A critical review of National Rural Health Mission in India

C Lahariya, H Khandekar, J Prasuna, Meenakshi

Citation

C Lahariya, H Khandekar, J Prasuna, Meenakshi. *A critical review of National Rural Health Mission in India*. The Internet Journal of Health. 2006 Volume 6 Number 1.

Abstract

National Rural Health Mission (NRHM) has been envisaged as a focal point of all the programs targeted to improve the health of people in rural India. It has been widely debated both, before and after the implementation. Ongoing corrective measures and performance appraisal are integrated with this program. Deliberations by experts from various fields, adaptation of the successful best practices, and learning from the failures make NRHM a different program. No government program was as meticulously prepared or planned as NRHM since Independence. The key functionary of this program, Accredited Social Health Activist (ASHA), a voluntary worker, incorporates all the good qualities of previous similar functionaries in various programs. The active involvement of Panchayati Raj Institutions (These Panchayati Raj Instittutions or PRIs, as they are known here, are the institutions for local self government where locally elected representatives make decision for the people in the area. The PRIs have been formed at every village level throughout the country.), community (The involvement of community ensure that people decide for themselves to increase their participation in the programs), (Non Government Organisations (NGO), and Private Practitioners are welcome steps. Although, this also does not mean that everything is good in NRHM. The issues of attrition of ASHA, over dependancy of it on Anganwadi (Anganwadi literally means courtyards, The government of India has setup an Anganwadi for every 1000 population in rural India, where one government worker provide immunisation , health check ups, supplementary nutrition, non formal preschool education, health education, growth monitoring and referral services for children and pregnant women to improve the health status of the rural population specifically women and child.) worker etc need to be addressed. This review analyse NRHM in the light of past health experiences, specially focusing on ASHA. At present, it can be said that this program has all the necessary components to make improved health scenario, in rural India, a reality.

INTRODUCTION

National Rural Health Mission (NRHM) [1] is not a first program on rural health in independent India, even then, the enthusiasm and attention of the health personnel and people toward the program is phenomenal. This may partially be attributed to the apparent commitment and sincerity of the government, which was rightly reflected in the confessional speech of the prime minister of India, on April 12, 2005, on the launch of this program, when he said “We have grievously erred in the design of many of our health programs. We have created a delivery model that fragments resources and dissipate energies. Most importantly, we have paid inadequate attention to the public health issues.” [2]

The attempts to improve rural health through various programs were started as early as in 1940 when, then British government in India set up ‘Bhore Committee' (This committee also known as Health Survey and planning committee was set up by government of India in 1943 to understand the health situation in the country. The committee was headed by Sir Joseph Bhore and it got this name of Bhore Committee. The committee submitted its recommendations in 1946 with elaborate planning for health services delivery in India.) to find out the ways to improve the health of the people. This was followed by a number of other committees and programs i.e. Balawant rai Mehta Committee (After the initial developments followed by Bhore Committee report, this committee was set up to know the progress since Bhore committee recommendations and, to give further suggestions to improve the health scenario in the country), Community Development program and Basic need programs etc. These attempts were only partially successful in changing prevailing health scenario [3]. The successive governments started its own program and strategy to change the health conditions of the people without understanding or fully investigating the reasons for the failure of the previous programs [3].

REVIEW

This NRHM aims to improve rural health by targeting phased increase in the funding for the health up to 2-3% of the Gross Domestic Product (GDP) in coming years. The

mission also tries to correct the most of the shortcomings of previous programs i.e. inappropriate training, lack of technical guidance, supervision and co-ordination and, poor community participation. Besides, this plans to cover capacity building, public private partnership and induction of management and public health and financial personnel [1].

In NRHM, the commitment of the government is palpable and categorical as the program is time bound, with clear objectives and achievable goals it all these factors make NRHM a different program then previous ones. The desire for achievable targets reflected in acceptance of Indian Public Health standards (IPHS) for Community Health Centers (CHC) accepting that BIS standards are very much resource oriented and difficult to achieve in present conditions of the health system in India [1].

It seems that before planning the NRHM, the target of meeting the Millennium Development Goals (MDG), of which India is a signatory, were also kept in the mind as the goals under NRHM similar to what has been envisaged in MDGs. Another pertinent point to be noted is that NRHM addresses two of the four major problems, identified in UN Millennium Project [4] and associated with the poor development of the countries. First is the problem of the poor governance and second of the policy neglect in form of unawareness of what to do, or neglectful of core public issues [4]. Both of these may be taken as right step in the direction of achieving MDGs.

The NRHM has a central functionary named Accredited Social health Activist (ASHA) [1]. This worker has been discussed a lot amongst the people involved in the health and, has received a lot of bouquets and brickbats from the experts.

This paper debate a few issues related to the implementation of the program. The experts have called ASHA a resurrection of earlier Community Health worker (CHW) or Village Health Guide (VHG), both almost 30 year old schemes [5]. Agreeably, ASHA is newer and modified version of CHW but lesson learned from older scheme or causes attributed to her failure i.e. improper selection, inadequate training, demand of fee for service, has been incorporated in the selection. At the same time ASHA is an activist and not a worker in the health system as the previous CHW or VHGs. Besides, ASHA is more similar to the very successful and the world famous concept of 'barefoot doctor's' in China [6]. ASHA appears to be an appropriate mix of the CHWs and idea of barefoot doctors.

Finding a women educated up to 8th standard to function as ASHA will not be very difficult, as apprehended by some people, as in last 2 decades, the literacy rate of women has improved significantly. The selection procedure has some relaxation in exceptional cases to facilitate the mechanism.

ASHA would not be drawing any fixed salary and would be given performance based compensation [1], a concept which matches closely with recruitment pattern in private organisations. This may start a new era of accountability in the health system. Without even fixed salary, if she performs, she would get more than Rs 10,000 per annum (During the training, Directely Observed Treatment- Short Course (DOTS) for Tuberculosis completion incentive or Allowance in Janani Suraksha Yojana (This scheme is the modification of the earlier National Maternity Benefit scheme, where women from the below poverty line community are given monitory assistance to improve the nutritional status and to encourage routine ante-natal checkups, Tetanus Toxoid immunisation and, to go for institutional delivery.), which is reasonably good amount for a women in rural area. Besides, there is a provision for non monetary compensation in form of recognition, awards and state level meetings of selected ASHAs, also. This way, success of ASHA also depends upon successful implementation of the other national programs also [3].

Above description does not mean that ASHA is a fool proof scheme. There are other issues related to its working which still need to be given due attention. The attrition may be taken as one such issue. Since ASHA is a main stakeholder in the program and it has not been planned that what should be done if an ASHA leaves the health system. The selection of ASHA is rigorous and time consuming besides she has to be given sufficient training to function properly so it would take approximately one year for selecting another similar functionary. Strategies to sustain ASHA, along with a contingency plan for a situation when ASHA leaves the system prematurely, need to be developed.

Secondly, dependency of ASHA on Anganwadi workers (AWW) and Auxiliary Nurse Midwife (ANM) is likely and it seems that there is hardly any freedom for her to work independently. It may be detrimental to the system in a way that other functionaries might start delegating their work to ASHA. The work responsibility of ASHA and other workers need to be more clearly defined and mutually exclusive.

Action plan in NRHM [1] discusses the making of health system functional from the subcenters level. An untied fund

of Rs 10,000 has been widely publicized as component of strengthening the subcentres. While, it is a well known fact that most subcenters are in operation without any available buildings, the priority should be given to find a building for subcenters and allocation of Rs 10,000 would be useful only when there a infrastructure is available to carry out activities. The strengthening of sub centers is of paramount importance and allocation of this money is good but it does not solve the most important issue of the building for the subcenters as SC are the point of first contact between the community and the health system and it should be presentable enough.

More focus should be given to the continuous on job training [1] for most functionaries as this would keep the workers motivated. Posting of another doctor from AYUSH [1] at Primary Health Centers (PHCs) would improve the functioning there but we still need some mechanism in place to deal with the absentee doctors at this level.

Rogi Kalyan Samiti (RKS) scheme was started in Madhya Pradesh [1], a low performance state and was very successful. This simply conveys that we need not to be unnecessarily cynical [5] but try to replicate it all over the country. It is a good step which can be extended to the all hospitals in our country in future.

The success of any program requires a system in place where no link is missing. Functioning from the level of ASHA, subcentres, PHC has to be improved to bring people to a referral facility. This period in improving health system at lower level can be utilised for implementation of IPHS standards [1] at CHCs, so the raised expectation are not marred by below par facilities at CHC. As some experts have suggested5 a system of concurrent evaluation should be in place and generated data may be utilised for ongoing corrective measures at all levels.

We can say, NRHM appears to be a well designed program with all components of a successful community based program, where existing health system is being utilised with community involvement and participation, supported by a community volunteer.

It would be too early to predict its outcome in terms of success or failure. The necessary political will, commitment at all levels, financial support and budgetary allocations, good supporting and monitoring system, efficient scientific and political leadership and, working in the coherence holds the ability of make this program successful. We doctors can play a major role by providing good scientific leadership. May be, NRHM is the much dreamt program which can make ‘Health For All' and ‘Placing people's health in their hand' a reality.

CORRESPONDENCE TO

Dr Chandrakant Lahariya Flat No.3302, Sector-D, Pocket-III, Vasant Kunj, New Delhi-110070 (India) E-mail: ck1800@rediffmail.com Tel. 0091-9811135381

References

1. National Rural Health Mission (2005-2012): Mission documents and monograph 1-6. Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi. 2005 also available at http://www.mohfw.nic.in/nrhm.html (Accessed on Jan 10, 2006 at 21:30 PM)
2. Governemnt of India. Prime Minister's speech on launch of NRHM on 12 April 2005. Accessed at http://www.pmindia.nic.in on 06.9.2005 at 8:45 PM.
3. Banergy D. Politics of rural health in India. Indian J of Public Health 2005; 49:113-22.
4. Sachs JD, McArthur JW. The millennium project: a plan for meeting the Millennium Development Goals. Lancet 2005;365:347-53.
5. Kapil U, Choudhary P. National Rural Health Mission, will it make a difference. Indian Paeditrc 2005;42:783-6.
6. Wen C. Barefoot doctors in China. Nurs Dig 1975;3(1): 26-8.

Author Information

Chandrakant Lahariya, MBBS
Resident, Department of Community Medicine, Lady Hardinge Medical College and Associated Hospitals,

Hyoti Khandekar, MD
Professor, Department of Community Medicine, Lady Hardinge Medical College and Associated Hospitals,

Joseph G. Prasuna, MD
Professor, Department of Community Medicine, Lady Hardinge Medical College and Associated Hospitals,

Meenakshi, MD
Resident, Department of Community Medicine, Lady Hardinge Medical College and Associated Hospitals,