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The growth of the National Rural Health Mission

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Abstract:

The National Rural Health Mission was introduced as a flagship scheme of the United Progressive Alliance (UPA-1) government in 2005-06 to deal with the requirements of the rural population through an architectural correction of the health system. With the completion period drawing to an in-depth in 2012, this paper critically evaluates the success of the intervention strategies under this scheme. Based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare India Government, and data reported on the NRM website, this paper attempts a desk review of the progress of the mission about its core strategies – provisioning of health services to households through accredited social health activists, strengthening rural public health facilities, enhancing the capacity of panchayats (Gram Panchayat) to regulate and manage the provisioning of health services and positioning of an efficient health management data system in rural area.

Key Words : NRHM, Health System, Rural Health, Health activity.

Introduction

The Alma-Ata Declaration in 1978 called on all governments to "formulate national policies, strategies on health problem, and plans of action to launch and sustain primary health care as a part of a comprehensive national health system". In India, however, health has traditionally received low priority within the central and state budgets since independent. Expenditure on the health sector comprised, as an example, but 1% of the gross domestic product (GDP) in 1999 – one among rock bottom within the world. Further, there was a substantial urban bias characterizing health policies and investment strategies – about 75% of the resources and infrastructure were concentrated in urban India (Patil et al 2002). The resultant increase in the incidence of both communicable and non-communicable diseases, including poor health facilities in rural areas resulted in high infant, child, and maternal mortality rates. While the United Progressive Alliance (UPA-1) government integrated public health as a critical component into its common minimum program, this objective couldn't be attained without providing efficient and affordable healthcare services to the agricultural population, which constitute three-fourths of India's population. However, the sheer enormity involved in servicing a population of over 75 cores population involves integrated macroeconomic and grassroots level efforts to enhance the agricultural health infrastructure, ensuring the adequate presence of

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healthcare manpower and addressing local needs and concerns. the necessity for a concerted targeting of rural India led the government to introduce the National Rural Health Mission (NRHM) as its health flagship scheme in 2005. the target of this scheme was to "carry out necessary architectural correction within the basic health healthcare delivery system to enhance the supply of and access to quality health care by people, especially for those residing in rural areas, the poor, women and minor children" (GOI 2005: 1).

Objective

This objective is sought to be attained through strategies aimed toward improving rural household health status through the introduction of female health activists, strengthening the three-tiered public health system, increasing community participation through the involvement of Panchayati raj institutions (PRIs), and strengthening capacities for data collection to facilitate evidence-based planning, monitoring, and supervision. With the deadline of this scheme drawing to an in-depth in 2012, it's an appropriate time to undertake an evaluation of the success of the NRHM. Three common review missions (CRMs) are completed. The population research centers (PRCs) have undertaken a primary round evaluation of the mission supported by rapid appraisal methods in select districts on behalf of the Ministry of Health and Family Welfare.

1 These reports and therefore the data available from the NRHM website provide a useful source of secondary. information to undertake a desk review of the progress made thus far.

2 This paper attempts such an evaluation, with attention on some key components: provisioning of healthcare at the household level through the accredited social health activist (ASHA), strengthening the agricultural public health facilities, decentralizing the health sector by enhancing the capacity of panchayats to regulate and manage the provisioning of health services, and positioning of a health management data system. Strengthening Rural Public Health Facilities One of the core strategies for providing accessible healthcare to the population is to strengthen the sub-centers (SCs), primary health centers (PHCs), and community health centers (CHCs) – units where healthcare is delivered. Accordingly, the NRHM envisages sanctioning of new SCs as per 2001 population norms, upgrading existing SCs, provisioning 24-hour service in half of the PHCs, upgrading all the PHCs and 3,222 CHCs as 24-hour First Referral Units (FRUs), etc.

a. Deficiencies in Physical Infrastructure Using data from the NRHM portal, we have estimated the number of units required, the number available, and the deficit (as a proportion of available units). It can be seen that a substantial deficit persists, particularly at the CHC level. The extent to which attainments have fallen short of targets is also indicated through the estimates of PHCs that are functional for 24 hours. Despite an increase of 44% (between 2005 and 2010) in their numbers, such PHCs comprise only 36% at the all-India level and 27% in high focus states. The corresponding figures for CHCs are 93% and 88%, respectively. The progress for up-gradation is also a matter of

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concern. About 71% of the CHCs have been selected for up gradation. While facility surveys have been undertaken in 95% of these CHCs, the process of physical degradation has been started in only 65% of the CHCs and completed in only a third of the CHCs. Another disturbing feature is that about 46% of the SCs are not operating out of government buildings. This figure is slightly higher in high focus states (49%). The evaluation surveys were undertaken by the PRCs also reveal that the availability of functional labor rooms is very low and that the Indian Public Health Standards (IPHS) facility survey remains to be undertaken in the majority of SCs. Gill's study (2009) also notes the lack of regular electricity supply to SCs in some states like Uttar Pradesh and Bihar (UP). The situation in PHCs and CHCs is equally distressing. In the majority of the states surveyed, PHCs did not have 4-6 beds, or care corner for newborn babies. Few PHCs are performing on a 24-hour basis. Except for Assam, Jammu, and Kashmir (J&K) and Rajasthan, provisioning of obstetric facilities is poor. Although the situation for infrastructural facilities in CHCs is reported to be satisfactory, the non-availability of facilities like mobile medical units,

3 blood storage, emergency care facilities for children and surgery needs to be addressed by the concerned states. Gill (2009) found an absence of toilet facilities and the medical waste disposal system in many SCs, PHCs, and CHCs. The general cleanliness of PHCs and CHCs is also lamentably poor, despite the presence of a sufficient number of cleaning staff. Gill suggests that this laxity could be explained by the fact that awarding regular or contractual cleaning jobs was one of the few patronage tools used by small-time decentralized functionaries, such as the Hospital Development Society members, to get known people employed and on the payroll.

Shortage of Equipment and Medicine

The shortage of medical equipment also needs to be addressed by the states. The rapid appraisal survey undertaken by the PRCs observed shortages in basic equipment. Some evidence in this regard:

(i) None of the surveyed community centers in Kanpur-Dehat in UP had an electrocardiogram (ECG) machines, operation theatre (OT) care fumigation apparatus, and cardiac monitors for OTs.

(ii) Shortage of baby cradles, laryngoscope, wheelchairs was observed in surveyed PHCs in the Sidhi district of Madhya Pradesh.

(iii) None of the PHCs surveyed in Shrawasti (UP) had oxygen cylinders, infant warmers, baby cradles, laryngoscope, or wheelchairs, while 75% of the PHCs did not have delivery tables.

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(iv) Around 42% of the SCs surveyed in Anuppur (Madhya Pradesh) did not have thermometers and fetoscopes; 83% lacked sterilizers; 92% did not have regent strips for urine tests.

Around 42% of the SCs surveyed in Siddhartha Nagar (UP) were found to lack blood pressure apparatus and 75% did not have fetoscopes. It is necessary to identify common shortages at each level and attempt to cover such deficits on a priority basis.

A similar shortage was also observed for the medicine stock. Surveys undertaken by the PRCs found a significant gap in the supply of essential drugs to the PHCs. Galati et al (2009a) found that iron-folic acid tablets, oral pills, vitamin A, measles vaccine, oral rehydration salts, and intrauterine devices (IUDs) were not regularly available in every 3 out of 4 PHCs surveyed by them in Bihar. Even basic medicines like albendazole/ mebendazole tablets, bandages, cotrimoxazole syrup, etc, were found to be out of stock or in irregular supply.

The non-availability of medicine and material at the health facilities is forcing patients to purchase them from private sources, where the cost of medicine is substantially higher (because of the large profit margins maintained by intermediaries). This is leading to high out of pocket expenditures, defeating the objective of providing accessible healthcare services to vulnerable sections of the population, and pushing households below the poverty line. Realizing the need to provide autonomy and flexibility to meet local needs, the NRHM had stated that SCs, PHCs, and CHCs would receive respectively Rs 10,000, Rs 25,000, and Rs 50,000 annually as untied grants. Based on figures relating to the disbursement of untied grants to SCs in 2008-09, an attempt was made to estimate the proportion of SCs covered under this component. It appears that only 49% of SCs received such funds; the figure is even lower in high focus states outside the northeastern region (40%).

The corresponding figures for CHCs and PHCs are 36% and 42%, respectively. Moreover, evaluation reports suggest that this money was generally spent on meeting telephone and power bills, maintenance, purchasing drugs, and facilities for patients. During the evaluation surveys, most local officials were found to be unaware of the guidelines for utilizing untied funds; the latter also reported that changes in the guidelines created confusion. This indicates the need to further simplify procedures for spending the untied funds. It is also necessary to monitor the proportion of expenditure of such funds under different heads.

Deficiencies in Manpower The quality of the health workforce is crucial in delivering good health outcomes. Evaluation reports have highlighted a shortage of manpower – of doctors at the PHC level and specialists at the CHC level (Table 2). Data from the health ministry reveals that 11% of the PHCs do not have a doctor (this is 17% in high focus states). At the CHC level, only 49% of the required specialist posts have been sanctioned so far, and 25% position. Less than a third of the required number of staff nurses has been positioned. The proportion of auxiliary nurse midwives (ANMs) staying at the SCs has reduced in several states, owing to the non-

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availability of quarters for them. ANMs also attribute reluctance to reside in staff quarters to the poor conditions of the quarters, lack of infrastructural facilities, and safety concerns. This has resulted in a low proportion of SCs with arrangements for night delivery and is responsible for the continued dependence of the rural population on district hospitals and private providers. In particular, the lack of availability of delivery arrangements has affected the JSY in many regions, thereby limiting the role of the ASHAs. Manpower shortage in rural areas has emerged as a major problem in other developing countries also.

An examination of the policies undertaken in other countries provides valuable insights into how this problem can be tackled in the long run. A cross-country study of the success of compulsory service shows that such a strategy can work only when supported by economic incentives (Frehywot et al 2010), though the type of incentives that are likely to be attractive varies among countries (Blaaw et al 2010). Some states like Rajasthan and Chhattisgarh have been successful in designing an attractive combination of financial and non-financial incentives (NRHM 2009a). Persons from rural backgrounds may also be relatively willing to accept rural postings (Serenely et al 2010); location-specific selection of ANMs in West Bengal, for instance, has been successful in this regard. Apart from a lack of manpower, another factor that affects the delivery of health services is absenteeism.

Evaluation reports identified the absence of social facilities like educational infrastructure for children, irregular supply of electricity and potable water, and safety of women in some of the rural tracts in UP, and unhygienic and insanitation in villages and health facilities as reasons underlying absenteeism and reluctance to accept rural postings. This led to suggestions that such handicaps be compensated by enhanced financial incentives in the form of non-practicing and transport allowances (Galati et al 2009). This view has been criticized by Gill (2009), who points out that given the lower cost of living in rural areas, paramedical and medical staff in rural India fare quite well in real terms (particularly after the implementation of the Sixth Pay Commission recommendations). Moreover, the disparity in the public/private pay packages applies to all spheres and in all countries irrespective of their levels of development. Rather, according to her, the main reason for absenteeism and other manpower-related issues is the complacency arising from the assured nature of regular lifetime employment in the government sector, along with a complete lack of monitoring by the state health hierarchy. This has eliminated the fear of reprisals (in the form of firing or transfers) for underperformance.

As a result, medical staff is scarcely accountable to the rural community they supposedly serve. This affects the ability to access health services, particularly by the poorer and often illiterate category of patients. The principal-agent problem characterizing patient-provider relations inhibits any kind of protest – "key informants articulated that the doctor might give them the wrong medicines if they complained too much!" (Gill 2009: 34-35). States have relied on contractual employment to solve the shortage of manpower. Under the NRHM, contractual appointments to the extent of 14% have somewhat reduced this deficit. This, however, may not be sustainable beyond the sanctioned NRHM period, especially where states have not planned

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for such expansion in their budgets (NRHM 2008). Apart from the genuine shortage in manpower, health departments in many states fail to utilize even the available resources optimally, leading to misalignment of services demanded and supplied. The third CRM has observed the irrational deployment of doctors in many areas. For instance, several specialists were not performing procedures in which they were trained. It is therefore necessary to improve the fit between the posting of specialists and the patient load.

Accredited Social Health Activist Global experience shows that women, even when briefly trained, can successfully increase the coverage of healthcare, particularly if they are locally recruited and made accountable to the local clients (Global Equity Initiative 2004). The introduction of the ASHA is thus an important and welcome step. The NRHM envisages that every village will have an ASHA, chosen by and accountable to the Gram panchayat, who will "act as the interface between the community and the public health system". ASHAs will be given induction training and provided with a drug kit containing generic AYUSH (Ayurvedic, Yogic, Unani, Siddhi, and Homeopathic) and allopathic formulations for common ailments. While ASHAs will be volunteers, they will be given a performance-based incentive for promoting immunization, referral, and escort services for reproductive child health (RCH) and other health delivery programs. Besides, they are also to be involved in the preparation of village health plans. The ASHA website reveals that 7.49 lakh ASHAs have been selected from 2005-06 to 2009-10. While this is a large number, implying that about 90% of all villages have been covered ; the selection process has to be made more transparent. Although norms for recruiting ASHAs state that they should be selected based on recommendations of ANMs, Anganwadi workers, and the panchayat head, in many cases they are recruited from influential families. In Madhya Pradesh, evaluation reports observed that the majority of ASHAs belonged to influential families of the villages, and selection criteria such as education, willingness to serve the community, and her background were not considered (Basu 2009: 148). Further, in some cases, wives of community health workers were appointed, with most of their duties undertaken by their husbands. The position concerning training and availability of kits is also not satisfactory Though 94% of ASHAs have received the first module training, only 26.6% have received the fifth level of training. While this can be explained partly in terms of the newness of the scheme – ASHAs inducted in the last two or three years can hardly be expected to have received fourth or fifth level training – it is also true that training is very discontinuous. and infrequent, and most states do not even reach a minimum of 12 days of training per year (against the desirable period of 28 days).

The quality of training has also been observed to vary between states due to a weak support structure. The experience of Andhra Pradesh shows that making such training residential improves quality. Fieldwork and visits should also be made an important part of the training to ensure on the job training of ASHAs. The provisioning of drug kits also needs to be improved. In 2008-09, only 56% of ASHAs had received kits. While the situation did improve in 2009-10, the current figure (69%) is still low. It has also been claimed that the kit often contains just four

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medicines (iron tablets, chloroquine, paracetamol, and oral hydration therapy packets); ayurvedic and homeopathic medicines have not been supplied to most of the ASHAs (Ashtekar 2008: 25). Evaluation reports also list complaints by ASHAs that their kits are not adequate and contain drugs close to the expiry date. Timely refilling of drugs is not undertaken in many states.6 This has restricted the role of ASHAs to essentially providing directly observed treatment, short-course (DOTS), immunization, institutional deliveries, and antenatal checkups. Even for increasing coverage of women under the JSY, as revealed by the evaluation reports, delays in the release of funds have eroded the faith of the community in ASHAs. In several states like J&K and Madhya Pradesh, delays in receiving incentives have resulted in dropouts of ASHAs (Bajpai et al 2009; Bhat et al 2009). Ashtekar (2008) also reports unhealthy competition between ASHAs and Anganwadi, with the latter viewing ASHAs as encroaching upon their jurisdiction and reducing their income. At the same time, it would be hasty to dismiss the ASHA scheme as a failure. A study by Bajpai et al (2009) found that the introduction of ASHAs has had a positive impact on increasing the proportion of women taking at least three antenatal checkups and immunization institutional deliveries. It should also be kept in mind that the scheme requires the volunteers to play an activist role in communities that are often characterized by religion and caste politics, conservative attitudes, and where women are still looked down upon. Expecting partially trained local volunteers to adapt to the complex dynamics of Indian rural communities and effect an immediate radical change in the situation is expecting too much. It is necessary to persist with the scheme and strengthen it by providing ASHAs with the improved support structure, regular financial incentives, and better quality of services through training. This will ensure that their activism is gradually accepted so that they can become "social workers", rather than merely "health workers".

Mainstreaming Indigenous Health Systems To meet the manpower and drug shortage in rural areas, the NRHM seeks to revitalize local health traditions and mainstream AYUSH infrastructure. This is sought to be attained through two means: (i) AYUSH medicine shall be included in the drug kit provided to ASHAs, and additional supply of generic drugs for common ailments at SCs, PHCs, and CHCs under the mission shall also include AYUSH formulations, and (ii) AYUSH practitioners will be mainstreamed at the PHC and CHC level – single doctor PHCs will be upgraded to two doctors PHCs by incorporating an AYUSH practitioner, and at the CHC level, two rooms will be provided for an AYUSH practitioner and a pharmacist. AYUSH is an innovative strategy with important implications for the provisioning of healthcare services and increasing choice available to households (Sinha 2009). Duggal (2009) reports that expenditure under this head has increased fourfold between 2005- 06 and 2009-10. There has also been a concerted attempt to incorporate AYUSH components in the state program implementation plans (PIPs) and in different organizations like health societies, state health missions, rogi Kalyan Samiti (RKS), and ASHA training. The record has been mixed. While AYUSH has been incorporated in the PIPs of most states, its record in ASHA training is quite poor – it has been introduced in only 56% of the states. In particular, the record for integrating AYUSH components into the health delivery system at the grass-root level leaves much to be desired. The

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health management information system (HMIS) data reveals that AYUSH staff has been integrated with only 49% of the district hospitals, 37% of the CHCs, and 29% of the PHCs. The record of such integration is also low in priority states outside the north-eastern region. The concurrent evaluation was undertaken in 2009 by the PRCs on behalf of the health ministry also presents a disappointing picture. Except in J&K, less than a third of the PHCs surveyed in UP, Uttarakhand, Madhya Pradesh and Rajasthan have AYUSH practitioners. In J&K, where the record of mainstreaming is relatively better, AYUSH practitioners complain that the lack of AYUSH drugs and pharmacists trained to deal with such drugs, and preference of patients for allopathic drugs have limited their role in offering alternative healthcare services. A study of Rajouri, a district in J&K, observes that in such circumstances many AYUSH doctors are forced to offer allopathic drugs to their patients (Bhat et al 2009). The availability of AYUSH practitioners has, in many cases, managed to sustain demand for public health facilities. A study by the Planning Commission, however, questions the limits to which alternative AYUSH practitioners can substitute for allopathic medical staff. Although the former can provide effective remedies in the case of minor and certain kinds of chronic ailments, such as skin and digestion-related illnesses, their remedial skills are inadequate in the cases of surgery and extreme life-threatening conditions (Gill 2009). Thus, AYUSH practitioners should be conceived as a supplement to allopathic staff and not their substitute. Further, their deployment should be keeping in mind a load of facilities and the observed preference of the public for AYUSH doctors only in the case of chronic ailments. Decentralizing Health Sector Recognizing the importance of involving grass-root level organizations in the healthcare delivery system, the NRHM has sought to encourage decentralization as part of its core strategy. Role of Gram Panchayats As pointed out by Gulati et al (2009), decentralization facilitates the integrated delivery of health services through the convergence of services like drinking water, sanitation, nutrition, empowerment, etc, that are of crucial importance in ensuring a healthy population, while simultaneously ensuring that local healthcare needs are addressed. The Integrated Health Action Plan is a major instrument in leading to the inter-sect oral convergence. At the initial stages, this plan would be prepared only at the district level – by the district health mission under the Zila Paris had. Given that this is a pioneering exercise in large-scale decentralization, the initial experience has been quite encouraging though diverse (Sinhala 2009). Some states have been able to involve panchayats in the planning process, resulting in the identification of important micro-level issues and problems. In other parts of the country, consultants with technical planning skills formed the core of the planning process. While this somewhat reduced the participative element in these plans, at least it has initiated the process in states where conditions were not conducive for decentralized planning (ibid). In 2006-07, about 48% of the districts had prepared district plans, and by 2008-09 this figure rose to 85%. However, 2009-10 witnessed a decline (74%) – which might indicate that the process of decentralization is running out of steam. Some of the State CRMs also support the observation that these district plans have not been repeated after the initial year in some villages. The PRIs from the village to the district level is expected to get the ownership of the public health system in their respective jurisdictions.

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While the CHC and PHC will involve the elected members of the panchayat raj in their management through the RKS, the SC will be accountable to the gram panchayat (GP) through the local committee under the village health and sanitation committee (VHSC). So far, VHSCs have been established in nearly 75% of the villages, and have received cumulative financial assistance of Rs 970 crore as untied funds. The objective of this committee is to help the ANM in preparing the SC action plan and help her in planning and implementing various programs related to health, hygiene, nutrition, sanitation, and drinking water. The NRHM guidelines state that the VHSC should comprise the ANM, ASHA, representatives of the village panchayat, women non-governmental organizations, and self-help groups. Backward social classes should also be represented. Some evaluation. studies have noted that the constitution of the VHSC does not always follow these norms – for instance, in J&K, representatives of the village, socially backward classes, or women representatives are not present in many of the VHSCs formed (Bhat et al 2009). The failure of the state health departments to provide training through orientation programs to the VHSC members has limited their role in helping the ANMs utilize the untied funds. Meetings are not regularly held in many states, and the role of the VHSCs in preparing the district plans has remained limited. Bajpai et al (2009) report that 95% of ANMs had joint bank accounts with the sarpanch of the panchayat. Further, analysis of expenditure patterns9 reveals that in general, funds were used for overcoming the infrastructural shortcomings wherever they were used. However, an expenditure of the untied funds in some cases is planned by the ANM in consultation with the block medical officers, bypassing the panchayat members (Bhat et al 2009). Increasing Accountability: Community Monitoring It was expected that the establishment of the RKS would improve service quality and management by increasing accountability, but the actual progress has again fallen short of expectations. While almost all district hospitals and CHCs have registered RKS, the coverage of PHCs is much less. At the all-India level, only 71% of the PHCs have registered RKS; this figure is slightly better in the high focus states covered in the rapid appraisal survey (77%). Despite expectations from the RKS, their actual performance has been below par. The first CRM observes that the role of the RKS is limited by the tendency to view them as an alternative financing device and the consequent emphasis on user fees as cost recovery. Further, the composition of these bodies and processes of functioning are also not always conducive to community participation (NRHM 2007). Evaluation surveys observed that display boards stating members and decisions about meetings are often not in order. There is no adequate system of grievance redressed. The RKS need to be strengthened as they can monitor the local health delivery system and also solve some of its deficiencies through its untied funds. The third CRM report for Bihar observes that though RKS has been formed up to the PHC level in most places, meetings are irregular and do not undertake the specific activities outlined in the NRHM documents (NRHM 2009b). Health Management Information System The mission statement acknowledges that a strong component of technical support is essential for the success of the NRHM. This requires, inter alia, the positioning of program management units, and an improved health information system. The overall situation for the positioning of district program management units (DPMUs) is quite satisfactory. While the coverage of blocks is still

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inadequate, the situation is slightly better in the high focus states. The problem lies at the PHC level. In their survey, Bajpai et al (2009) found a lack of coordination and cooperation between the health facilities and the DPMUs. Another important issue is that the role of the DPM us has been so defined that they lack the required authority to take crucial. Administrative decisions. For instance, in case of non-performance of paramedic staff (ASHA or ANM) at the village level, the DPM us cannot take any corrective action directly; nor is the feedback given by these units to the paramedic staff always accepted by the latter. Further, to complete unfinished tasks, it is necessary to identify weaknesses in the implementation procedures of the NRHM. A crucial component in this context is the health management information system (HMIS). The HMIS should be so designed that it can serve as a mechanism for effective monitoring and supervision of the Mission activities and evidence-based planning. Unfortunately, despite the elaborate structure created and data validation checks, the quality of the HMIS reportedly remains poor. At the PHC and SC level, all registers are not maintained; those maintained are not updated regularly or following the RCH formats. Part of this may be attributed to the unrealistic expectations of "health managers" regarding the information that the health facilities can furnish, and seeking too much information – even if it is not used subsequently. Often the same data has to be repeatedly supplied. Further, the second CRM found that multiple reporting existed, with earlier forms still being used (NRHM 2008). It also identified the existence of various constraints for data collection and flow. This creates pressure on the PHC and SC personnel, often making it difficult for them to both undertake their health-related duties and keep detailed records of their activities. The CRMs have also noted that copies of reports sent to higher authorities (like an office of the chief district MO) are not maintained by the facilities. Overall, as CRMs have observed, the HMIS is not used adequately to inform planning and responsive corrective action. It is, therefore, necessary to revamp this system by identifying essential informational requirements, eliminating redundant formats, revising formats for primary data capture by taking into account operational constraints, increasing the quality of data input at the grass-root level through proper training and capacity building, greater convergence between staff supplying data and providing a loop for feedback to the SC and PHC level. The PRCs may be involved in the process of capacity building to the HMIS.

Conclusions, To sum up, the actual delivery of the NRHM has fallen far short of its targets. Evaluation studies were undertaken by the Planning Commission, the Ministry of Health and independent authorities indicate that the situation in terms of quantitative goals and quality of service in many states leaves much to be desired. With the mission nearing its deadline in 2012, it is unlikely that unfinished tasks can be completed within the remaining period. However, within this limited period, the NRHM has succeeded in putting back the issue of public health at the top of the government agenda. This has put pressure on the state governments to divert resources to the health sector, thereby substantially strengthening the public health system, including its workforce (GoI 2010). Although these achievements have fallen short of what was originally conceptualized, the investment has had a positive impact on several health indicators like immunization, institutional deliveries, and antenatal care (Duggal 2009).

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A study of UP and Bihar found that the service delivery capacity of the public health system had increased at each level (Kumar 2010). Outdoor patient visits had increased at all three levels (SC, PHC, and CHC). The maximum improvement was found at the PHC level (129%) followed by an almost similar increase at the district and CHC level (86%). The main beneficiaries of indoor services at each level were invariably women followed by children and men, respectively. Given the condition of the health infrastructure and manpower shortage in 2005, and the size of the country, the NRHM had an immense task before it. The fiscal crisis of the states, diversity in administrative ability and political will to administer the architectural modifications envisaged under the NRHM, and constraints in creating the workforce essential to provide the quality health services promised to a rural population of 75 cores perhaps made the targets and goals of the NRHM overambitious – particularly in a period of less than a decade.14 Above all, the NRHM did not adequately take into account the complexities of Indian rural societies, characterized by gender disparities, and divided between the lines of caste, micro-politics, and economic class. In its focus on architectural modification of the health system and introducing modern managerial concepts, the NRHM did not pay sufficient attention to the sociocultural context in which the health system is situated and which ultimately determines the success of policies and measures, including decentralization. This is perhaps the most important factor limiting the success of the NRHM

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