Evaluation Theory and Evaluation Practice - in the NRHM context

A NHSRC presentation.

Evaluation as Surveys:

- Concurrent Evaluation of the NRHM- 2009- International Institute of Population Sciences. Mumbai.
- Coverage Evaluation Survey – UNICEF- 2005 and 2009.
- District Level Household Survey- 2007-08 and 2002-04 (i.e. 2003 and 2007)
- Annual Health Survey- 2010.
- Sample Registration Surveys- Annual- CBR, CDR, IMR and MMR.(2002-04; 2004-06, 2007-09)

Evaluation as Reviews and Appraisals

- Mid-term Appraisal of 11th Five Years Plan, Planning Commission of India(Planning commission website)
- Common Review Mission Reports- 2007. 2008, 2009, 2010
- Concurrent Assessment of JSY Scheme in selected states of India, 2008, (available at NRHM website: http://mohfw.nic.in/NRHM.htm)
- Public Accounts Committee- Report on National Rural Health Mission.
- CAG report on National Rural Health Mission.

Evaluation as studies.

- Bajpai Nirupam , Sachs D. Jeffrey and Dholakia H. Ravindra , "Improving access, service delivery and efficiency of the public health system in rural India" Mid-term evaluation of the National Rural Health Mission, CGSD Working Paper No. 37 October 2009
- "Primary evaluation of service delivery under the National Rural Health Mission (NRHM): Findings from a study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan"
- Mukherjee Srabanti , "A Study on Effectiveness of NRHM in Terms of Reach and Social Marketing Initiatives in Rural India", European Journal of Scientific Research ISSN 1450-216X Vol.42 No.4 (2010), pp.587-603

NHSRC studies:

- "An Evaluation of the ASHA programme in eight states, which way forward?" National Health Systems Resource Centre, 2010
- "Programme Evaluation of the JSY", National Health Systems Resource Centre ,2010
- "*Status and Role of AYUSH and Local Health Traditions, under National Rural Health Mission"*, National Health Systems Resource Centre, 2010
- "EMRI – an evaluation", National Health Systems Resource Centre, April 2009,
- "HMRI evaluation", National Health Systems Resource Centre, December 2010
- " HR studies – Nursing in five states, medical officers and specialists in six states, retention case studies from over 5 states", National Health Systems Resource Centre, September 2009

Evaluation as governance

1. Did it work .. To achieve the change needed.?
2. Are we getting our money's worth? Is it well spent- or should we have invested it differently? Was there an efficient use of resources? What were the opportunity costs.. of the way it chose to work?
3. How does one improve design- so that it works and we get our money's worth
4. What are people saying about the programme? What are the implications for the various stakeholders in the way it works?..
5. How Sustainable/Replicable/Scalable is the way in which it works?

- "*Policy must be evidence based- Evaluation generates the evidence needed. Provides the power to justify decisions*"-

Evaluation as Knowledge generation

- Do we know what works?
- What were the learnings? Can we explain what happened? Can we predict what is going to happen- with the current programme and with replication/continuation/ expansion?
- Does it support existing theory or challenge it?
- How do we theorise what happens? To what extent can a particular experience be theorised into a general theory of health systems?

Monitoring and Evaluation

Monitoring: Tool of management: How are we faring with respect to what we said we would be doing- in processes, outputs and outcomes:

Evaluation

- Are we doing the right things?
- Are we doing them in the most effective way?
- Are we doing them on a scale that makes a measurable difference?

Internal Evaluation: Focus is on processes and relationship to outcomes. Usually it gives more valuable and actionable information. And it can be objective and fair too. Its bias is obvious.

External Evaluation: More of a governance too. The choice of the programme design itself is in question. Its bias is more subtle. Evaluators measure a programme against implicit programme theories.

Types of evaluation

- Impact Evaluation: The impact of the programme on the societal goal. It is the sum of changes wrought by the programme plus the changes brought about by about by other societal processes taken together. Did achieving the programme outcome- to 'x' degree- have an impact on the problem?
- Programme Evaluation: It is the study of how far the programme achieved the objectives it set itself. And how this relates to processes: Process evaluation + outcome evaluation= Programme evaluation.
- Process Evaluation: studies the integrity of processes and to how far desired/designed processes were achieved.
- Outcome Evaluation: studies how far outcomes aimed for were achieved.

The Normative evaluation: Randomised Control Trials/cohort studies/cross-sectional before and after..

Technical Intervention evaluation

- Define the change to be demonstrated.- eg this drug works …..this vaccine prevents 'x' disease.
- Double blind the investigator and the investigated: to remove all subjective factors.
- Design a study that eliminates the influence of all factors except the property to be tested- using controls.
- Repeat studies, done by different persons, contexts, shows same outcomes.
- Further eliminates subjective and contextual factors.

Health programme intervention

- Start with the programme objectives.
- Set up a credible team of evaluators- neutral, unbiased, objective.
- Define the baseline and measure what change took place because of the programme.
- Eliminate all confounding factors- contextual factors- ideally by controls or else by matching or suitable analysis/interpretation
- Get a before – after comparison

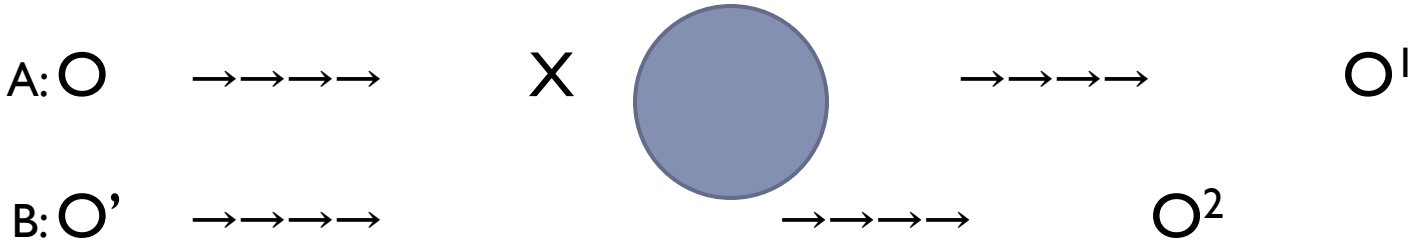
The Pragmatic Approach

- The boss is right- approach
- Only evaluate if there is an audience/client for it and only to meet his objectives: assumes programme theory of the boss and is bound by it. Almost a form of monitoring and accountability- " I have done more than a 1000 evaluations- got every NGO working with us evaluated- it is very useful."
- only on terms of cost effectiveness and practicality and if it can be done fairly and ethically;
- if all above are satisfied – then work out the technical adequacy.
- The results – enlighten the decision maker- and is successful to the extent that it is accepted/influences choices. Learning is very limited and incidental
- (eg NRHM evaluation, RCH evaluation, national programmes evaluation, UNFPA sponsored JSY and ASHA evaluation,)

The Constructivist(some-times relativist) approach

- Its just a conversation:
- Truth is always attached to some standpoint instead of being external to the beliefs of any group.
- Programmes are amalgams of a range of stakeholder interests: research each stakeholders' meanings, expectations.
- Open ended goal- enlarge collaboration- empower and educate all stakeholders.
- Problem- but funding agencies do exist- government do exist – choices do have to be made

The experimental design;



Did programme X contribute to a change?

Does O^2 differ from O^1

1. Do a baseline- get the situation O and O' in place A and place B respectively
2. Do the programme in Place A; Do not do the programme in Place B.
3. After programme is done measure situation again in both places and compare. The difference has to be statistically significant.

If it is then X made a difference.

Repeat this process in many places- if it works in all places then programme X works!!

Problems with such evaluation reports

- Most often- the report is not taken seriously- consciously rejected or ignored.
- Even if taken seriously – no change occurs- it tells us – pass or fail – but does not tell us why?
- Difficult in complex health programmes to construct a control- or even to construct a counter-factual. Often difficult to construct baselines.
- In which case we are left with a cross- sectional study- from which we derive conclusions and recommendations.
- If it tells us why – it states obvious limitations and unavoidable circumstances or non workable ideas-
- The evidence that evidence from evaluation is used is pretty thin eg Lancet article on decision making in WHO

Averaging ***out*** the context

- A study on impact of village health and sanitation committees – looked at 200 villages across four states. In one state, the VHSC had not yet been formed. In another it was formed , but funds were not transferred. In a third, it was formed, funds were transferred, but no training or guidelines were done. And in the fourth – all the above was completed. Only 15% of VHSCs were found to be functional- of which 10% were from one state, 2% from two other states and 1% from one state….
- A study of Mitanin programme showed that only 30% of Mitanins of the 100 Mitanins from 9 blocks studies ere effective in all four components.
- A study of "multi-skilling for emergency obstetrics" showed that only 21% of those trained were utilised effectively for providing emergency obstetric services

Object and Subject:

- Programmes do not work- people do!!! How does this experimental design.. study the subjective element:
- If adminstering ORS or a dose of chloroquine is administered by a RMP or a nurse or a doctor, its effect on the patient should be the same.
- But if IMNCI/HBNCC or NRHM is conducted by a motivated officer, or a person himself trained in pediatrics, or an able administrator would it not be more effective than the converse of each of the above.
- Is it HBNCC that worked or is it Abhay Bang? Are these valid questions in a social programme? How does evaluation theory factor it in?

Do we evaluate an intervention or a programme theory?

How are the following programmes expected to work?

- *ASHA*
- *VHSC*
- *Mother and child tracking?*
- *EMRI*
- *NRHM*

There are multiple contested narratives of even what outcomes are expected of a programmes and how exactly a programme is expected to deliver these outcomes.

Objective and subjective

- Does not the interviewer bring in his world view? Does evaluator have a programme theory which is at variance with the implementor. In terms of what are the interventions, what are essential determinants and preconditions, what is the context etc.
- Do they have an agenda- set by the person who asks for the evaluation? Which also sets up a relationship between evaluator and the evaluated?
- Is there a relationship of power set up between the evaluator and the evaluated? Does it question existing relationships of power within the organisation, provoking a response?

Complexity

- All health programmes are composites of many components- relate to each other – dynamically-
- People in an organisation relate to each other- enabling - constraining relationship- enable others and are enabled by others- relationships of power.
- It is difficult to map the relationship between contexts, mechanisms, and outputs for each component separately and in an inter-related way.

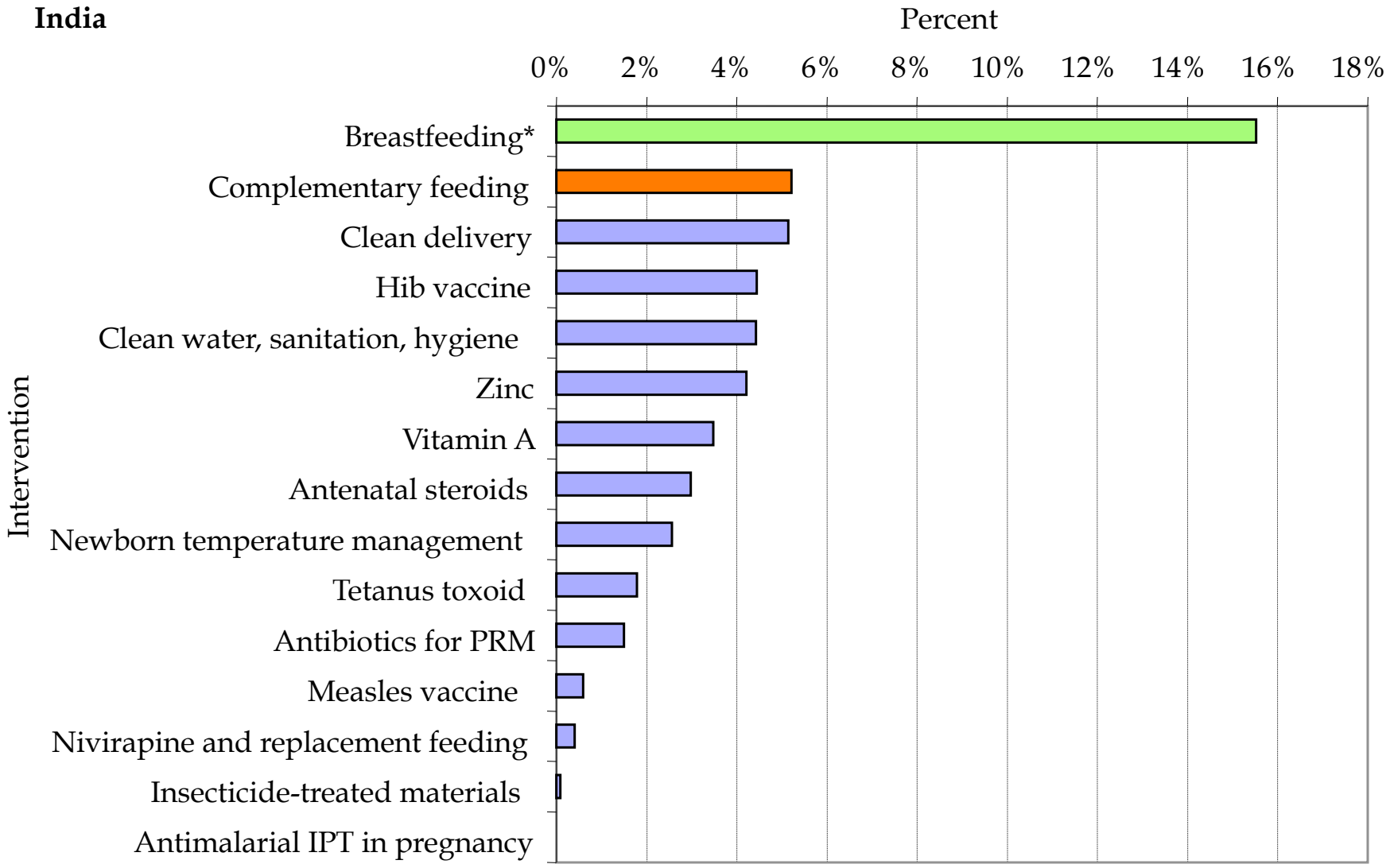
What could be the problems

- Difficult to get baseline – as programme is already ongoing. How could we estimate the baseline?
- Difficult to get a control in place- that is not contaminated… other dts would tend to catch on to good practices
- Need a counter-factual…but difficult to construct one- are changes due to NIPI or would they have happened anyway?
- Difficult to measure outcomes- sample sizes needed may be too large to show significance. Thus to comment on neonatal mortality- of 1000 live birth, 60 die and of these 30 in neonatal period and expected change in deaths would be down to 20 in one year. – so to know whether a change of 7 is significant of not – one has to have almost 30,000 live births..
- Difficult to measure with accuracy and quality once the sample sizes are large. And it is expensive too. Begins to rival programme costs

complex interventions: single outcomes

- IMR/MMR and NRHM:
- IMR and HBNCC/IMNCI:
- IMR and ASHA Programme.
- What are the essential components of each of these programmes? What are the expected outcomes in each context of trial?
- If there are a large number of possible outcomes than by sheer probability something would work.
- But if there is a single outcome measured- it may neither be sensitive nor specific.
- And there are unintended outcomes- which could be significant.
- How does one attribute causality between an outcome and an input?

Does evaluation work for single interventions ?.



***Breastfeeding: Exclusive for first 6 months and continued for 6 to 12 months**

Source: Jones et al. LANCET 2003;362:65-71: bellagio child survival study.

Two ways of looking at programme evaluation

- Experimental Design: Let us identify the best practice innovation- let us evaluate it to ensure its claims are true- let us then replicate it – and scale it up – to achieve the impact: OR did this programme achieve the objectives it set itself:

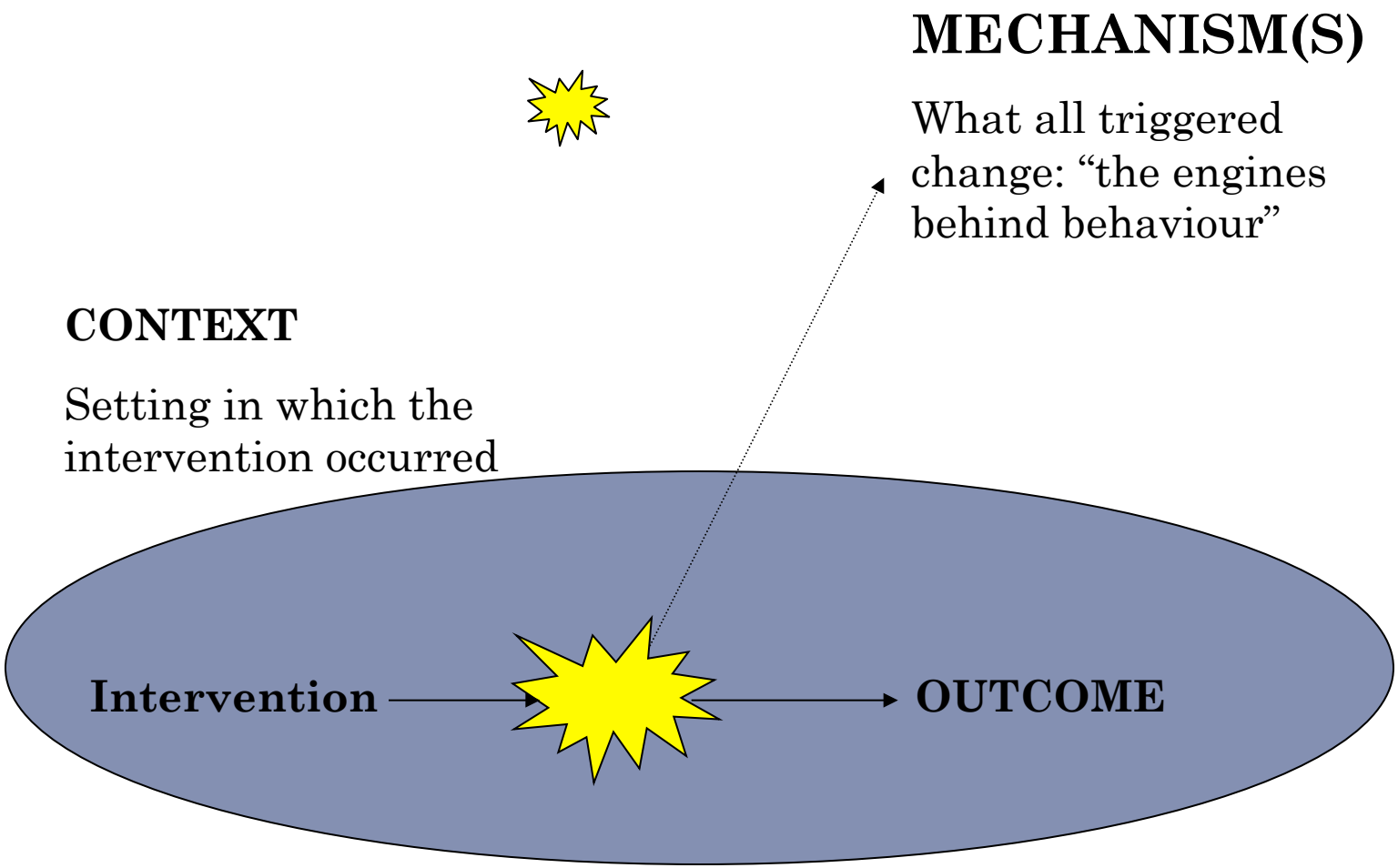
- *Realist Design: "Show me the options and explain the main considerations I should take into account in choosing between them"* OR *" under what circumstances and when done by whom will this option work"*
- (Pawson et al, 2004:12)

Research question:

- *"what is it about this program that works for whom in what circumstances"*

- instead of: *"does this work"*

C-M-O


MECHANISM(S)
What all triggered change: “the engines behind behaviour”
CONTEXT
Setting in which the intervention occurred
Intervention
OUTCOME

Main elements in realist review

- Outcome

Changes in behaviour: changes in processes:
Result of the interaction of the intervention within its context

- Context

Settings within which the intervention occurred

- the organizational, socio-economic, cultural and political conditions, and the stakeholders involved, their interests and convictions and the process of implementation

- Mechanisms

What triggered change: "the engines behind behaviour" the different components of the programmes, the various processes involved.

Realist inquiry

- Interventions are complex social and behavioural set of activities, that need to be described and understood
- Same intervention is implemented differently in different settings and with different stakeholders
- Different stakeholders would have different programme-effect theories of how the intervention works:
- Aim for a better understanding of interventions working "sometimes" or "to some extent"
- Use of quantitative and qualitative data collection methods
- Programmes embedded in diversity of individual and institutional forces :limitation to any stakeholder understanding: neither treat them as the privileged view nor as trivial.
- Need to look at unintended consequences and un- acknowledged conditions of their decisions. These are particularly informative- not confounding factors-
- See how contexts and existing mechanisms influence new mechanisms

Reflexive Nature of Knowledge

- See outcomes as multiple and processes as multiple and see what is the process outcome relationships-
- conclude on CMO – what seems to be working for whom under what circumstances.- The configuration is the focus. It gives rise to theory and it modifies existing theory.
- What was the programme theory which the evaluators started- and how is it modified? What was the programme theory with which planners initiated the programme and how is it modified?
- So what are the learnings and how can it be applied in situation "X".
- Learn stakeholder theories, formalise them, teach them back- let him clarify, further refine- and repeat to wider circles of enlightenment.

Evaluation as governance and evaluation as knowledge

- That many changes affect decision: Evidence and study generated insights shall be only one amongst them.
- Choices are better informed if there are learnings – presented as context and subject specific- and not as absolute truths. But still for each situation choices would still have to be made.
- There is a cumulative growth of knowledge and progress, and much more autonomy and choice with evaluation that positions itself as a discussant – rather than as the judge- which acknowledges reflexivity as one of the key features of science- instead of searching for absolute truths-

Approach to ASHA Evaluation

- Uses the realist approach: not does -"Does the programme work"?, but "***What components work? Where? What context? and to what extent?***

- ***Framework of analysis***:
  - Who is the ASHA? What is the profile of the woman who has emerged as ASHA? Time spent, coverage, selection process.
  - What is ***the functionality*** of the ASHA- is she doing the task assigned. R***ange: the mix of*** tasks she undertakes: ***coverage***: the percentage of potential users the ASHA reaches,
  - How ***effective*** is she in bringing about an outcome- through enabling behaviour change, providing first level contact care, and the actual use of facilities by beneficiaries
  - How do functionality and effectiveness relate to programme dynamics? What are the main constraints to effectiveness?
  - ***In different contexts- how do varying programme mechanisms interact with different subjective understandings of the programme amongst implementers to yield outputs and health outcomes. How can outcomes be maximised? What are the implications of different choices on mechanisms and understandings that constitute the programme?***

METHODOLOGY

- Conducted in three phases: Two districts (one well performing and one with high SC/ST population) per state and eight states.
- Phase 1: Qualitative: To understand views of programme managers at various levels by senior public health experts
- Phase 2: Cross – Sectional Sample Survey, by research teams

  - Per district : 100 ASHAs, 100 Anganwadi Workers, 100 PRI members and 25 ANMs.
  - The beneficiaries (Service Users) were of two categories
    - ***Service Users A***: Mothers with children between 0 – 6 months of age (400 in each district)
    - ***Service Users B***: mothers with children from 6 months to 2 yrs with illness in last one month.(200 in each district)
- Phase 3: Report back to states, build consensus on recommendations, observe implementation for a year

ASHA evaluation –Geographic coverage

State	District
Assam	Karimganj, Dibrugarh,
Bihar	Khagaria, Purnea
Jharkhand	West Singhbum, Dhanbad
Orissa	Nayagarh, Angul
Rajasthan	Banswara, Boondi
Andhra Pradesh	Khammam , East Godavari,
Kerala	Wayanad, Thiruvanthapuram,
West Bengal	Birbhum, Malda

FUNCTIONALITY AND EFFECTIVENESS

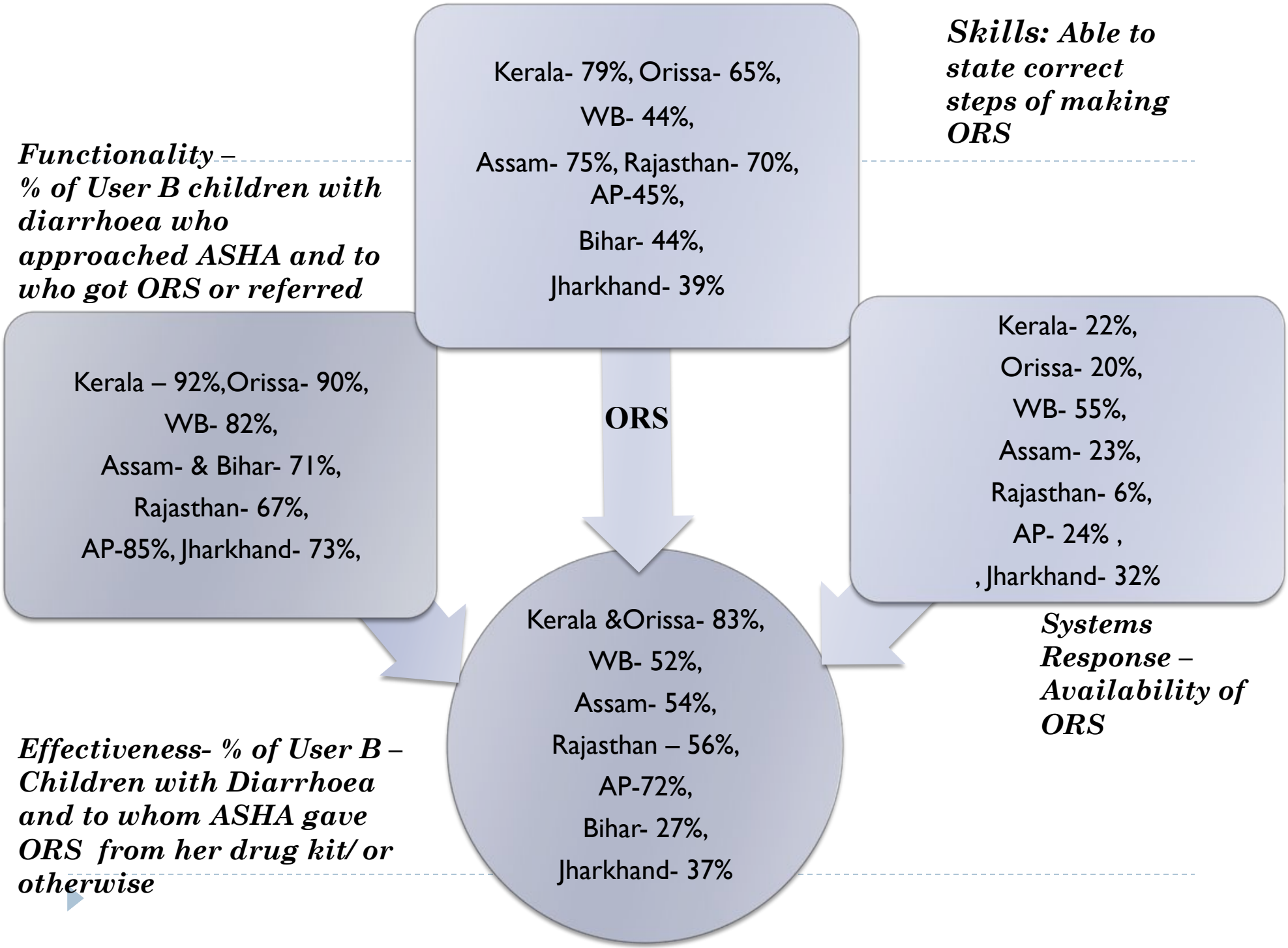
- Functionality is a resultant of the way programme theories – the subjective aspect- interact with support- in the form of payments and monitoring.
- Effectiveness is a response to the way functionality interacts with the supply side arrangements and the skill levels.
  - A high skill level will not result in better services if the supply side is not in place.
  - A high skill level and a supply side will not lead to better outcomes if the ASHA is not functional in this area.
  - And an ASHA will be functional in areas where she is encouraged to be active- by payment and by the understanding of those reviewing and supporting her.

Even if ASHA is functional- it would not convert into effectiveness- because of lack of support and lack of medicines.

ACCESS	Access : Service user A	Access: Service User B :
Kerala	**84.69**	**90.44**
TVM	80.60	83.18
Wyd	89.09	96.40
Orissa	**75.87**	**75.31**
Nayagarh	66.72	61.94
Angul	84.63	88.35
W.B	**67.24**	**81.87**
Malda	53.18	73.55
Bhirbhum	86.30	91.28
Assam	**76.89**	**67.19**
Dibruagh	73.59	59.75
Karimganj	78.43	69.74
Rajasthan	**76.43**	**67.44**
Banswada	77.06	72.02
Bundi	75.92	64.30
AP	**49.90**	**76.79**
E. G	42.17	73.24
Khammam	67.68	78.43
Bihar	**72.54**	**45.20**
Khagariya	71.34	45.65
Purnia	73.83	44.50
Jharkhand	**59.67**	**46.49**
Dhanbad	55.45	44.75
W.S	63.07	47.76

Factors that could have affected coverage:

- Geographic dispersion
- Social barriers and marginalization- activist character meant to over come this issue
- Only reaching those who are likely to bring in an incentive- not covering the home delivery woman
- Inability to respond to felt needs, undermines their credibility.
- Poor support and payment- so does only what is immediately possible.
- Little understanding of necessity of universal care- voluntary- so does what she can do easily.
- PLUS:
- Households missed because these were not allotted to any ASHA. Will not be picked up in our methodology.


Kerala- 79%, Orissa- 65%,
WB- 44%,
Assam- 75%, Rajasthan- 70%,
AP-45%,
Bihar- 44%,
Jharkhand- 39%
Skills: Able to state correct steps of making ORS
Functionality – % of User B children with diarrhoea who approached ASHA and to who got ORS or referred
Kerala – 92%,Orissa- 90%,
WB- 82%,
Assam- & Bihar- 71%,
Rajasthan- 67%,
AP-85%, Jharkhand- 73%,
ORS
Kerala- 22%,
Orissa- 20%,
WB- 55%,
Assam- 23%,
Rajasthan- 6%,
AP- 24% ,
, Jharkhand- 32%
Systems Response – Availability of ORS
Kerala &Orissa- 83%,
WB- 52%,
Assam- 54%,
Rajasthan – 56%,
AP-72%,
Bihar- 27%,
Jharkhand- 37%
Effectiveness- % of User B – Children with Diarrhoea and to whom ASHA gave ORS from her drug kit/ or otherwise

Immunization

	% of ASHAs who attended at least 3 VHND sessions in 3 months self reported	% of AWWs reporting that ASHAs regularly attend the sessions	% of ANMs reporting that ASHAs regularly attend the sessions	% of users A who received three ANCs	% of service user B – child immunized for measles
Kerala	88	90.5	58	89.4	82.7
Orissa	90.5	95.5	98	70.4	64.6
W.Bengal	89.6	89.2	97.9	48.8	67.4
Assam	92	92	96	54	62.6
Rajasthan	91.5	89.7	93	52.2	49.6
AP	84	89.1	74.3	82.1	32.9
Bihar	95.5	88.4	72.7	20.8	53.5
Jharkhand	86.8	86.4	84.3	50.7	63.6

Programme theory -1

- ASHA should be a ***link worker*** promoting utilization of govt. services. Her main contribution would be by her referral to the health facility. She should neither be a service provider, nora n activist.

  Teaching her skills could be dangerous because:
  - She could become a quack.
  - Government would withdraw from its commitments. ANM would stop working.
  - She would demand to become a permanent staff.
  - She could start referring to private sector in a situation with inactive public sector.

Programme theory- 2.

- ASHA's effectiveness depends *on her providing essential services that save lives- at the level of community* .
- She also needs to be a link worker – for many services she cannot give but are needed to save lives and for her own credibility.
- She needs to be a mobilizer to reach all and to respond to lack of service delivery.
  - Variant. - as much as possible, should be managed within communities- facility based care should never be the first option.

Programme theory- 3.

- ASHA should work by mobilizing communities to work for their health care entitlements.
- Thus her training should focus on an understanding of the health systems and on community mobilization.
- Service provision would distract- and that level of skills cannot be built up by existing system.
- She cannot play much of a link worker role because public services are in disarray- and there is is the danger of her becoming a tout of the private sector.
- There is evidence that mobilization alone makes a difference.
- We should not agree to a poorly skilled worker as a substitute to the fully trained professional- and teaching more skills does this.
- Such an ASHA needs a programme led by strong NGOs

Where is the programme today and which is the way forward?

The two most successful tasks

1. Attending the immunisation day- mobilising for immunisation :
2. 2. Promoting institutional delivery.

- ***Reasons* :**
  - Incentivization-
  - Most Supervised elements of the programme.
  - Requires relatively little knowledge or skills or on the job supervision or any other form of support. The incentive is everything. Focus only on how payment is made.
- ***Reasons for concern:***
- Are associated health behaviours being addressed?
- Is there value addition or just piggy-backing?
- Is there a gaming of the system to maximise incentives ? i.e only reach those who have a higher chance of going institutional and leave out those who are left out?
- Or other windows of opportunity being missed.

The Escort or Birth Companion Function

- Achievements in the escort function in the high focus states, is modest – ranging from 20 to 60%. In **Bihar and Rajasthan choices have been made to contact only those women who are likely to opt for institutional delivery, since over 90% of those they met opted for institutional delivery though they reached only 75% of the pregnant women**.
- Lower in those states which are non high focus and the need for such promotion is much less- Kerala (9%), West Bengal(5%) and Andhra Pradesh(53%), given higher rates of institutional delivery.
- In Jharkhand 50% of women counselled by ASHA, did not opt for institutional delivery-

Care of the Sick Child

- At least 40% of ASHAs are being consulted and in states other that in Bihar and Jharkhand it is well above 60% - going upto 88% in Angul or 91% in Bhirbhum.
- High figures where sub-district the programme is supportive (as expressed in drug kit refilling, the understanding among leadership, officers and support from providers).
- There is no major private sector referral and even in Jharkhand's West Singhbum and Khagaria, where 25% of cases are referred to the private sector this could be due to the lack of alternatives, more than anything else.
- Indicates that ASHAs themselves have shown considerable "agency" in responding to felt needs.
- At the sub block levels, this function of responding to the felt needs of the community and especially the sick child is felt as an urgent necessity.
- Effectiveness is however constrained by lack of drugs and lack of monitoring- and where these are being provided, the results are positive.
- WINDOW OF OPPORTUNITY IS LOST- ASHA is doing her job- but does not have the skills or support to make an impact on saving lives.

Newborn Care

- **Angul acts as a best practice examplar in this area.**
  - high performance on newborn care has had spin off effects in all aspects of ASHA functionality- most dramatically in coverage. (there is still a last 15 % to be reached!!).
  - More reliable, a more accountable payment and are the best paid ASHAs of all our district case studies.
  - Newborn care is incentivised.
  - Strong emphasis that support and supervision are critical to ensure effectiveness in areas in which the ASHA is skilled.
  - Training on some aspects – especially child nutrition and post partum care remain very weak- but now that the gap is known it can be easily corrected. (In Angul on the quality of complementary feeds none of the ASHAs knew the answers).
- It is worth noting, that even in Nayagarh, though nowhere near Angul, the performance on many parameters of care in newborn would be much better, perhaps a reflection of the programme theory and support mechanism on Orissa.
- In most other states newborn visits are still upto 40% of families who are under ASHA coverage of any sort. Even this level of functionality means a large number of visits , – in absolute numbers and this could have resulted in more outcomes, but then the skills and support are just not in place.

Relationship with ANM/AWW, and the private sector

- **There is no evidence of any major conflict between ANMs, AWWs and ASHAs though this is one of the most commonly heard of problems.**
  - because the ANM has shifted her work burden onto ASHA.
  - Perhaps it is because the early conflicts are all over, and everyone is used to the other being there and no longer threatened.
  - Perhaps it is because the incentive is now clearly in different silos and there is no competition for the same incentive. In Institutional delivery only the ASHA gets it and in family planning the ASHA almost never gets any.
- **There is no evidence of her charging fees, or setting up private practice, or becoming a dai or becoming a tout of the private sector.**
- There is 1 % to 10% range of private sector commissions across the states and that could generate a huge number of anecdotes.

As a Community Activist

- Not uniformly an activist- but there is a significant minority who are playing one or more of a multitude of possible activist functions.
- Initial thrust given in this direction in Andhra and Jharkhand has not been sustained in the nature of support provided, but there is still such energy in the programme.
- Jharkhand did select NGOs for this support, but either due to poor choice or poor support to the NGOs themselves, this was not sustained.
- Module 5 (focus on leadership and empowerment) training was rigorous in Orissa and Assam, and this is evident in modest levels of such activity.
- In other states including West Bengal, Kerala, Bihar, Rajasthan there is not much evidence of this.
- There is also a reluctance to involve NGOs, and caution about activism- but the price paid is failure to reach the unreached.

Where is the programme today?

- The success of the programme at this point of time is limited.
- Orissa seems to be more responsive and effective. West Bengal and Assam are functional on this aspect but need more inputs to be effective.
- The other states have to take this seriously – but for this they would need to understand the ASHA as more than demand generation.
- Window of opportunity is lost – ASHA is doing the work in 30 to 70% of cases but even here is not empowered to make the difference
- Programme cannot be expected to have an impact on IMR

Recommendations.

- Need a combination of facilitation, mobilisation and community level care roles. For impact on child survival the community care role needs to be central
- Emphasize reaching out to marginalized sections.
- Persistent need for advocacy with programme managers to ensure structures and systems for support
- Focused advocacy with programme managers to explain the activist dimension
- Strong support system, greater NGO involvement., link with VHSC component.
  Mode of payment does not decide outcomes, but better payments relate to better outcomes.

The JSY Evaluation

- Two programme theories- is the programme act by enabling and empowering pregnant women to access essential services? Or is it changing health behaviours? Sustainably? Or is it to provide social protection against rising costs of care?
- How does it reduce maternal mortality? Because skilled birth attendance reduces maternal mortality per se and because access to emergency obstetric care improves ?
- How does one test reduction in maternal mortality? Which is a very rare event.

JSY evaluation methodology:

- Sample of 300 women with recent child birth in 30 sampled villages; First line list all women with recent child birth and estimate institutional delivery rate. And complications rate. And hospitalisation for complications?
- Take a sample of home deliveries and a sample of institutional delivery in proportion to rate and get information on costs of care and quality of care and outcomes and ? Also reasons for choice of care, care seeking behavior in previous pregnancy and satisfaction levels.
- Interview all complications and look at their experience in finding transport, referrals, costs of care and outcomes.
- Document all female deaths in 14 to 49 age group and find out case of death and due verbal autopsy in maternal deaths.
- Do this for each district . Treat each district as an independent case study and compare the Context- Mechanisms – Outcomes of one district with the next.

JSY Evaluation Findings

- There is increase in institutional deliveries and with equity: more in SC/ST/ BPL, though majority home deliveries from these same groups.
- High proportion of home deliveries in those below 19 and high parity- which means higher mortality risk.
- Persistent Home deliveries
  - One thirds due to referral transport issues.
  - One thirds due to Poor service quality and cost barriers.
  - One thirds due to behavioral and social issues. .
- OOPs on institutional delivery – average Rs 1400 to 1600!! Main expenses were on drugs. Home deliveries also costs!!
- Most JSY payments are delayed and happen between 4 to 15 days after delivery. Need to aim for same day payments.
- Transport component of ASHA package not usually used for transport. Only small % of pregnant women use EMRI is there – use in complications and where transport is difficult is low. Nabrangpur however 60% use referral transport.

JSY Evaluation- 2: Management of Complications.

- Deliveries predominantly in public sector, but 55% of complication requiring hospitalization go to private nursing homes.
- In public sector even basic obstetric complications are managed in only very few facilities – usually DH or nearby medical college. Same situation for sick newborn care also
- First resort of care and first referral for complications in private sector. But second and third referrals are usually back to public sector.
- Not For Profit Hospitals, especially Mission hospitals provide a major part of the care needed for complications management- and urgent need to protect the poor from the high costs of complications management.

JSY Evaluation -3: Quality of Care

- Only approx. 14% are staying 48 hours, only 33% stay 24 hours.
- Gynecologists unable to do justice to both needs of sterilization camps and of emergency obstetric care simultaneously. If they focus on one, the other suffers.
- Poor record of following clinical protocols.
- Oxytocin misuse a major problem- in a number of districts- could contribute to still-births, neonatal deaths. Co-relation to lack of nurses. Poor and irrational use of anti-biotics and pain killers.
- 75% of newborns were weighed.
- Diet provided in some DH, otherwise not present. Even in DH it was a paid service.

Evaluating NRHM?

- Best to evaluate sector level changes in the last 5 years and then trace out and attribute " NRHM effect ".
- Programme theories of NRHM:
  - NRHM seen as an enabling financing mechanisms for strengthening state health systems and health sector reform.
  - NRHM as achievement of service guarantees in health care.
  - NRHM as attainment of targets with respect to facility development and to IMR, MMR,
  - NRHM as the sum of its schemes- ASHA, JSY, mother and child tracking, MMU, EMRI, etc etc.
- What do we measure for each of these programme theories?

Thank You