# From Policy to the Periphery:
## *A Look at India's National Rural Health Mission*

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The World Health Organization refers to health policy as "decisions, plans, and actions that are undertaken to achieve specific health care goals within a society."[1] This description is deceivingly simple; health policy is complex and requires short and long term goals, prioritization, and the involvement of a wide array of stakeholders ranging from funding bodies and healthcare providers to, of course, the members of the community.[1] Implementation of health policies, therefore, requires a multidimensional approach and when completed successfully, is a vital tool in the improvement of the overall health of a population.

In today's world of policy, it is not uncommon to encounter the terms "bottom-up" and "top-down" in regards to policy implementation. The 'top' refers to governing bodies and policy-makers where schemes originate, whereas the "bottom" is in reference to the grassroots where we find the community and lower levels of governance.[2] Many national policies and programs, specifically the ones that will be further discussed in this paper, are defined from the top, yet require administration and implementation from the bottom. This is an integrative approach, where communication and accountability between service delivery on the grassroots and the expectations from the "top," must be reconciled.[3,4] The **National Rural Health Mission** (NRHM) introduced by the **Government of India** (GOI), is an interesting case in point. Today, the GOI's agenda places heavy emphasis on this integrative process in order to increase access and quality to healthcare for the country's rural areas. However, with a large and extremely diverse population, integrating the multiple levels of governance to deliver improved healthcare can be difficult. This paper will investigate India's NRHM to better understand the importance of an integrative approach to health policy.

### HEALTH POLICY IN INDIA

India has a population of 1.2 billion people, the second largest in the world—70% of that number lives in a rural setting where healthcare is lacking in access and quality.[5] The rural-urban gap across India has consistently plagued the country's healthcare sector; the rural sector faces a constant lack of resources, infrastructure, and primary healthcare providers. Socio-cultural dynamics and harsh living conditions also contribute significantly to barriers for accessible healthcare.[6]

In an attempt to target this inadequacy in the rural health sector, the central government launched the NRHM, a seven-year program to be implemented by 2012.[7] Amongst its many goals, the NRHM emphasizes the importance of increasing the standards at which peripheral health centers operate. As a tool to meet these goals, the GOI has developed the **Indian Public Health Standards** (IPHS) for health centers, which outline the bare minimum requirements for the delivery of adequate and quality healthcare.[7,8,9]

### THE IMPORTANCE OF THE PRIMARY HEALTH CENTRE

The rural healthcare system in India is three-tiered in nature. At the most fundamental level is the health sub-center, which triages and refers patients to the second pillar, the **primary health center** (PHC). At a PHC, a physician and other health workers provide primary care. The Community Health Centre, which is the highest pillar of the three-tier system, functions similarly to the PHC, but caters to a larger population with more specialized services. Coverage

| Health Personnel | # Req'd as per IPHS |
|---|---|
| Medical Officer | 1 |
| Pharmacist | 1 |
| Nurse-midwife | 1 |
| Healthworkers (Female) | 1 |
| Health Educator* | 1 |
| Health Assistant* | 2 |

**TABLE 1: PHC staffing requirements specified by the IPHS.** Depicts the minimal staffing positions and number of personnel required at each PHC under the NRHM.
*Indicates male and female

of each of these centers can be seen in Table 2.[9] The three health centers operate in unison to collaboratively achieve quality and accessible healthcare for all.

The PHC is the first contact point between the community and the public health doctor, making it India's 'cornerstone of rural healthcare.'[9] The PHC therefore acts as an essential hub, accepting patients from sub-centers lacking the clinical knowledge, and referring patients further when needed.[9] Though PHCs do not solely indicate the quality of the rural healthcare sector, their importance makes them a highly reflective indicator of the rural community's access to public health facilities. As the NRHM aims to increase quality and access to healthcare for rural populations by 2012, it is crucial that PHCs, critical actors in the implementation process of the program, are assessed to evaluate whether the mission has had an effective presence on the grassroots level. The results are ultimately a reflection of how well the top down and the bottom up approaches to policy are integrated. Using the GOI based IPHS documents as a basis of assessment, the aforementioned integration will be assessed by evaluating the PHCs in the rural, hilly, and tribal regions of the Kangra district in Himachal Pradesh (see Figure 1).

**FIGURE 1: Map of the Kangra district of Himachal Pradesh.**

## THE REALITIES OF THE PRIMARY HEALTH CENTRE

To better understand the current resources and quality of healthcare delivery for its constituency, Jagori Grameen, a local non-governmental organization in the Kangra district, evaluated six Primary Health Centers against the standards set by the NRHM. Through consultation of the official governmental IPHS document and public health officials, five integral areas of assessment were identified for the questionnaire: Treatment & Testing, Resources & Services, Manpower, Educational Services, and Monitoring.

The results were far from proclaiming the PHC as the "cornerstone of rural healthcare." Of the PHCs surveyed,

| Centre | Population Norms | |
|---|---|---|
| | Plain Area | Hill/Tribal/Difficult Area |
| Sub-Centre | 5,000 | 2,000 |
| Primary Health Centre | 30,000 | 20,000 |
| Community Health Centre | 120,000 | 80,000 |

**TABLE 2: Coverage of 3-tier healthcare system.** Listed above are the three pillars of India's healthcare system. The health centres covering larger areas (eg. community health centres) are typically the most adequately prepared in regards to resources and health personnel.

| | Primary management of wounds | Primary management of fractures | Primary management of poisoning | Primary management of burns | Minor surgeries | Labour room and services | Cataract surgery |
|---|---|---|---|---|---|---|---|
| **PHC1** | yes | yes | yes | yes | yes | yes | no |
| **PHC2** | yes | no | yes | yes | yes | no | no |
| **PHC3** | yes | no | no | no | no | no | no |
| **PHC4** | yes | yes | no | yes | yes | no | no |
| **PHC5** | yes | yes | yes | yes | no | no | no |
| **PHC6** | yes | yes | yes | yes | yes | yes | no |
| **Percentage Yes (%)** | **100%** | **67%** | **67%** | **83%** | **67%** | **33%** | **0%** |
| **Percentage No (%)** | **0%** | **33%** | **33%** | **17%** | **33%** | **67%** | **100%** |

**TABLE 3: Availability of treatments across PHCs.**

a mere 50% were aware of the term IPHS or its Hindi equivalent; none of those aware of the term had read or received an official IPHS document from the central, state, or local governments. This again highlights the importance of the top and bottom integration in policy implementation. Without a sound communication strategy between the varying levels of governance, awareness at the grassroots will not exist, and goals on a national level will not be met. The IPHS documents have been created by the central government and are hundreds of detailed pages outlining the roles of staff, programs, and resources that should be available at the PHC.[9] In this case, however, crucial information has failed to reach important stakeholders at the periphery due to a lack of integration. Without awareness of the IPHS and their importance in healthcare delivery at the periphery, the documents are ultimately useless in increasing the quality of rural healthcare as they are intended to.

Moreover, all five areas of assessment in the questionnaire across all PHCs uncovered significant deficiencies. Simple standards set by the IPHS (i.e. physician availability at each PHC)[9] were not met. Two PHCs were missing doctors entirely; the other four lacked at least one other important healthcare professional outlined in Table 1.[9] Table 3 and Figure 2 further outline the list of vital treatment and testing facilities that should be available at each PHC and their actual prevalence across the centers. Overall, although well intentioned, the apparent failure to achieve many of the goals pursued under the NRHM leaves little room for optimism. All personnel interviewed had the same response: resources are scarce, quality of healthcare delivery is low, and therefore the community lacks confidence in the rural healthcare system. Consequently, the following questions naturally arise: are the standards set by the IPHS realistic or just appropriate on paper, and who exactly is accountable for ensuring that these standards created by the central government are met at the periphery?

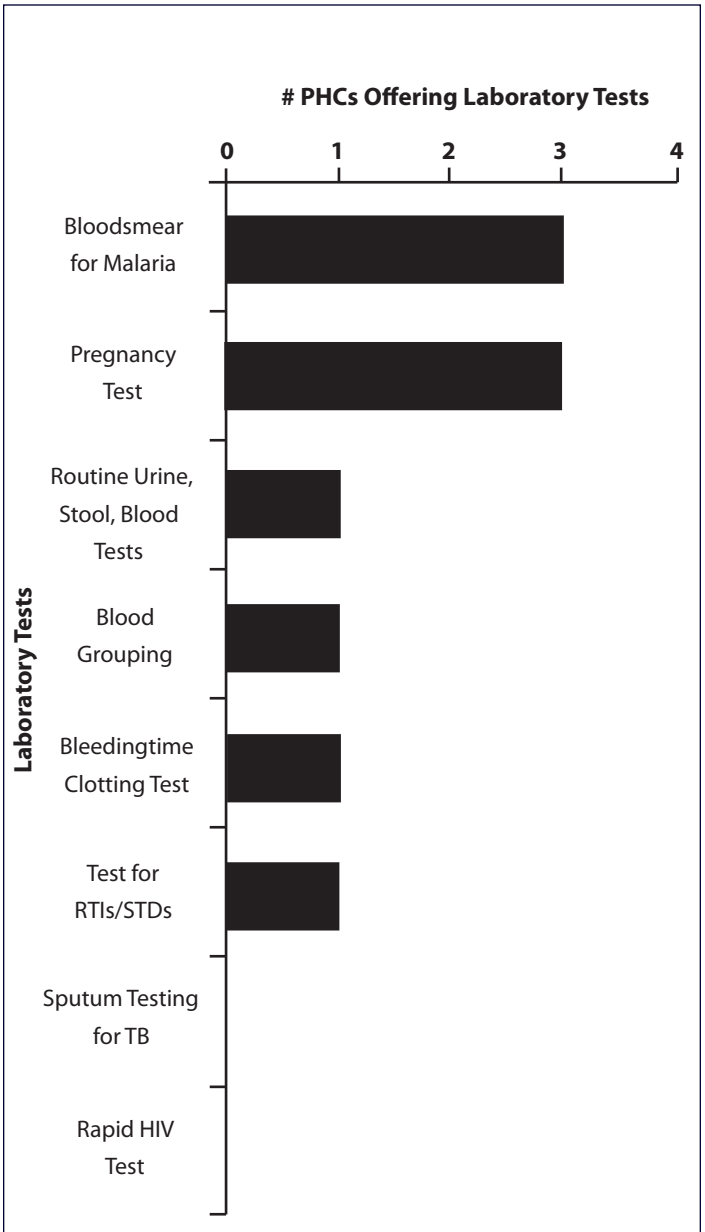


**FIGURE 2: Number of PHCs offering laboratory tests.**

## POLICY AND THE PERIPHERY

The Government of India has addressed the importance of "architectural correction" in the nation's rural healthcare sector. It has also created tools such as the IPHS to improve the standards of rural healthcare delivery.[10] Though the mission has indeed addressed the need for improvement in rural health, it has also been criticized for taking a "simplistic approach to a complex problem."[7] The development of the IPHS for PHCs is a case in point; creation of documents and standards is simply not enough. Policy, programs, and standards must have an avenue of reaching the periphery from a higher level of government. As seen in this study, PHCs in Kangra have no access or exposure to information considered vital to the success of the NRHM. Successful implementation of the NRHM and IPHS for PHCs requires a sound communication strategy to bridge national expectations from the "top" with the healthcare providers responsible for implementation at the "bottom." Moreover, once a communication strategy is in place and the peripheral PHCs are aware of the standards, they must be held accountable for meeting these standards. Lower levels of health governance, close to the periphery, such as district and block health officers, must be involved in ensuring that these standards are indeed met.

The NRHM is headed in the right direction. It is addressing major needs in rural healthcare and creating tools to accomplish its goals. However, as it is approaching its 2012 deadline rather quickly, it is unacceptable for stakeholders at the periphery to be unaware of the policies. If the periphery is unaware of the policies and standards, accountability is essentially out of the question. Rather than just creating tools like the IPHS, the NRHM must focus on sound communication strategies so that health centers, like those in Kangra, have an awareness of these tools and policies and ensure accountability so the standards do not go unmet. ▪

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**Reviewed by Kaelan Moat, Ph.D. Student**

Kaelan is currently a second year PhD Student in the Health Policy program at the Centre for Health Economics and Policy Analysis (CHEPA), McMaster University, and is being supervised by Dr. John Lavis. His research interests include analyzing the influence of evidence-informed policy briefs as a mechanism to translate research evidence to health systems policy decisions, with an emphasis on low- and middle-income countries and a particular focus on Africa. He has also explored the impact of decentralization policy in India on its public health system and has a keen interest in comparative health systems studies in both low- and high-income countries. He is currently working within the Program in Policy Decision-Making as a research assistant on a project with the Canadian Cochrane Network and Centre to help develop a database of systematic reviews focusing solely on health systems research. Prior to arriving at McMaster, Kaelan earned a Master of Science degree at the London School of Economics and Political Science in International Health Policy and has worked for NGOs in both Canada and India.

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