Viewpoint

National Rural Health Mission (NRHM): Will it Make a Difference?

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Since independence, the country has created a vast public health infrastructure of Sub-centres, Public Health Centres (PHCs) and Community Health Centres (CHCs). There is also a large cadre of health care providers (Auxiliary Nurse Midwives, Male Health workers, Lady Health Visitors and Health Assistant Male). Yet, this vast infrastructure is able to cater to only 20% of the population, while 80% of healthcare needs are still being provided by the private sector(1). Rural India is suffering from a long-standing healthcare problem. Studies have shown that only one trained healthcare provider including a doctor with any degree is available per every 16 villages. Although, more than 70% of its population lives in rural areas, but only 20% of the total hospital beds are located in rural area. Most of the health problems that people suffer in the rural community and in urban slums suffer are preventable and easily treatable. In view of the above issues, the National Rural Health Mission (NRHM) has been launched by Government of India (GOI).

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What is NRHM

The National Rural Health Mission (2005-12) was launched in April 2005 by GOI. It seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or 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. GOI would provide funding for key components in these 18 high focus States(1).

The NRHM will cover all the villages in these 18 states through approximately 2.5 lakh village-based “Accredited Social Health Activists” (ASHA) who would act as a link between the health centers and the villagers. One ASHA will be raised from every village or cluster of villages, across 18 states. The ASHA would be trained to advise village populations about sanitation, hygiene, contraception, and immunization; to provide primary medical care for diarrhea, 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 rehydration; to give folic acid tablets and chloroquine to patients; and to alert authorities to unusual outbreaks. ASHA will receive performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other health care delivery programs(2).

Goals and strategies

The goals of the NRHM includes:

(*i*) reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR); (*ii*) universal access to integrated comprehensive public health services; (*iii*) child health, water, sanitation and hygiene; (*iv*) prevention and control of communicable and non-communicable diseases, including locally endemic diseases; (*v*) population stabilization, gender and demographic balance; (*vi*) revitalize local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH); vii) promotion of healthy life styles(1).

The strategies to achieve the goals includes (*i*) train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services; (*ii*) health plan for each village through Village Health Committee of the Panchayat; (*iii*) strengthening sub-center through an untied fund to enable local planning and action (each sub-center will have an Untied Fund for local action at Rs. 10,000 per annum. 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); (*iv*) provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH man-power, (*v*) preparation and implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition; (*vi*) integrating vertical Health and Family Welfare programs at National, State, Block, and District levels.

The duration of NHRM will be from 2005 to 2012. The total allocation for the Departments of Health and Family Welfare has been hiked from Rs. 8,420 crores to Rs. 10,820 crores. in the budget proposals for the year 2005-06.

Constraints in NRHM

However, the constraints in NRHM are:

(*i*) There is no data from pilot studies on the technical, operational and administrative feasibility of NRHM implementation in any state of the country. There is no corrective action plan in case of failures.

(*ii*) Increasing Budgetary allocation is not sufficient to ensure success of a program. For instance, for making institutional deliveries a reality it would require availability of all weather roads and transport facilities from the villages to the hospital where patient friendly trained proactive staff with support facilities are available to conduct the deliveries. However in reality, it would not be uncommon to find the SC/PHC / CHC tangentially located in a rural area because of the political consideration rather on population needs. Beneficiaries still have to travel long distances to reach these health centers to avail facilities. The strengthening of infrastructure such as the FRUs under CSSM and RCH-I programs remain under or non-utilized. The new mission is being launched without taking stock of our failures with previous programs.

(*iii*) The currently available regular village level health functionary (at a salary of Rs. 8-10 thousand per month) is infrequently available. It is envisaged that this lacunae will be bridged by ASHA, who being a local resident would be available in the village and act as a link in the provision of primary health care services to the community. Infact, the introduction of ASHA rather than enhancing the ANM's performance, may actually increase the existing indiscipline amongst the regular village level health functionaries. There appears to be some ambivalence in the role and location of the ASHA. She is to act as a bridge between the ANM and the village and, at the same time, she is to be accountable to the

panchayat. When the ANM (who is a functionary of the Health Department) herself is not accountable to the panchayat, how is the ASHA supposed to do the balancing act between the ANM and the panchayat?

ASHA and Voluntary Health Guide (VHG) scheme launched in 1977 are almost similar in characteristics and philosophy (people's participation in the care of their own health). The fate of the VHG scheme is well known. It is not clear if the lessons learnt from that failure have been taken into account when planning to launch the NRHM.

For village level health functionaries, a better vigil with inbuilt mechanism for prompt disciplinary action, including termination of job of the offender is urgently required, which should not be mixed up with politics and personal vendetta. Local populace and the care seekers have stopped airing their views and problems, which if at all are more often than not, never heard and no remedial action is instituted(3).

(*iv*) The NRHM ignores the urban population which constitute now more than 30% of the population. The health parameters in the urban population is similar or at times even worse.

(*v*) The mission has a high priority on training, especially as new components such as supply of AYUSH drugs have been added. According to the projections made, for an unit of 100 ASHAs which would be in each block of 100,000 population the total cost of training would be Rs. 741,500. In a district with 12-15 blocks, about 1 crore of Rupees will be available for training of ASHA. As with most programs in the past, a greater part of the mission's tenure will be spent on training with little or no time to assess the impact.

Optimizing success

A few suggestions that may help optimizing success of NRHM are:

(*i*) The NRHM should have active participation of academic community from Medical Colleges in the country. At least senior faculty member with interest in public health should monitor 2-3 districts and facilitate the implementation of the NRHM. The faculty of medical colleges should be given responsibility to visit the district and provide catalytic role in training of the ASHAs.

(*ii*) A system of concurrent evaluation of the Mission activities needs to be developed and data should be generated for undertaking immediate corrective action.

(*iii*) For implementation of NRHM, more flexible and be user friendly guidelines should be made for the State / District / Block rather than the central monolithic norms which are routinely issued by government of India. This would help in judicious utilization of funds. The benefits of the underprivileged population should be main considerations rather then procedural formalities while implementing the mission.

(*iv*) The ASHA should not be confined to dispensing services for a few selected vertical programs over the larger part of 12 months, as it will result in the neglect and erosion of other components of primary health care. A prime example is the erosion of routine immunization services related to intensive pulse polio immunization resulting in stagnation in under-5 and infant mortality and reemergence of vaccine preventable diseases such as diphtheria and pertussis(5-7).

(*v*) The ASHA should be given a reasonable sum to support herself and her family so that she should not be made subservient to the ANM and the anganwadi worker.

What is presently needed is developing a comprehensive strategy and deciding what are

our health priorities. Increasing budget and number of functionaries is not the answer to health problems faced by rural population. There is an urgent need of motivating and tightening of the regular health functionaries of the existing system. ASHA would be of great help to the remote villages but can not be a replacement of the regular trained health functionaries of the health system. If the health functionaries are busy for 8 month for one communicable disease and one micronutrient, all the other component of primary health care would definitely neglected.

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