M.P.

Year	Income	Expenditure (In Crores)
1995-96	0.59	0.44
1996-97	3.0	1.36
1997-98	4.93	4.18
1998-99	5.23	4.09
1999-00	9.70	7.44
2000-01	12.80	9.07
2001-02	13.97	9.21
2002-03	8.88	6.41
2003-04	18.64	4.91
2004-05	11.58	11.35
2005-06	11.51	9.18
2006-07	10.57	10.20

From website http://www.health.mp.gov.in/rogi.HTM

We find that with increasing spread of RKS institutions, both total income and expenditure have increased manifold over the period 1995 to 2000. What requires explanation are the major fluctuations in both income and expenditure after the year 2000-01, and major divergences between income and expenditure in several years. For

example, RKS incomes jumped to more than double between the successive years 2002-03 (8.88 cr.) and 2003-04 (18.64 cr.) and then fell dramatically in the next year 2004-05 (11.58 cr.). In 2003-04, the year which saw the highest total RKS income in its history till now (18.64 cr.) has also witnessed the lowest expenditures since the year 2000 (4.91 cr.), with a large gap of over 13 crores between income and expenditure. In this context it may also be noted that in the years 2000-01, 2001-02, 2003-04 and 2005-06 there have been significant gaps of over 2-3 crores between income and expenditure. These large fluctuations and significant gaps between income and expenditure need explanation and seem to indicate lack of adequate planning despite the experience of RKS of more than a decade. Given the significant dependence of RKS in MP on user fees, *if in several years a large proportion of collected funds remain unspent, then either the charging of fees should be scaled down or expenditures need to be more properly planned*. However, these figures also have to be interpreted keeping in mind the massive under-reporting of RKS to the State health department as discussed below.

Inadequate reporting of Rogi Kalyan Samiti data

Rogi Kalyan Samitis have been formed in Health care institutions across M.P. by means of a Government order to that effect. Hence these semi-autonomous institutions have definite accountability to the State Health department. However, it seems that despite the wide publicity and recognition given to these institutions, official supervision of RKS from the State level is insufficient. This is exemplified in the large scale lack of reporting by RKS from various districts, leading to major gaps in information which would consequently affect related planning.

According to official data made available to us, ***no RKS reporting was received during the current year, April to Oct. 2007, from the following 16 districts:***
Vidisha, Rajgarh, Datiya, Ashok nagar, Jhabua, Barwani, Katni, Narsinghpur, Dindori, Anuppur, Umaria, Damoh, Panna, Tikamgarh, Nimach, Ratlam

This appears to be quite an inadequate state of reporting, where in the current year ***one-third of the 48 districts in M.P. are not reporting any RKS data.*** The official at state level who gave us the RKS related data stated that the situation even from the reporting districts is not satisfactory, and about half of the CHCs and PHCs are not submitting RKS data to the state level regularly.

RKS incomes and expenditures – data at state level

When we look at the data for income by RKS across the state in the current year, we see the following picture:

Type of income	**Amount Apr. – Oct. 07**	**Percentage of total income**
Donors	448932	0.66
Income from user charges	23961789	35.2
Commercial income	13343673	19.6
Other income	30313998	44.53
Total income	**68068392**	**100**

Here we see that user fees form over one-third of the income by RKS, while donations are a miniscule amount, less than one percent. This confirms the significant dependence of RKS on user fees in M.P. What requires further explanation is *the largest category, the blanket 'other income' head which covers somewhat less than half of the total income by RKS*. Related to this, it also needs clarification as to where the untied funds being made available under NRHM fit in this income distribution. It is obviously desirable that the classification and compilation of expenditures is done in a manner which breaks up the large 'other' income into specific items, and the NRHM untied funds are separately displayed.

When we look at total expenditures by RKS in M.P. in the current year we see the following situation:

Type of expenditure	**Amount Apr. – Oct. 07**	**Percentage of total exp.**
Construction and repairs	6594845	12.15
Medicines	6782837	12.5
Equipment	3834989	7.07
Staff honorarium	3720642	6.86
Other expenses	33327357	61.42
Total expenditure	**54260670**	**100**

Here we see that construction / repairs and medicines form two significant heads of expenditure, each being somewhat above 12% of the total expenditure. While use of the flexible RKS funds for some expansion of construction and occasional repairs is logical, it needs to be considered whether dependence on RKS funds for supply of medicines – a routine and regular expenditure - on such a significant scale, is justified. Here the observation that RKS funds in M.P. are being used to partly *replace* routine government funding (instead of mainly providing an autonomous mechanism and just supplementing official funds) gains strength. With a major infusion of untied funds under NRHM, it appears even more unjustifiable to depend significantly on RKS funds for routine medicines and salaries.

Further, the blanket 'other' category which looms large in RKS incomes, appears in an even larger form in the expenditures, forming over 61% of total expenditures. We asked for an explanation of the 'others' head, and it was told that items like stationery and printing are covered under this. However, this does not seem to be an adequate explanation, we need to keep in mind the possibility of covering different types of more or less justified expenditures by a variety of Rogi Kalyan Samitis across the state under a blanket 'others' category. Hence it is very important that reporting of expenditures is further classified and made specific, and necessary heads are added, so that 'others' is reduced to a small and truly miscellaneous category, rather than overshadowing the entire expenditure by RKS in the state.

In summary, concerning RKS in M.P. we see large financial fluctuations and significant divergences between income and expenditure in several years; large scale non-reporting

or inadequate reporting from RKS institutions, with RKS from one-third of districts not reporting at all; an unacceptably large 'others' category in reporting both total incomes (44.5%) and expenditures (61.4%) which conceals more than it reveals; over one-third of RKS income coming from user fees which is regarded as a regressive form of financing; and significant proportion of RKS spending on routine expenses such as medicines, which should be primarily met through Health department funding. All these observations point to the fact that the much-celebrated innovation of RKS in M.P. needs much better stewardship, supervision and support from the state level. RKS should move from a model of partly substituting state financing by user fees, towards a model of autonomous management which is based on NRHM untied funds, and decentralises decision making without placing the onus for resource generation on ordinary patients.

D. Programme and financial management

M.P. has been able to put in place a very robust system of programme management set up at State and district level. The SPMU is fully in place with right mix of skills. However, 7 posts of District Programme Manager & 6 posts of District Accounts Manager are lying vacant which need to be filled up immediately. Block level identified institutions are being strengthened with accountants to streamline financial management. M.P. is also pioneer in the concept of decentralized planning and they have a very elaborate state and district PIPs. Also, as learnt, the process of PIP preparation is quite systematic with inputs being taken from districts and being compiled at state level. Block PIPs have also been prepared and last year sample village health plan has been prepared.

For the current year, the process of PIP preparation has already been identified and state has already issued elaborate guidelines to the districts for this purpose. This year 45 village per block will prepare the village health plan. SPMU and DPMU are fully involved in preparation of PIP. However, it was seen that the number of activities taken up by some of the districts are too large and they are finding it difficult to implement and monitor them. The system of appraisal of PIP at state level is very systematic and is worth replicating by other states. The system of monitoring of activities against PIP is also well developed. Divisional level teams have been constituted at the state who appraises the PIP. The approved PIP is being communicated to the district. From this year fund is also being released to the district in form of flexi pool which is the strength of NRHM. Barwani district where we interacted with the functionaries it is learnt that districts have also started releasing funds to the blocks in form of flexipool recently.

Progress of PIP is monitored through a monthly HMIS system which is based on the activities approved under PIP. MP is also pioneer in introducing the system of concurrent audit. This is helping the state in timely submission of SoEs and U.C to Govt. of India, and timely submission of audit reports. We were told that MP is the only state to submit the audit reports to Govt. of India within stipulated deadline. At district level a chartered accountant has been appointed who audits the accounts of all the programmes including National disease control programme. Due to this, expenditure is being booked and advances are being settled quite regularly. State is able to submit updated HMIS as well as SoEs to Govt. of India well in time and thus are able to claim more amount of

fund. The system of concurrence audit, PIP based HMIS as well as process of PIP preparation is worth replicating by other states.

M.P. is also a pioneer in the concept of RKS. However, in the field during our visit to district hospital and different block level hospitals shows that so far functioning of RKS is not uniform everywhere. Also the concept of decentralized decision Making, delegation of administrative and financial rules appeared to have not been understood well.

The State PIP is very strong in national health and child health component of RCH. State has identified 150 institutes to be developed as FRU out of which 64 are presently functional. There is an ambitious target of balance 85 institutions to be made functional this year. Similarly, against the target of 500 BEmONC to be made functional this year, 334 are already functioned and another 63 are to be made functional this year. State has also shown remarkable progress in increasing institutional delivery. The state has also developed a system of incentives to good performance of CHCs and their staff.

E. Selection & Training of ASHAs

Against the target of 44,379 ASHAs the state has been able to select 38,464 ASHAs so far. The reason given for non selection of remaining no. of ASHA was that they are not able to get sufficient no. of ASHA with 8^{th} pass qualification. There is a provision for relaxation of qualification for ASHA under Govt. of India guideline, which has not been implemented in M.P. as it appeared that they are not fully aware of this relaxation. Against 44,379 ASHAs only 2192 has been trained in all the modules so far, the state needs to expedite the ASHA training. Specially developed training material for less educated ASHAs which is available may be used for this purpose.

F. Innovative schemes under NRHM in Madhya Pradesh:

The State Government has initiated several innovative schemes to implement NRHM more effectively:

- Janani Express Yojana
- Janani Sahyogi Yojana
- Dhanwantri Block Development Scheme
- Bal Shakti Yojana
- Deendayal Chalit Aspatal
- Swawlamban Yojana
- Matri Shakti Yojana (proposed)

- *Janani Express Yojana* is an initiative to provide assured 24 hours availability of emergency transport – named 'Janani Express' - for safe institutional deliveries, post natal and other health emergencies, in all blocks of the State. The scheme aims to provide a single phone number which transfers the calls to call centers that have been set up in every district and at which the women who are in labour pain or their families can make a call for providing transport from their homes to the health centers for delivery. The transport is especially available for any complication during pregnancy and for new-borns.

The vehicles are run in a partnership with private transporters for a cost that is taken out from the money which is to be paid to the ASHA for transport, at a flat rate of Rs. 250 per delivery.

This scheme has been largely fairly successful as it is well publicized, is being utilized well by the beneficiaries and works well in most places in ensuring round the clock transport from doorstep of the homes of women to the institutions.

- *Janani Sahyogi Yojana* is a scheme for accreditation of private and other non-governmental hospitals that conform to a detailed checklist/ guidelines for minimum conditions of infrastructure and staffing, e.g., 10 beds, functional OTs, labour rooms, cold chain, water and power supply; and availability of gynaecologists, anesthetists and paediatricians, for carrying out deliveries. The accreditation of these Janani Sahyogi hospitals is meant to be especially carried out for remote and inaccessible areas and the hospitals are remitted directly by the government. Till now 138 private health establishments have been accredited under this scheme.

- Under the *Dhanwantri Block Development Scheme* high performing health institutions are identified for each block where model services are being provided on pilot basis to set up exemplary standards for integrated management and implementation of all health services of the government.

- *Bal Shakti Yojana* is a fairly successful scheme aimed at addressing severely malnourished children, i.e., children who come under grade 3 & 4 of malnourishment, who have been identified in the villages and who are now being taken in rotation to Nutritional Rehabilitation Centers (NRCs) in district hospitals, along with their mothers/ guardians, for training and counseling and other necessary supports, including intensive observation and medical treatment, in nutrition, hygiene, and health care under the guidance of paediatricians and nutritionists. Noticeably, apart from the stay arrangements, the transport cost for travel to the centre and the loss of wage earnings for the mother/ guardian accompanying the child are also covered by the government, to encourage access to this scheme. A follow up card is made through which the ANMs and AWWs carry out 6 months follow up to ensure sustainability. At present 40 NRCs are operational and it is planned to increase the number to 100 by the end of 2008. A visit to an NRC at the Elgin Hospital in Jabalpur showed a very positive picture of success of this scheme.

- *Deendayal Chalit Aspatal* (mobile health clinics) scheme is meant especially for the tribal blocks of the State whereby the remote tribal people are visited on particular days/ timings, by a team of doctor, nurse and compounder with facilities for conducting all basic diagnostic tests and the services are provided totally free of cost. The scheme is well conceived, but there are some questions about its cost-effectiveness and also there are questions about fairness in awarding management of these clinics to powerful private business houses.

- *Swawlamban Yojana* is a scheme for bridging the gap in the number of available and required nursing and para-medical staff, by sponsoring training of 500 nurses, ANMs, lab-technicians, X-ray technicians in undertaking professional studies, in government as well as private institutes, in lieu of an undertaking to serve in rural areas for 7 years after completion of their courses. At present 29 existing ANM schools run by the government are being covered under this scheme but proposals from 19 districts for setting up private ANM schools are in pipeline to augment the scheme.

- *Matri Shakti Yojana* is a proposed scheme for tracking and providing care to women with high-risk pregnancies who are identified on the village health day. These women are to be given 'red cards' on the basis of which they will be given totally free treatment, medicines as well as nutritional support.

Some good practices towards improving health services that we came across in the State are:

- The Principal Secretary, Mr. M.M. Upadhyay has initiated the practice of carrying out a personal appraisal of the 50 Dhanwantri BMOs' of the State through monthly meetings when he personally meets with all these BMOs and appraises them on the basis of a checklist. Apart from helping in monitoring, this also helps keep up motivation among the BMOs as was confirmed by some BMOs we met.

- The State Government has started carrying out concurrent audits at district levels in all districts and the way to next step, of block level concurrent audits, is already being paved.

- Some of the HMIS initiatives undertaken by the State Government at district level are laudable. For instance, the Jabalpur Collector has initiated a new software called Child Record Information System (ChRIS) whereby the data on marriages, pregnancies, childbirths and immunizations etc are systematically recorded for the entire district on the web, with inbuilt mechanism for reminders on health actions to be taken on the particular dates by the service providers. In Bhopal, the CMES (Center for Emergency Maternal Services) which is run in a public-private partnership with a local NGO has a software that compiles data on pregnant women with mechanism for reminders on their EDDs and other health relevant dates. Accordingly, the NGO makes phone calls and keeps track of the actions to be taken at their end during the entire pregnancy till the childbirth. The same NGO also provides emergency transport service to nearest accredited private institutions for deliveries when they receive phone calls requesting for the transport. The systems for providing prompt and continued need based support throughout within this programme seemed extremely impressive and the NGO showed confidence about taking it to scale.

- There was a visible emphasis on health information and communication, at least of the minimum level of information, for instance on JSY and other health schemes, the user-fee to be charged, the common health issues and so on.

- At the Elgin District Hospital in Jabalpur, there was a clinic for women above 40 years of age aimed at providing services like pap smear test, mammography for women above 40 years of age and also special services for the needs of post-menopausal women, which was impressive.

G. MNGO scheme and involvement of NGOs

In both the districts visited, it was enquired about the functioning of the MNGO and processes for involvement of NGOs. In Barwani district, the DPM mentioned that he was not aware of current activities of the MNGO, and there was no specific mechanism for coordination between the District health system and the MNGO. All reporting by the MNGO is done directly to the state level. When we enquired about the office of the MNGO in Barwani to interact with them, it emerged that this organisation has no office in Barwani, nor does it have a regular presence in the district, being based over 150 km away at Indore! The selection of such a non-resident NGO (again done from the state level with no involvement of the District health system) in Barwani is quite surprising, especially given the existence of other NGOs with long standing work in the Health field such as Ashagram Trust.

Similarly in Jabalpur the MNGO was not found to be in active operation.

Keeping such instances in mind, it needs to be considered whether the selection and coordination related to MNGOs needs to be centralized to the state level, without involvement of the District health system. Similarly criteria for selection of MNGOs and supportive oversight of their work also need to be strengthened.

Regarding the issue of larger involvement of civil society organisations in NRHM processes, we did come across some positive examples such as 'Nivedita' involved in Janani Express Yojana in Bhopal and SATHI involved in innovative training of ASHAs (with pictorial training material) in Barwani. However there is presently no state NGO coordinator since several months, and there does not seem to be a systematic attempt to involve NGOs on a large scale in aspects of NRHM like ASHA training. Keeping this in mind, the involvement of NGOs with a definite track record of work in the Health sector, in various aspects of NRHM needs to be systematically expanded in M.P. The emerging activity of Community based monitoring of Health services under NRHM is another area where the lead should be given to NGOs and civil society organisations with a Rights-based approach to Health issues.

H. Meeting with Civil society organisations in MP

On the last day of the visit, the team also met with civil society organisations working on health rights across MP under the umbrella identity of Peoples Rural Health Watch MP and as MPJSA (MP chapter of Jan Swasthya Abhiyan). About ten representatives from the member organisations came for a meeting with the team to share their experiences and knowledge on the progress on health status of the State, including a detailed study "Two years of NRHM in MP", carried out on the basis of facility surveys of CHCs, PHCs and Sub-health Centres as also personal interviews with in-charge medical officers, ASHAs; exit interviews from patients; and interaction with communities. Some of the 32

member groups of Peoples Rural Health Watch are: MPVS, MP-BGVS, SATHI-CEHAT, MPVHA, IWID, NAWO, Ekta Parishad, NFIW, AIDWA, Jan Sangharsh Morcha. Those represented in the meeting included Dr. Ajay Khare (MPVS), Dr. Rahul (MPBGVS), Sudeepa (IWID), V.N. Tripathi (samavesh) Bharat Sharma (Desh and some journalists also joined them, like Rakesh Diwan (Dainik Bhaskar). Dr. Ajay Khare of MP Vigyan Sabha led the group and briefed the team of the key findings of the state study, some of which are as follows:

- 90% CHCs studied are not capable of conducting caesarian section deliveries.
- 83% PHCs and 50% CHCs studied do not have facilities for dog bite and anti rabies injections, snake bite treatment if also not available.
- In 80% PHCs and 64% CHCs studied "water availability is a problem".
- In 60% PHCs and 43% CHCs studied, toilets are in "bad condition".
- At 84% sub centres important medicines like iron, folic acid were lacking
- Only 52% sub centres had a thermometer.
- Only 68.42% PHCs have medicines for malaria.
- Only 66.1% ASHAs were recruited through the prescribed procedure, rest were recruited without following Gram Sabha and wider consultation in the village.
- Only 68.6% ASHAs studied had received honorarium during trainings.
- About 28.3% ASHAs studied began work without any training at all.
- Only 70.14% ASHAs studied have received the kits and 40.25 have received the books.
- Only 2.47% patients were exempted charges for services on basis of BPL, although MP has 37% BPL population.
- Community health manager is not appointed in any place.

All the CSO representatives voiced concerns about corruption at all levels of the health system and in recent times especially in JSY disbursements, bad quality of care, rude behaviour of the service providers, weak referral chains, lack of availability of medicines, syringes, lack of clarity on roles of ASHAs and AWW. Almost all of them stated that largest single reason for rural indebtedness, especially in rural areas, continues to be disease burden of the families and expenses on Health care.

I. Issues related to transparency and over-centralisation

The recent incident of the suspension of the Director, Public Health, M.P. after an Income Tax raid which had uncovered huge amounts of unaccounted cash and property, was mentioned on various occasions during our visit. It was observed that the concerned official had been in the Director's post since several years and occupied a very senior position. It is highly unlikely, given the scale of funds amassed and the apex post occupied by this person, that this was an isolated incident or limited to only one person in the department. Subsequently a complaint has been lodged with the Lokayukt against another Director of the department, concerning mismanagement of funds on Pulse Polio Immunization, ordering advertisements and purchase of drugs and instruments. During our visit to Bhopal in mid-November, the newspapers covered large scale purchases of Streptomycin injection by the State health department, despite this Anti-TB drug being regularly supplied free of cost to the state by the Union Ministry of Health and Family

Welfare. Another recent issue raised has been the purchase by the Health department of a large number of laparoscopes at a cost alleged to be three times higher than the market rate.

Given these incidents, which might be the tip of an iceberg, two larger issues need to be kept in mind. The first, which is of relevance not only to MP but applies to NRHM as a whole, is the large scale flow of funds under the Mission that relates to major purchases of drugs and equipment, construction and other activities. If financial regulatory systems and monitoring are not effective, then precious taxpayers money intended for the health of the rural poor might end up in certain places where it is not intended. The second observation points towards the hazards of over-centralization of power within the Health system in MP. While power should be used for positive purposes, if power is highly centralized and not independently monitored then the scope for misuse can also not be overlooked. Given this situation, effective delegation of financial powers, tighter financial regulatory mechanisms and full transparency at all levels especially regarding NRHM funds seem essential. Creating independent ombudspersons related to the Health department, making freely available all financial information in the public domain, and independent civil society monitoring of major financial transactions could be some of the related measures to be put in place.

J. Recommendations

While suggestions have been mentioned in various sections throughout the report, the main recommendations are mentioned below:

- While the substantial increase in institutional deliveries in M.P. is recognised, the insufficient increase in general utilisation of Public health institutions observed by the team in several health facilities needs to be addressed. Otherwise the NRHM goal of overall rejuvenation and increased public utilisation of all Public health institutions may not be achieved.
- Supply of medicines needs to be strengthened and monitored as we frequently came across complaints of non-availability of medicines. Availability of all essential medicines to all patients is a major factor which inspires confidence in the general public, while ensuring proper compliance with prescribed care. This needs to be completely ensured as a service guarantee and widely publicised in all Health care institutions.
- Charters of citizen's health rights and NRHM Health service guarantees need to be universally displayed and much more prominently publicized at all levels.
- Variations in quality of care, including less rational prescriptions, lead to poorer health outcomes and possible impoverishment of patients who are forced to buy expensive drugs. These need to be checked by ensuring Standard treatment protocols at all levels, along with ensuring adherence to essential drug lists while prescribing.
- Various other aspects of inadequate functioning of public health facilities could be addressed by a combination of better supportive supervision and community based monitoring of these institutions, towards their full effectiveness and accountability.

- While the model institutions are showing good results, their model performance only sharpens the deep polarities in the quality of institutions in the State, the ones on the other end of the spectrum continuing to graphically show all the malaise in the public health system. The State government must accelerate reforms especially at the latter end of spectrum as these institutions continue to undermine people's confidence in NRHM and its sustainability.
- Notwithstanding its success, the JSY must be subjected to critical evaluation and monitoring for its cost-benefit analysis and its accountability. JSY cannot be developed as a stand-alone programme without comprehensive strengthening of all aspects of Public health institutions.
- There is need to pay urgent attention to reform towards not just the deployment but also and perhaps more importantly, the career development of human resources for health to keep them motivated to serve especially in difficult areas.
- The Rogi Kalyan Samiti model in M.P. needs to be modified in the light of the availability of untied funds under NRHM. There must be fixed standards for the quantum of user fees charged from patients as it seems to differ over a range in various health institutions. Overall dependence on user fees should be scaled down, given the situation of a significant section of marginal poor and persons who do not have BPL cards but have limited resources. In contrast to user fees, the role of NRHM untied funds needs to be increased. RKS generated funds should not be used in a major way to support routine expenses such as medicines and regular salaries.
- The dynamic role of SPMU at the state level and DPMs at the district level needs to be appreciated and supported, with further roles, responsibilities and resources.
- While compilation of PIPs at district and state levels is systematic, the involvement of people from the community and active civil society organizations in the process of developing local plans at village, block and district levels needs to be greatly strengthened.
- Positive innovations such as concurrent audit should be maintained and could be suggested for generalization in other states.
- The State Government is still looking for ASHAs with minimum qualifications of 8^{th} standard as a result of which they are not able to identify sufficient number of ASHAs. The Government should lower the educational eligibility requirement as many states are doing and fill up the gaps especially in tribal areas. Training of less educated ASHAs may be carried out effectively by use of available special pictorial manuals already being used in the state as in Barwani district.
- Conflicts of interest between ASHAs, AWWs, ANMs and Dais related to the focus on one person receiving JSY incentive for a one-time activity (bringing the woman in labour to the institution) need to be resolved by making care for the pregnant woman through all stages a team activity which is rewarded as a process. The payments to ASHAs must also be made through cheques to fix greater accountability.
- Selection and functioning of MNGOs needs to be reviewed. The district health system needs to be involved in a major way in coordination with such NGOs. Non-functioning and non-resident MNGOs need to be replaced.

- Involvement in NRHM of civil society organisations including NGOs needs to be encouraged and developed on a much larger scale. ASHA training and mentoring, Community monitoring and capacity building of Village health committees are some areas where NGOs and Community based organisations should be systematically involved across the state.
- Since a large part of the reforms in the State are being planned with private partnership, this needs to be preceded and accompanied by effective legal and operational regulation of the private health sector.
- Some of the officers at the highest level still seem to be working within the population control paradigm and have poor understanding of the NRHM as an overall systems overhaul and convergence model of health reform. There is thus need to sensitize and train officers from the highest level downwards.
- The IDSP has not been made functional for want of only a small investment in infrastructure which must be done.
- Block Medical Officers must be given financial and administrative powers to enhance their capacity to spend at the block level.
- There must be inbuilt quality of care parameters at every step in the process of reform, thus not limiting it to reform of systems around merely infrastructure and staffing. While the existing IPHS standards are not totally satisfactory towards ensuring quality of care, even those that are on paper are not being implemented.
- There must be more emphasis on integration of the PRIs as currently that seems to be not very strong and is infact very weak in many places we visited.
- The programs for control of other diseases, and for sanitation and nutrition ought to be integrated within NRHM which is not being done currently.
- Genuine delegation and decentralization of financial powers, stringent financial regulatory mechanisms and overall transparency regarding NRHM funds must be ensured. Independent ombudspersons may be created for the Health department, all financial information should be made freely available in the public domain, and independent civil society monitoring of major financial transactions could be institutionalized to ensure full transparency and public accountability at all levels.