

# *Action alert on* **National Rural Health Mission**

Issued by Jan Swasthya Abhiyan

## **Introduction**

The Indian health system is one of the most privatised in the world, with just about 17% of health care costs being borne by the Governments at all levels taken together. A few tertiary care urban areas eat up a large part of this meagre allocation. The public health system has been consistently undermined with the acceleration of the liberalisation process since early 90s. There has been stagnation in the number of rural public health institutions and beds in public hospitals, with a decrease relative to population and the general functioning was inefficient and inaccessible. Today, in most states, the number of facilities, available, staff and supply of drugs and equipment are much below the norms set by the government. This forces a vast majority of the population to be at the mercy of a private sector that is unregulated, expensive and often known to take recourse to unethical practices.

The National Rural Health Mission is being projected as a major undertaking by the newly elected UPA government to honour the electoral mandate of 2004, and to realise its promises under the Common Minimum Programme, which articulated commitment on rural health and access to primary health care. This has been a positive change from the previous NDA government's almost exclusive elite health care agenda - of opening six AIIMS, promoting medical tourism, telemedicine, etc.

The NRHM aims at provision of effective healthcare and universal access to rural population with special focus on 18 states, architectural correction of the health system, decentralisation of programmes and population stabilization.

The basic objectives of the NRHM, as they stand now, are as follows:

- a. a commitment to provide effective health care to the rural population with special focus on 18 states (U.P., Uttaranchal, M.P., Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, H.P., J&K, Assam and the 7 states in the North- East).
- b. A commitment to increase public spending on health from 0.9% of GDP to 2- 3% of GDP.
- c. To ensure integration of health concerns with determinants of health like sanitation and hygiene, nutrition etc
- d. Decentralize the management of health.

State Governments are expected sign an MOU with the Central Government signalling agreement with and commitment to implementation of the NRHM. A State Health Mission along the lines of the proposed Central Health Mission is to

be set up, and States have to commit to a 10 per cent increase for public health expenditure in the State budget every year.

### **Context and evolution of NRHM**

In the run-up to the elections, social organisations, particularly the Jan Swasthya Abhiyan (JSA), had lobbied with several major political parties for inclusion of critical health issues in their election manifestos. The defeat of the ruling NDA alliance in the 2004 Parliamentary elections with its discredited “India Shining” campaign, and the compulsions of an alternative alliance around the Common Minimum Programme (CMP) forced the political leadership to introspect about the silent majority - India’s rural population, 72.2% of the total population according to the 2001 Census. Therefore even to those political classes who would accept globalisation and privatisation as inevitable or desirable, the need to show pro-poor developments in social policy has acquired a sharper focus.

Although several members of the Jan Swasthya Abhiyan were involved in the consultative process of drawing up of the NRHM, and certain suggestions were reflected in draft proposals, neither the process of decision making nor the incorporation of their recommendations was to their satisfaction.. There was no systematic analysis of previous policies, and no major lessons seem to have been learnt from the past. The NRHM documents do not appear to analyse why the Primary Health Care approach was never implemented effectively and the goals of ‘Health for All by 2000’ have not been met.

### **Financing of NRHM**

Despite so much talk about the NRHM and the proposed increase in public spending on health, the allocation in the 2005-06 budget falls far short of the kind of increase which would be required progressively to make public health spending 2-3% of the GDP by 2009. Further, while this is a National mission, transnationally funded programmes presently have a strong presence compared to augmented national finances for the Mission. As discussed below, the Rural Family Welfare programme including the RCH-II package negotiated with the Donor Consortium appears to be de facto the main financial instrument of NRHM.

The Union health budget for 2005-06 is Rs. 10,280 crore, which is an increase of Rs. 1860 crore over the previous year’s Union health budget. At a first look this increase may appear positive though inadequate, but a closer look shows that it provides very little in the direction of NRHM related rural health system improvements. If we analyse this increase in some detail, we see that the budget for HIV/AIDS program has doubled from Rs. 232 crores in 2004-05 to Rs. 476.5 crores in 2005-6. Similarly there is near doubling of funds for the RCH program, increasing from Rs. 710.51 crores to Rs. 1380.68 crores, while medical education increased 50% from Rs. 912.82 crores to Rs. 1360.78 crores.

Just these three increases (rather than any new measures under NRHM) account for nearly three fourths of this year's increase in the health budget!

Actually the original 2005-6 Health budget does not even have a separate budget head for NRHM. However, the subsequently released 'outcome budget' gives us an indication of how NRHM funds are being formed by collapsing existing programmes. In the 'outcome budget' for Family Welfare, the budgets for *all Family welfare activities* except the Urban family welfare services, Direction and Administration and grants to some training and research institutions have been *clubbed together as the budget for NRHM* (and to this are added some outlays from the Health and AYUSH budgets). In effect, this means that the budget for NRHM is nothing but a repackaged Family Welfare budget, with some Disease control programmes from the Health budget and a small AYUSH budget component added on. This not only reinforces the apprehension that the Family Welfare programme will be at the centre of NRHM, but also raises the question as to what extent major systemic improvements or significant new activities would be possible with an essentially repackaged budget, 'old wine in a new bottle'.

Finally we may keep in mind that at the national level today, the Central and State governments together spend about Rs. 25,000 crores annually on healthcare. If the CMP promise is to be fulfilled, this would need an *additional allocation* of Rs. 30,000 - 60,000 crores by 2009. The Union health budget increase of Rs. 1860 crore is but a small step in this direction, and it remains to be seen what is the scale of increase in state health budgets, if any; it is obvious that both Union and state health budgets will have to be augmented very substantially for this declared increase to be actually achieved.

### **NRHM links to RCH programme and family planning agenda**

It may be noted that the NRHM was mooted at a time when the MOHFW had already concluded planning for a second phase of the Reproductive and Child Health Programme (known as the RCH-II programme) that had been carefully negotiated with a consortium of all donors notably including World Bank, USAID, EU, DFID, WHO and UNICEF. The Ministry's immediate challenge was to absorb the energies unleashed by the announcement of the Mission without losing step in its RCH-II calendar.

Historically, the RCH programme has evolved out of the failure of coercive population control policies of the 70s. With the realisation that fertility outcomes were related more to social determinants and to outreach of maternal and child survival services, the focus shifted from narrow provision of contraceptive methods to provision of RCH services. However unfortunately the population control mindset continues, and this has often popped up its head in NRHM documents.

Initially (reading from the earlier Mission documents circulated in late 2004) the Mission appeared to be very much focussed on a targeted population

control programme. For example, the ASHA programme was to be linked with the CMP's mandate to prioritise health care improvements in the 150 districts chosen on the basis of "high fertility". However after a lot of objections, protests and interventions from organisations and individuals including many from Jan Swasthya Abhiyan, the government has given an assurance that this would not be so, and the current main mission document does not explicitly indicate such a trend except for the Janani Suraksha Yojana component, which is discussed below.

We may note there is a justified place for programmes which genuinely address women's health and child health, in any overall strategy for comprehensive health system strengthening. However, attempts to push family planning that is coercive in any form, under the rubric of 'Reproductive and Child Health' which presently has a central place in the NRHM will need to be critiqued and opposed, and we would need to be vigilant about such trends, whether explicit or implicit.

### **Major components of the NRHM action plan**

As part of the 'Plan of Action' to be adopted by NRHM, certain components have been detailed, key components could be broadly categorised as follows:

- ASHA programme
- Strengthening SCs, PHCs and CHCs; Indian Public Health Standards, integrating AYUSH, Rogi Kalyan Samitis
- District Health Planning, converging sanitation and hygiene activities
- Public private partnerships, regulation of private sector, new health financing mechanisms
- Janani Suraksha Yojana

Certain critical issues related to these components are analysed below.

### **ASHA programme**

The NRHM has proposed the creation of "a new band of community based functionaries, named as Accredited Social Health Activist (ASHA)" who would be a health activist and mobilize the community towards local health planning and increased utilization and accountability of the existing health services". The plan of having a community health worker is certainly welcome. However the conceptualisation of roles and mode of functioning of ASHA in the RHM raises a large number of questions and concerns. In the design of the ASHA programme we see a number of serious issues, which would need to be addressed, for the ASHA to be able to function with even a minimum level of effectiveness:

- ***Selection criteria*** - at present, an educational level upto eighth class (middle education) is expected for a woman to qualify as ASHA. An analysis of the 1991 census data shows that in the rural areas of the NRHM states in Northern India, *over 91% women did not have middle level education* - and more recent data shows that this situation has not changed significantly in the subsequent period. In the hierarchical, often

caste-ridden villages of North India, if this educational criterion is rigidly imposed, it will impose a bias against women from disadvantaged groups such as poorer women with less formal education, and SC and ST women. Myriad experiences of NGO health worker programmes have shown that insisting on formal education is not necessary, provided the training of health workers is properly designed. However, with the present educational barrier, the women with strongest social motivation, women who are representative of deprived groups, are likely to get excluded from the programme.

- ***Lack of adequate regular compensation*** - In the final programme design, ASHA is supposed to work primarily as a volunteer. She would be compensated on performance of certain specific tasks related to National programmes. However, for her major routine activities such as immunisation, weighing of newborns, facilitating ANC, treating patients, visiting households, giving education to mothers, mobilising the community etc., as per the financial norms, the maximum compensation from the Village Untied Fund that may be given is mentioned as Rs. 1000 annually, or *about Rs. 83 per month*. To sustain the motivation and activity of village women working as ASHAs, who would have many other competing work priorities and domestic responsibilities, will be a challenge given the very limited and uncertain compensation they would receive.
- ***Limited provisions for First Contact Care*** - One of the strongest felt needs expressed by communities is the need for basic curative care being made available within their village. Many NGOs have demonstrated that well trained Health workers can give a wide range of First Contact Care effectively. However, the ability of ASHA to give basic care in simple illnesses is dependent on adequate relevant training, provision of a proper kit and regular replenishment of the range of necessary medicines. The drug list for ASHA as has been presently proposed is extremely limited, and the budgetary norm for drugs is Rs. 50 per month (the same as for CHVs way back in 1978!) which raises doubts about her being made capable to meet people's needs for First contact care. If she is seen as a person who cannot give significant care to persons with health problems, her credibility in the village as a Health facilitator and hence her overall effectiveness may also become limited.
- ***Activist or appendage?*** By her very name - 'Accredited Social Health Activist' the ASHA is supposed to be an 'Activist' mobilizing people and facilitating their access to health services as a right. However, given the fact that the ANM will be involved in sanctioning her compensation, and she would be reporting to the health system for implementation of various programme related activities, would she be realistically able to function as an 'activist' and lead people to put pressure on non-performing health services? Given the way in which the programme is presently structured, there are strong inhibiting forces to prevent her from really becoming an 'activist' vis-a-vis the health system. Moreover,

unless the other levels of the Health system such as PHCs and CHCs are substantially improved, their services upgraded, and the staff made responsive to people claiming Health rights, ASHA would not be able to make much headway in her task of facilitating people's access to health services.

- *Focus on RCH, possible adverse influence of Family Planning programme* - While the ASHA's role in providing primary medical care at the village level appears weak, a look at the indicators to be used for monitoring her performance shows that out of the eight outcome indicators for ASHA, seven are related to RCH. The strong influences of the RCH programme on NRHM in general have already been noted. In this context, it needs to be seen whether a key component of the RCH programme, the Family Planning component, influences ASHA's functioning in a disproportionate manner, since it has often distorted the priorities of other Primary Health functionaries and has reduced their overall effectiveness.

#### *Some points for action and change*

The ASHA terms and conditions of service and work profile must be changed and further clarified, otherwise it is very likely that it would not achieve its stated objectives:

- *The role of ASHA is not to substitute elements of the existing health system*, but to complement it and promote its better utilisation. The ASHA should not be viewed as a replacement for any of the functions to be performed by the ANM, Anganwadi worker or other public health functionaries.
- *Training of ASHA should be substantial and adequate* to equip her for her multiple and reasonably demanding roles, this would require at least about one month of initial training followed by regular (monthly or once in two months) follow up training. Training needs to be a continuous effort, provided over a period of a few years.
- *A specially developed cadre of local trainers / facilitators* would be required to provide adequate training support and ongoing other types of support to ASHAs. These may be drawn from existing staff or may be newly appointed, but must devote practically full time efforts for supporting the ASHA programme. Lack of such dedicated support would fatally weaken the programme.
- Principal amount of *remuneration for ASHA should be assured* and delinked from specific activities; this amount should be substantial, commensurate with her work responsibilities; there may be a small performance linked component if necessary. The remuneration for regular health activities and village level processes could be routed through the Panchayat or Village health committee if required. Monitoring of ASHA should involve social monitoring by the *Gram Sabha* and Village health committee, and technical monitoring by the Public health system.

- *Adequate budgetary provisions must be made to support all the critical elements of the ASHA programme* including training and training compensation, cadre of trainers / facilitators, regular replenishment of the drug kit, remuneration for regular tasks and additional activities done by ASHA, capacity building and support to Village health committees etc.
- There will be efforts to convert into ASHA into gathering sterilization cases - and even into making it her main activity - which would need to be countered.
- If care is not taken to ensure that the ASHA is chosen through a consultative process known to all, and mechanisms are devised so that she is accountable to a village level group, the ASHA will not be able to strengthen community ownership and control. There is a danger of the ASHA ending up merely as an assistant to the ANM and AWW.

There would have to be a strong component on rational drug use so that there is no degeneration into quackery and no encouragement to prescribe unnecessary drugs and injections. This aspect is not present in the Mission draft and needs to be introduced.

#### **Strengthening Sub-Centres, PHCs and CHCs; IPHS, AYUSH integration and RKS**

The strengthening of PHCs and CHCs is an important component of the Mission, which is central to the upgradation of Health services in rural areas. The intention to adopt and operationalise Indian Public Health Standards (IPHS) for CHCs is a definite step forward. However, while operationalising this process of strengthening, certain serious issues have to be addressed while designing strategies:

- In a significant departure, the Mission Document states that “secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral Units (FRUs) and the district hospitals” and also that “all the National Health Programmes (NHP) should be delivered through the CHCs”. These are significant changes weakening the role of the PHC and focusing on specialised medical care services at the CHC level; it medicalises the notion of the Primary Health Care approach. In contrast to the role of CHCs, the current trend looks at PHCs as being much less important. In contrast to this, it is necessary to ensure that PHCs are substantially upgraded to provide a full range of basic services including primary medical care, institutional deliveries, basic emergency care, and referral transport services. This would require renovation of infrastructure, provisioning of adequate and regular drug supply, functional ambulance facilities, adequate all-round staffing, multi-skilling of paramedicals, and adequate facilities for health professionals with time-bound postings in difficult areas with necessary incentives.

- A 'Generic model for Hospital Management societies' has been circulated as an annexure to the Mission manual, which would presumably guide societies which would manage CHCs and other hospitals being dealt with by the Mission. This document includes under the Aim and Objectives of the Society - '*Generate resources locally through donations, user fees and other means*'. Under the scope of functions of such societies, points include - '*Entering into partnership arrangement with the private sector (including individuals) for the improvement of support services*' and '*Developing/leasing out vacant land in the premises of the hospital for commercial purposes*'. Such provisions raise an apprehension about the processes that might be followed while managing such Hospital societies, and whether these could lead to semi-privatisation of such public hospitals. Specifically, implementation of such societies and related committees (such as *Rogi Kalyan Samitis*) should *not be accompanied by any introduction of user fees or any resort to privatisation*; rather the improvement of services should be provisioned through enhanced public funds. The experience of user fees in rural public health facilities, in other developing countries as well as in India, is that such fees can form a significant barrier to utilisation of services by the poorest. Exclusion mechanisms (such as the 'BPL' criteria) frequently do not work, and the genuinely poor often end up paying while certain politically influential individuals may avail the benefits.
- A salient feature of the so called Indian Public Health Standards for CHCs is to bring CHCs first to a Minimum Functional Grade (assuming 60% bed occupancy), to provide minimum assured services and to ensure accountability & quality of services. It proposes 24 hr emergency obstetric care including caesarean section at all CHCs, provision for an Anaesthetist and Public Health Programme Manager on contractual basis. However these standards are developed primarily to strengthen the 'Hospital' that the CHC is to become. Further more the IPHS at present are basically just hospital standards, while *Public health* standards imply something much more than this. Thought has to be put in evolving standards relating to broader determinants of health, the water supply system and sanitation being among the most important ones. PHCs and SCs also need separate Public health standards.
- One of the provisions of NRHM is mainstreaming of AYUSH into the rural health system, and integration of practitioners of Indian System of Medicine with the existing Modern System of Medicine. This itself is conceptually a positive goal, however we need to see carefully if the steps being proposed will achieve this in practice. The mission proposes posting of one AYUSH doctor at each PHC in addition to an existing allopathic doctor. This raises concerns about the possibility that instead of practicing the skills which they are trained in, AYUSH doctors may be

expected to provide allopathic care in PHCs without having the requisite knowledge or training, which is already a well known phenomenon in the private medical sector. It would be important to ensure that the AYUSH physicians in PHCs are given the appropriate facilities, infrastructure, medications and support to practice the system of medicine they have been trained in, with full effectiveness. These substantial additional inputs at PHC level do not seem to be emphasised in the Mission documents. Further, if AYUSH physicians are expected to provide some basic or emergency allopathic care, then this should be an explicit decision to be taken after due consultation and debate, keeping all aspects and implications in mind. In such a scenario, it would be essential to organise adequate training for these doctors regarding basic or life saving allopathic medicines. There are also issues related to motivational factors of an AYUSH doctor expected to work in a predominantly allopathic set-up, which would need to be addressed.

*Some points for action and change*

While the formulation of 'Indian Public Health Standards' for CHCs is a welcome step, such standards should include not just hospital standards but standards regarding public health activities. IPHS should be formulated for PHCs, and sub-centres and should mandate *Charters of Citizens' Health Rights* applicable at various levels. Accountability, committees for PHCs and CHCs should involve not only Panchayat leaders, but also representatives of local Community based organisations, Women's groups, locally active NGOs and Village health committees. The IPHS needs to be demystified into terms comprehensible to individuals and communities and has to be published widely in the local media and in the hospitals. The same applies to the Citizen's charter.

**District Health Planning, integration of disease control programmes and convergence of sanitation and hygiene programmes**

The District has been given a predominant position in the NRHM as the fulcrum of decentralized planning and action. This is a welcome departure from the earlier concept of National planning where priorities are determined nationally, and the outcome of which have been as many as eighteen National Health programmes.

The NRHM claims to integrate various ongoing national programmes. There are no intentions, however, of touching certain major disease control programmes such as the programme for HIV-AIDS, which has substantial funds and will continue in a verticalised fashion. Its integrative strategies are focussed around RCH and Family Welfare Programmes, which are basically to promote fertility control and lower Maternal and Infant Mortality Rates. As part of RCH 2, district level Project Implementation Plans (PIP) have been prepared in some districts. Now there is a possibility that the same *RCH -2 PIPs might continue (with some minor additions) as the framework for the District Action Plans*

*envisaged under the NRHM.* This would defeat the objective of comprehensive planning and integration of various activities of the public health system.

Mechanisms for inter-sectoral convergence at the district level are to be attained through the creation of quasi-government societies that would further enable withdrawal of the state. A lack of faith in the departmental ability to accomplish developmental objectives also manifests itself in the Collector becoming the titular head of all developmental schemes (especially Centrally sponsored ones) at the district level. In practice the Collector may not even remember the number of committees she/he already heads in the district. This means that there is a limit to the amount of time they would be able to devote to the NRHM, and the commitment may not last beyond an initial high impetus input. The CMO, who is responsible for the administrative oversight has not been considered appropriate to be the key functionary, and nor has the ZP chairperson.

According to the NRHM timetable, State PIPs were expected by 31<sup>st</sup> May 2005, and some level of District PIPs are expected to be ready by October to December 2005. This urgency for action at the state and district levels, without any community level processes or involvement of social and health sector organisations, and lack of proper comprehension of the principles of the NRHM may vitiate the process of decentralized planning and monitoring. So far there seems to be no genuine attempt towards a participatory and qualitative assessment of community needs and priorities, as well as provider needs and limitations. The urgency can be further aggravated if additional budgetary instalments are linked to completion of these processes, leading to hasty preparation of documents without undergoing the proper processes.

#### **Public Private Partnerships and new health financing mechanisms**

Public-private partnership is projected by the Mission as one of the ways for providing more accessible and better quality health services to people. The mission document on public-private partnership clearly states that: "Public private partnership under National Rural Health Mission would not imply transfer of government responsibility of providing health care, but instead means synergizing the efforts of the private sector to provide quality, accessible and affordable comprehensive health care facilities to people." It states that the objective of these partnerships is to ensure that it would enhance availability and affordable health care to communities. It then proceeds to state that: "PPP initiatives are intended to improve access to good quality healthcare services, promote exchange of skills and expertise between the public and private sector and mobilize additional resources for healthcare activities."

While this preamble gives the impression that these 'partnerships' are going to answer some of the problems that are faced by the rural health services, it is *based on the assumption that the private sector is providing good quality care* and that it is available across the country. However, given the heterogeneity

and lack of regulations, there is enough evidence that shows the variable, and often poor quality of private services. There is also evidence that the private sector focuses exclusively on curative services and is prescribing irrational drugs and diagnostic tests. Hence the foundation of any relationship between the Public and Private sector must be *the effective public regulation of quality, rationality and costs of care in the private sector*. There is no reason why Indian Public Health Standards cannot be applied to the private sector as well.

Unfortunately the Mission document does not mention any specific legislative or operational mechanisms to address this major concern, and only talks of the 'need to refine regulation', which appears to be a gross understatement given the magnitude and seriousness of the problem.

A second set of concerns is that the NRHM is going to be implemented in some of the poorest districts of this country where the formal private sector is virtually absent. What kind of partnerships is being envisioned in these districts? Are these partnerships going to be with informal practitioners? What is the government's position for dealing with them? Is the public health system going to train these informal providers? What is the kind of investment that is required in terms of finances and human resources for any meaningful partnership?

These questions need to be satisfactorily answered before any attempt is made to develop 'partnerships' in such areas.

Further, any measures under the banner of 'partnership' which may lead to privatization of existing public health services should be strongly questioned and opposed, since the consequence of such privatization has often been introduction of steep user fees, barring the poor and lower middle class from accessing services. The exact nature of any partnership needs to be clearly specified to prevent the abuse of public funds and efforts for private benefits.

Another concern is private practice by public employees in the health sector, and their well entrenched linkages and interests in the private sector. Given this situation one could argue that there is already a vibrant 'public-private partnership' in this country, which has completely drained the public sector over time. Once again this key issue remains unaddressed in the document!

Finally, the overriding role of the Public Health System in defining public interest needs to be stressed, while enforcing the consequent responsibilities of private medical providers. The obligations of the Private Sector towards Public Health (in terms of National Programmes, disease surveillance and notification etc.) should be emphasised, and their regular fulfilment of these obligations should be one of the pre-conditions for their being further involved in any form of 'partnership'.

### **Janani Suraksha Yojana**

A new scheme is proposed as part of the NRHM called the Janani Suraksha Yojana which is to replace the existing National Maternity Benefit Scheme linked to better diets, provision of iron tablets etc. by adding a certain amount of cash assistance for institutionalised deliveries for the first two deliveries. This is a targeted scheme for BPL families which will exclude a large number of eligible women. *The third childbirth is ineligible for maternity benefit unless sterilisation is agreed on and fourth child onwards no benefits can be given.* There is even a stricture against giving maternity benefit to a woman below 19 years delivering a child. The income of the health worker who is to bring the pregnant woman to the centre and to follow up the case is also linked to the number of "cases" she can bring. This scheme brings back the discredited and discarded concept of targets for sterilizations in the name of encouraging institutional deliveries, and reinforces the 'two-child norm' in a coercive manner. Hence there is a need to substantially restructure this programme, moving away from the target approach and coercive imposition of the two-child norm.

### **Community monitoring in NRHM**

The NRHM documents accept that one of the important drawbacks in the current system is the lack of community ownership which affects the effectiveness, efficiency and accountability of the Health system. The decentralised planning model proposed in the NRHM, which aims at integration of the ongoing programmes is looking at change from the correct direction.

In all NRHM has certain features which could increase community ownership and accountability -

- Village Health Planning
- ASHA to be chosen through local consultative processes, accountable to Village Health Committee
- Village Health and Sanitation Committee to oversee implementation and monitoring of the village health plan
- Provision for Citizen's charter
- Provisions for Community Monitoring and Social Audit

These are combined with provisions for involvement of PRI at various levels to be involved in the planning and monitoring process.

Here we may note that involvement of PRIs is seen as the main mechanism for improving community ownership. However it would be a mistake to substitute PRIs for the community, because even though it may seem theoretically tenable, the way the PRI mechanisms have developed over the last ten years in different states show that the process has often become dominated by interests of political parties, and has even decentralized corruption. Keeping this in mind, involvement of PRIs must be complemented by active involvement of representatives of beneficiary groups, women's groups, community based organisations, and local NGOs involved in health activities. Effective

involvement should enable the community and community-based organisations to become equal partners in the planning process. This would change the status of community from passive beneficiaries to active rights holders.

In this context, the framework of community monitoring in NRHM needs to be more carefully thought out, and implemented in a genuinely participatory and empowering manner. This could be done on a pilot basis in some states to begin with, which could pave the way for further generalisation of effective models. Some concerns and suggestions in this regard are as follows:

- Community Monitoring must be seen as an integral part of all activities and levels of the Public Health System, and not as a stand-alone 'component'.
- Monitoring mechanisms for the National Rural Health Mission at all levels should be operationalised through monitoring and consultation bodies that have *majority representation* of community-based representatives; these would include (depending on the level) direct community representatives, community based organisations and other civil society organizations, and health networks. It should be emphasised that this would involve not only the community level of services, but *all relevant levels* of the Public Health facilities (village to national), which can be monitored by organisations with active links at the community level.
- In the NRHM framework, the Rogi Kalyan Samiti model being drawn from M.P. needs to be independently evaluated and seriously reviewed before considering its generalisation in any form. As mentioned above, the user fees component of RKS needs to be universally avoided, given the experience that it forms a barrier for the needy when they access care - especially keeping in mind the highly flawed exclusion mechanisms like 'BPL'. Further the mode of functioning of RKS has often been found to be non-transparent, not accountable to the larger public, with prioritisation of expenditures not in keeping with direct needs of patient care.
- The monitoring system must be directly linked to corrective decision making bodies at various levels. The information and issues emerging from monitoring must be communicated to the relevant official bodies responsible for taking action so that monitoring results in *prompt, effective and accountable remedial action*. The system should be based on a Rights Based framework and should be actively responsive, with proper redressal mechanisms at various levels, having powers to take adequate action in case of denial of the Right to health care in any form.

### **JSA perspective regarding NRHM**

NHRM as a statement of intention to strengthen rural public health services has aroused many hopes and expectations. The stated guiding principles of the mission are to "*promote equity, access, efficiency, quality and accountability in Public Health Systems; enhance People oriented and community-based approaches; decentralize and involve local bodies; ensure Public Health Focus;*

*recognize value of traditional knowledge base of communities; promote new innovations, method and process development”* which would be recognised by all as being positive. However, the details of the actual measures to be taken as part of the Mission do not appear equal to these lofty principles, as has been pointed out in the previous sections of this Action Alert. Keeping this in mind, if the Mission is implemented in its present form it is likely to fall significantly short of expectations; to this must be added the presence of definite negative elements, which are likely to continue existing trends of privatisation, coercive family planning and bureaucratic implementation in the health system. Although the Mission is based on a decision to strengthen national health services, it is significantly linked to internationally funded programmes; there is a statement of intention to improve public health but this is mixed up with notions of privatisation. The overall health crisis and the need for a comprehensive public health system have been recognized, but the response is fragmented and lacks an integrated, health systems approach.

Keeping this in mind, while continuously stressing the need for a more comprehensive and participatory approach along with related programmatic changes, it is necessary to press for appropriately modified, effective and accountable implementation of certain positive elements of the Mission. This should be combined with strongly critiquing negative aspects of the Mission, while presenting relevant alternatives. JSA-linked organizations across the country can play a major role in critically influencing the Mission; there are a range of changes in the NRHM plans at various levels that need to be pushed for, to make it work in a pro-people direction. This document has already discussed some of the points on which JSA linked organizations can work at various levels, which should be part of an overall approach to critically influencing the Mission as given below.

### **JSA’s call to critically influence the Mission**

Jan Swasthya Abhiyan and its constituent organisations need to critically engage with the Mission to influence it at local, State and National levels. This would involve taking up at whichever forum may be available, various issues outlined in the discussion on the Mission components above, along with the following issues, to shape and influence the Mission activities.

#### *Need to review the overall design of the Mission*

One of the key criteria to assess the strength of political will supporting the Mission is to see whether a *substantial scale of additional domestic funding* (not just repackaged external funds) is allocated to Public health in general, and the Mission in particular, in the coming few years. The Mission should be based on a sustained increase in domestic budgetary allocation to health care,

and not dependent on donor funds or ad hoc reallocation of funds from the very limited existing pool of resources available in the health sector.

The Mission must call for and *coordinate with increased investments and better design and implementation in a number of sectors related to health* - especially food security, water and sanitation, elementary education, shelter, urban development, environmental safety, poverty alleviation programmes and livelihood issues. The Mission must ensure that investments in health not only increase universal access but also address issues of gender and socio-economic inequities in health status and health care services.

Access to quality health care services are basic inalienable human rights and should never be dependent on the ability of the citizen to pay for health care. The Mission at present is ambiguous regarding its approach to universal access to health services. *It needs to be ensured that access be universal, care be available to all as a right, no targeting is resorted to and user fees are not used as a medium of targeting.*

The Mission should be a programme to *strengthen comprehensive Primary Health Care within which RCH must be positioned as one of the components.* A focus on just sterilisation and family planning is neither desirable nor useful. The JSY has to be reworked to eliminate the stress on sterilization and targeting.

The Mission would have to have strong links with the Panchayati Raj System and should develop *structural mechanisms for involvement of community members, beneficiaries and local organisations in the planning and monitoring of health activities.* There should be movement towards devolution of greater funds and responsibilities in health care to the panchayati raj system and to the Gram Sabha.

#### *People's Rural Health Watch*

With a view to critically influence the Mission, JSA has decided to initiate a 'People's Rural Health Watch' that would monitor, assess and analyse the activities of the Mission at state and national levels, providing a feedback for improvement.

The 'People's Rural Health Watch' would collect information about the policies, evolving programmatic designs and implementation of the National Rural Health Mission at various levels. Periodic surveys and preparation of reports at State and National levels would provide the analyses of this information.

The Rural Health Watch also intends to assist people's monitoring of health services in districts and states where the Watch functions; to sound alerts and facilitate communications regarding possible negative developments in the context of the Mission.

JSA would disseminate the results and reports of the Watch, and would provide policy suggestions and alternatives, with a view to support the genuine strengthening of the rural Public Health System. These reports would be

disseminated among the general public, to civil society organisations, to the media and to decision makers with a view to building accountability in the health system and to make it more community responsive. Along with social and health sector organisations, Public Health professionals, academics and health workers should contribute to this process and thereby help strengthen the rural health system, in a setting of social accountability.

There is a national team of JSA centred at Delhi, which would facilitate preparation of the national level reports and publicizing them. This team would also coordinate the countrywide Watch process and would provide help in the orientation of the State JSA units. In various NRHM states, it is expected that state JSA units would set up similar teams to coordinate the 'Watch' activity by various organisations in their state.

In conclusion, Jan Swasthya Abhiyan calls upon all those concerned with rural health - social movements, people's organisations, Health sector organisations, health professionals, academics and community health workers, to widely discuss and raise the issues highlighted in this Action Alert. Whether involved in policy consultations, from various public platforms, or while involved in the process of programme design and implementation, we should highlight the key concerns, and try to critically influence the Mission in a pro-people direction. We should make the Mission accountable to ordinary people and communities, for whose benefit it is supposed to be designed. It is our collective responsibility to actively 'Watch' and monitor the implementation of the Mission, and to try to ensure that people's Right to health is strengthened in the processes that unfold in the coming years; by various means we need to ensure that the perspective of 'Health for All' remains firmly on the national agenda.