

Strategies for Revamping of National Rural Health Mission in India

Brij Pal*

* Department of Public Administration, S. A. Jain College, Ambala City 134003, Haryana, India

E-mail of the corresponding author: drbrijpal@yahoo.com

Abstract

Recognizing the significance of health, Government of India launched National Rural Health Mission (NRHM) in 2005. A lot of emphasis was given to strengthen the rural health infrastructure, including the physical manpower, and other facilities. However, as on date a huge gap is clearly visible between demand and supply of health centers, and facilities. The current health conditions are one of the reasons for India's poor rank in Human Development Index. This programme has put rural public health care firmly on the agenda, and is on the right track with the institutional changes it has wrought within the health system. This paper is an attempt to highlight the development of health services in India. Besides, the goal and strategies of NRHM has been discussed in detail. Present paper also explains the working of this programme which is a programme to fulfill the objectives of Millennium Development Goal.

Keywords: NRHM, Health, Rural, PRIs

1. Introduction

Over the last several years in India there has been a drastic change in the national government's approach to the health sector. India was one of the pioneers in health service planning with a focus on primary health care. It is estimated that, China in 2000 had a life- expectancy at birth of 69 years (M) and 73(F) whereas India had respectively 60 (M) and 63 (F). More importantly, healthy life expectancy at birth in China was estimated in the World Health Report 2001 at 61 (M) and 63.3 (F) whereas in Indian figures were 53 (M) and 51.7 (F). If we look at the percentage of life expectancy years lost as a result of the disease burden and effectiveness of health care systems, Chinese men would have lost 11.6 years against Indian men losing 12.7 years. The corresponding figures are 13.2 for Chinese women and 17.5 for Indian women. Clearly, an integrated approach is necessary to deal with avoidable mortality and morbidity and preventive steps in public health are needed to bridge the gaps, especially in regard to the Indian women. Taking all the factors into consideration, longevity estimates around 20-25 could be around 70 years, perhaps, without any distinction between men and women. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhose recommended establishment of a well structured and comprehensive health service with a sound primary health care infrastructure. In 1952, the Bhore Committees recommended to establish Primary Health Care Centres to promote, prevent, curate and rehabilitate the services to entire rural population, as an integral component of wider Community Development Programme. The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision of Sokhey Committee of having one Community Health Worker for every 1000 people to entrust 'people health on people's hand'. India has come quite close to Alma Ata Declaration on Primary Health Care made by all countries of the world in 1978. The Declaration included commitment of governments to consider health as fundamental right; giving primacy to expressed health needs of people; community health reliance and community involvement; Intersectoral action in health; integration of health services; coverage of entire population; choice of appropriate technology; effective use of traditional system of medicine; and use of only essential drugs. National Health Policy was formed in 1982 to make architectural corrections in health care system. National Health Policy gave a general exposition of the policies which require recommendation in the circumstances then prevailing in health sector. The Universal Immunization Programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases. In 1997, Reproductive and Child Health (RCH- Phase1) programme was launched which incorporated child

health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health. RCH Phase-2 (2005-2010) aims at sector wide, outcome oriented programme based approach with emphasis on decentralization, monitoring and supervision which brings about a comprehensive integration of family planning into safe motherhood and child health.

2. NRHM Model

Most of the Indian population lives in rural areas and they are suffering from long-standing healthcare problems. It is estimated that only one trained healthcare provider including a doctor with any degree is available per sixteen villages. Although more than 70 per cent of its population lives in the village, only 20 per cent of India's hospital beds are located in rural areas. Most of the health problems that people suffer from in the rural community and in urban slums are preventable and easily treatable. In view of the above issues, the National Rural Health Mission (NRHM) was launched by the Government of India in April 2005. The duration of NRHM will be from 2005 to 2012. The total allocation for the Departments of Health and Family Welfare has been hiked from Rs 8420 crore to Rs 10,820 crore in the budget proposals for the year 2005–2006. NRHM is a flagship scheme of central government to improve the provision of basic healthcare facilities in rural India by undertaking an architectural correction in the existing healthcare delivery system and by promoting good health through improvements in nutrition, sanitation, hygiene and safe drinking water. It also seeks to revitalize Indian health traditions of Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH), and mainstream them in to the healthcare system. NRHM is an umbrella programme subsuming existing health and family welfare programmes, such as the second phase of the Reproductive and Child Health programme (RCH II), National Disease Control Programmes for Malaria, TB, Kala Azar, Filariasis, Blindness, Iodine Deficiency (NDCP), and the Integrated Disease Surveillance Programme (IDSP). By integrating these vertical health programmes, This programme seeks to optimise utilisation of funds and infrastructure, thereby strengthening delivery of public healthcare. A task force has been constituted to recommend strategies for expanding the programme to include the urban poor

3. Objectives of NRHM

National Rural Health Mission seeks to provide effective healthcare to the rural population throughout the country with special focus on eighteen states, which have weak public health indicators and weak infrastructure. These states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal, and Uttar Pradesh. In the beginning Government of India was to provide funding for key components in these eighteen high focus states. This programme has to cover all the villages in these eighteen states through approximately 2.5 lakh village-based 'Accredited Social Health Activists' (ASHA) who has to act as a link between the health centres and the villagers. One ASHA will be raised from every village, or cluster of villages, across these eighteen states. The ASHA will be trained to advise village populations about sanitation, hygiene, contraception, and immunization to provide primary medical care for diarrhoea, minor injuries, and fevers; and to escort patients to medical centers. They would also be expected to deliver direct observed short course therapy for tuberculosis and oral dehydration, to give folic acid tablets and chloroquine to patients, and to alert authorities of unusual outbreaks of disease.

The goals of the NRHM were as given below:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR);
- Universal access to integrated comprehensive public health services;
- Child health, Water, Sanitation and Hygiene;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Population stabilization, gender, and demographic balance;

- Revitalization of local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha, and Homeopathy Systems of Health (AYUSH);
- Promotion of healthy lifestyles;
- The strategies to achieve the goals include;
- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services;
- Health plan for each village through Village Health Committee of the Panchayat;
- Strengthening sub-centre through an untied fund of Rs.10000 for local action and planning. This Fund will be deposited in a joint Bank Account of the ANM and Sarpanch and operated by the ANM, in consultation with the Village Health Committee, and more Multi Purpose Workers (MPWs);
- Provision of 24 hour service in 50 per cent PHCs by addressing shortage of doctors, especially in high focus states, through mainstreaming AYUSH manpower;
- Preparation and implementation of an intersectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation, and hygiene and nutrition;
- Integrating vertical Health and Family Welfare programs at National, State, Block, & District levels.

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4. Functioning of NRHM in India

Health is listed as a state subject in the Indian Constitution while family welfare is in the concurrent list. Primary healthcare is a subject of local self governments. Therefore, public expenditure is restricted by resources available at the state and sub-state levels. NRHM envisages a significant role for communities in the delivery and monitoring of primary healthcare. One of the scheme's core strategies is to build the capacity of Panchayati Raj Institutions (PRIs) to control and manage public health services. NRHM has a provision for professional bodies and non-governmental organizations (NGOs) to conduct monitoring and evaluation. It also relies on communities to monitor the delivery system and the provision of health services. Preparation of annual district health report involves government line departments and NGOs, and state and national reports are tabled in State Legislative Assemblies and the Parliament. At the national level, NRHM is a joint Mission Steering Group, headed by the Union Minister of Health and Family Welfare, and an Empowered Programme Committee, headed by the Union Secretary for Health and Family Welfare. A Mission Directorate has been created for planning, implementation and monitoring day-to-day administration. At the state level, the State Health Mission headed by the Chief Minister, carries out the activities through State Health Societies. At the sub-state level, The District Health Mission shall be led by the Chairman of the Zilla Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant

Departments, NGOs and private professionals. District Health Societies are responsible for preparing perspective plans for the entire period (2005-12), annual plans of all NRHM components and for integrating public health plans with those for water, sanitation, hygiene and nutrition. Block level health plans on the basis of district plans are formulated to integrate the village plans. Rogi Kalyan Samitis (RKS) at the block level are responsible for the day-to-day management of hospitals. In each village, a Village Health and Sanitation Samiti is accountable to the panchayat and is comprised of a female Accredited Social Health Activist (ASHA) who is the bridge for the village, an ANM, a teacher, a panchayat representative, and community health volunteers. Primary Health Centres are staffed by a medical officer and fourteen paramedical staff, and provide integrated curative and preventive care. PHCs are the first point of contact with a medical officer. At the block level, CHCs, serving as referral units for four PHCs, are manned by four medical specialists (surgeon, physician, gynaecologist and paediatrician) and provide obstetric care and specialist consultations. NRHM seeks to bring CHCs and PHCs on par with Indian Public Health Standards (IPHS) and makes the provision of adequate funds and powers to enable these committees to reach desired levels.

5. Issues

Poor coordination and integration with other health institutions is a major problem of NRHM. The objectives of NRHM to increase expenditure on public health, provide access to healthcare to the rural poor. It recognizes that diseases are caused by several factors and stresses on the convergence of inter-sectoral services, such as nutrition, water, sanitation and hygiene. It integrates previously vertical disease-specific programmes at the national, state and district levels, ensuring that these different aspects are represented in the district health plan. NRHM is designed to coordinate efforts between related schemes such as Total Sanitation Campaign, Integrated Child Development Services, Mid Day Meal, and National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme. However, Coordination between different ministries and integration between various intersect oral programmes remains the biggest challenge for NRHM. The NRHM framework states targets for public health outcomes, but lacks mechanisms to judge state performance against targets. Ministry of Health & Family Welfare maintains annual state-wise data, but without state targets in the framework, it is not possible to arrive at meaningful regional and inter-state comparisons. Baseline surveys, that are important to estimate current status and to measure all future progress, were completed in only eight states and Union Territories (UTs), were incomplete in eight, and were not initiated in twenty states and UTs. The lack of baseline data prevents any meaningful evaluation of progress of the scheme in the states and in the country. In the absence of complete, timely and accessible household and facility data it is not possible to adequately plan future interventions based on relative need analysis.

6. Strategies for Implementation

6.1 Untrained Personnel

Lack of trained personnel and infrastructure is a major concern for proper implementation of NRHM. Presently, at the District Level and below there is a hurry to achieve 'targets' which cannot be achieved in absence of trained personnel and improvement in infrastructure. There is acute shortage of all categories of staff in health sectors across the length and breadth of the nation. Most glaring are the lack of specialist doctors, laboratory technicians, and male health workers. A need for a second Auxiliary Nurse Midwife (ANM) is felt in all the states. According to the Bulletin of Rural Health Service on 31 December, 2008, 14851 SHCs had no ANM, 130812 had one ANM, and 25743 had two ANMs. At CHCs, 5117 specialists were posted against a requirement of 16180. The gap was highest in the high focus North Eastern states where only nine positions were filled against a demand of 868. To improve the health care system in rural areas, the Government should ensure the proper arrangements of trained health personnel. There should be fixed quota of the specialist doctors in the recruitment policy and some extra benefits should be given to these specialist.

6.2 Association of District Health societies

Implementation of NRHM in many states like Jharkhand is very challenging. These states lack the basic infrastructures for implementation of national health programmes and state health societies were not constituted here for long. Formation of District Health Societies in the districts was also delayed. It is suggested that District Health Societies in each District should be constituted and the members of these societies should be aware about their rights.

6.3 Contribution of local self-government

At present, the NRHM is being seen as a package of schemes but in reality it is a participative programme of different stakeholders like Community, PRIs, government and non-governmental organizations in a well co-ordinated manner. The involvement of local self-governing bodies therefore seems very limited. NRHM programme can be successful only with the involvement of PRIs. This programme could not achieve the desired results due to petty politics at grassroot level and lack of political will. In tribal villages there are Traditional Manki/Munda/Pahan and village heads without legal or administrative powers of the PRI system. However, PRI participation has not been systematically implemented. There is no clear plan of Action, including capacity building plans on how panchayats should be involved. The PRIs should be given some legal and administrative powers for their active participation in the implementation of this programme. There is need of capacity building of health service providers.

6.4 Dishonesty in Implementation

There is possibility of corruption in the implementation of this programme. Recent example of Uttar Pradesh state indicates the possibility of corruption at higher level. The chief secretary of Uttar Pradesh conceded that it was the rampant corruption at various levels in the execution of Rs.3,000 crores under NRHM schemes that led to the murder of two successive chief medical officers in Lucknow. There should be check on the corrupt practices of the engaged bureaucrats. The officials should engage civil societies and local peoples while making expenditure on health services under NRHM.

6.5 Use of secure funds

Civil society engagement has not yet taken place at the state level. Unfortunately, sometimes untied funds are not being released at proper time and most of the Medical Officers and ANMs were unaware about the proper utilization of these untied funds. Secondly, due to lack of proper training of Panchayati Raj Institutions, there is lack of clarity on how the fund will be operated. There should be special steps taken to institutionalize civil society participation in NRHM activities, including monitoring at the state and district levels. MNGOs should be selected in consultation with civil society at the state level. The involvement of MNGOs as principal NGO partners in planning and particularly monitoring processes should be reviewed as it can lead to conflict of interests.

6.6 Patient Welfare Committees

There is provision of up gradation of PHCs and CHCs in the states. But in some states these PHCs CHCs have not been upgraded. The quality Assurance Committee has not yet been constituted to maintain the medical services. PRIs, ANMs & AWWs are also not aware about their duties and responsibilities. Thus the status of NRHM is quite dismal in some states. It is suggested that proper training programmes should be organized for the representatives of PRIs and they should be aware about the NRHM policies. The ANMs and AWWs should be trained and held responsible for the quality assurance of medical services.

6.7 Public-private joint venture

Public-private partnership processes should not encourage the privatization of health services. Financing should be from public funds so that universal access to services is ensured. Other challenges hampering access to better health services are, hard to reach areas, low acceptance level in some areas, extremist prone areas, quality assurance in strengthening the Village Health Committee and Sahiya training, lack of infra-structure and trained human resources and frequent transfer of health personnel. Mechanisms for introducing social audits and Jan Sunwai should be drawn up and implemented with care as soon as possible. District level planning has started in several places without village level planning processes being put in place first. This may set a counterproductive precedent. Village level planning should be introduced as soon as possible.

6.8 Appointment of Specialist

NRHM should welcome partnerships with the Non-Governmental Sector in a fully transparent manner to ensure that quality services are available at affordable costs to communities. The Hospital Development Committees at District, Sub-District, CHC, PHC, Hospitals is an opportunity to move towards need based and health facility based engagement of Specialist services. In emergency there should be provision of engagement of some specialist doctors working in the private hospitals under this programme.

7. Conclusion

The overall health status of the deprived and communally excluded population is meager in some states. The reasons for the poor health status of millions of people are not hard to find. Major factor hindering access to quality health services are lack of or non existing inter-sectoral linkages between different stakeholders. This phenomenon is also found between different Government Departments. Here the role of Panchayati Raj Institutions and civil society organizations becomes pertinent as one of the important stakeholder. There is also need of forging alliances with wider determinants of health. Existence of services in terms of structure will never ensure its utilization to fullest unless and until there is proper channel between different stakeholders which can link people to these services. It requires concerted public action to establish an accountable and affordable public health system, in partnership with non-governmental providers. It requires participation of democratic institutions like Panchayats, user groups, women's groups, NGOs in health delivery from public and non-governmental providers. Such health sector reforms require higher order of management of resources. Even though much of the responsibility for efficient working of the public health system lies upon the government, the people also need to assert their rights. To address the issues related to quality primary health care services, capacity building of health service providers, accountability and use of right to information for improving the quality of health care services are very critical factors. It is a challenge to the PRI and civil society institutions to make a difference in improving the access to primary health care services and contribute in ensuring access and utilization of services in their area. The factors that hinder proper implementation of NRHM from the beginning are not addressing existing problems in the health systems before initiating NRHM. Other reasons are lack of systematic coordination and implementation of various programmes and mechanisms by state Governments.

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Dr. Brij Pal (RO’02-APS’04-AP’08). The author became Research Officer (RO) in 2002 at the Institute of Integrated Himalayan Studies (Center of Excellence under University Grants Commission) Himachal Pradesh University, Shimla, India; Additional Private Secretary to Union Minister of Law & Justice, Government of India in 2004 and Assistant Professor & Head Department of Public Administration in 2008 at S. A. Jain College, Ambala City, Haryana, India. The author obtained his Post Graduate and Doctor of Philosophy Degrees in Public Administration and was awarded University Research Fellowship from Kurukshetra University, Kurukshetra, Haryana, India. Besides, he got LLB (Bachelor of Law) Degree from Chaudhary Charan Singh University, Meerut, Uttar Pradesh, India. The major fields of studies are Rural Development, Indian Administration and Contemporary Social Problems.

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