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Ensuring Perceptible Transformations in Rural Health Sector: A Critical Study of Execution And Achievements of National Rural Health Mission

* Krishna Kant Sharma

* Doctoral research scholar, Department of PMIR, Patna University

ABSTRACT

This doctorate research examined the execution and achievements of National Rural Health Mission in the whole country intact during the year 2005-12. Research did not generate its own data however some perceptible transformation could see in form of increase in Immunization coverage, Outpatient & Inpatient department cases, Ambulatory services, Institutional deliveries. No polio cases reported for the year 2011-12. Institutional arrangements, Rogi Kalyan Samities, Janani Suraksha Yojna made the public health system lively and in addition, overall management improved considerably due to deployment of Program management units. States were categorized and poor performing states were highly focused.
Despite discrepancies persisted in form of dissimilar health indicators at national and international levels, corruption issues, HR practices, lack of work force, quality services and high stake of private health sector.

Keywords : Ensuring; Perceptible; Transformation; National Rural Health Mission

1. Introduction
The poor performance of the Indian Public Health System was not just easily perceivable but widely acknowledged through different agencies (WHO, 2010). NRHM was a major intervention of the Government of India unleashed in April, 2005 continued until March 2012 (MOHFW, 2005). NRHM aimed to correct the belongings and expected to address health determinants by establishing wide ranged convergences with relevant departments. Several reviews of NRHM had found it a successful program (MOHFW, 2011).

2. Methods:
Extensive literature review was a major part of this research along with case studies, interviews and e-mails data collection. The *Executive summary of NRHM* or *MIS on NRHM* (MOHFW, 2011) *was* a periodical source of secondary data which contained information about the account of *National Rural Health Mission* such as its execution, performance and achievements. In addition, other documents such as *Sample registration survey* of Registrar General of India (India, 2010), *Rural Health Survey* or *RHS Bulletins* (MOHFW,2010) of the Ministry of Health and Family Welfare, National Family Health Survey or NFHS (MOHFW, 2010), *District Level Household Survey* or *DLHS* (MOHFW, 2010) and ultimately the Census reports (Census, 2001)were important secondary data sources under this research.

The *World Health Organization Country's Health Statistics* was also utilized extensively under the research. All such data pertaining to two point of time i.e. 2005-06 and 2011-12 were taken, processed and analyzed to give findings. Data realized from qualitative methods were considered in terms of observations from the completely randomized survey within '*infinite universe'* as per *Grounded Theory* prior to give results (Glase, Locke, & Strauss, 2011).

There were three major components of this research firstly the execution, secondly the performance and thirdly the achievements of *NRHM*. All the three components were interdependent but required measuring through varied manner and approach. All the questions and hypothesis thus directed to substantiate those parameters.

The execution of *NRHM* was rightly measured through qualitative form of research involving Case studies and Interviews. The performance was largely measured by secondary data sources such as *MIS on NRHM, RHS Bulletins*. The achievements were also correctly measured through *SRS Bulletins*, *Census reports* and other secondary data sources such as *MIS on NRHM, NFHS reports* and *DLHS reports*. Therefore the methodological process and selection of literature and data is fully competent and could be beyond any reasonable doubt.

3. Findings:
Prearranged guidelines, action points and time line to implement NRHM were made available to respective states. Dedicated institutional arrangements at various levels were accomplished to carry forward the mission objectives and merger of societies also performed.

Massive deployment of work force, supply of logistics and creation of infrastructure resulted in some perceptible transformations, could be in form of marked increase in immunization coverage, OPD/IPD cases, Ambulatory services and Institutional deliveries. Provisions under the aegis of *Accredited Social Health Activists, Rogi Kalyan Samiti, Janani Suraksha Yojna* and *Indian Public Health Standards* had benefitted public health system great extent.

MIS on NRHM June 2011 stated that 833243 *Accredited Social Health Activists* were selected. Likewise almost 380 meetings of all the state health societies held in the country over the period of last six years which averaged almost 63 meetings each year. It indicated that almost 2-3 meetings of each state health societies held in the country in every year which almost according to the suggested pattern. Further almost 6363 meetings of the district health societies were held in the country over the period of last six years which almost averaged to about 1000 meetings per year. 27125147 village health and nutritional days organized up to June 2011, which was tremendous performance and it indicated the capacity of public health system to organize such events. 6833 health *melas* were organized over the last five years up to year 2010 that means almost 1400 health *melas* organized in the country each year on the average. Almost every state i.e. all the 35 states submitted their year wise program implementation plans. Similarly almost all the districts submitted their annual

district health action plans regularly. Thus flow of reports, plans, utilization certificates were highly commendable.

The immunization coverage was reported to be 43.50 percent as per *National Family Health Survey*-III data. No polio cases reported for a year January 2011 to January 2012 in the country. Almost 40 million women were benefitted under the *Janani Suraksha Yojna* program. The total number of institutional deliveries in the country since inception of *NRHM* had surpassed 113 million.

Program management units were constituted in all 35 states of the country at state level. Whereas in 625 district program management units were set up, in 628 districts District Program Managers were deployed, in 618 districts District Accounts Manager and in 539 districts Data Assistants were deployed in the country. In 3529, 3261 and 4525 Primary Health Centers Block Program Manager, Accounts Manager and Data Assistants were provided respectively in the country. In almost 636 districts and all the 35 states merger of societies took place. Number of *Rogi Kalyan Samities* registered for District Hospitals, Community Health Centers, First Referral Units and Primary health Centre were 599, 4210, 1136 and 17097 respectively in the country. Similarly 6862 Rogi Kalyan Samities were registered for other health facilities which included Additional Primary Health Centers. Number of prosecution and action taken under the Pre Natal Diagnostics Test Act were 706 and 462 respectively in the country. In 323 districts Integrated Management on Neonatal Child Illness (IMNCI) were implemented and 330526 persons were trained in the country on IMNCI. Number of districts which covered by Mother Non Governmental Organization scheme was 460 in the country.

The coverage of *NRHM* was extended to a 743 million population spread over 642 districts, 2502 sub divisions, 6348 blocks and 638588 villages of the country. 300 meetings of the State health missions/ societies and 6000 meetings of District health missions/societies were organized during the whole tenure of *NRHM*. A total number of 29904 *Rogi Kalyan Samities* were constituted in the country out of which 599 were at District Hospitals, 4210 at Community health Centre, 1136 at above block level but below district level, 17097 at Primary Health Centre and 6862 at other Health facilities above Sub Centre but below block level included Additional Primary Health Centre.

A total number of Additional Primary Health Centre, Primary Health Centre, Community health Centre & other Sub District facilities functional as 24X7X365 bases in the country was 16338 and 145920 HSCs were functional in the country out of which 79216 were in govt. building and 50728 were with second Auxiliary Nurse and Midwives. Total number of Primary Health Centre functional on 24X7X365 bases increased from a level of 1263 in the year 2005 to a level of 8717 in the current year. Similarly Community health Centre functional on the 24X7X365 basis increased to a level of 3942 from a level of 980 in the year 2005.

Number of Community health Centre selected for up gradation to Indian public health standards were 2921, number of Community health Centre for which facility survey was completed were 2864, number of Community health Centre for which physical up gradation started were 2051 and number of Community health Centre for which physical up gradation completed were 1141. Total Number of specialists at Community health Centre required as per rural health survey 2009 was 18040. Total numbers of posts sanctioned as per Rural health survey 2009 were 9028 and total number of specialists in position were 5789 whereas a total number specialists appointed on contract basis under *NRHM* were 1572.

All those efforts lead health indicators of the country being marvelously upgraded. The Infant mortality rate came down from a level of 62 in the year 2005 to a level of 50 in the year 2012. Similarly maternal mortality rate reduced to 300 in the year 2011 from a level of 360 in the year 2005. The bed availability and occupancy rate per 10000 populations rose smartly. Disease prevalence rate and cure rate improved significantly. Occurrence of polio was almost negligible. The infrastructure and logistics improved considerably in the tune of Indian Public Health Standards. The immunization coverage increased by almost 35 percent. The census reports 2011 also confirmed the achievements of *NRHM*. The population growth rate had declined by almost 5-6 percent. The decadal growth rate had come down from a level of 23 percent to 18 percent. Analysts presented a comfortable picture for the population stabilization believed to be achievable at least by the year 2044 or earlier. The sex ratio in the country improved to a level of 940 from 933 but in the age group 0-6 years it had come down to a level of 914 which was a matter of concern.

5. Conclusion:
Under the premises of above findings it could establish that though *NRHM* provided a platform for the public health sector of the country to take off despite job could not finish. Although NRHM had definitely put the country public health sector on the right track however it could not be fully given credit for positive changes in health indicators as there was a most formidable private health sector in the country and it was not analyzed that how much contributions made by public and private health sector respectively. Therefore research scholar would suggest developing methods to determine this.

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7. Declaration of conflicts:
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8. Vitae:
Author Mr. Krishnakant Sharma is a doctoral research scholar of Department of PMIR *(Formerly Department of Labour & Social Welfare)* Patna University and previously worked as Divisional Program Manager under the aegis of National Rural Health Mission with the Jharkhand Government.

REFERENCES

Census, I. (2001). Demographic tables and indicators. New Delhi: Government of India Census Publications. | Glase, B. a., Locke, K. 2., & Strauss, A. a. (2011). Grounded Theory: Cobined methods, using quantitative methods in a qualitative research. London: Open access publications. | GOI, M. (2010). Indian public health standards 2005 and revised draft 2010. pdf. Retrieved December 10, 2010, from Ministry of Health & Family Welfare: www.mohfw.nic.in/nrhm | MOHFW. (2010). 1st, 2nd and 3rd NFHS Reports. Retrieved January 2, 2012, from National Family Health Survey: www.nfhs.nic.in | MOHFW. (2011). Common Review Mission Periodical Reports. Retrieved December 3, 2011, from Ministry of Health & FW, GOI: www.mohfw.nic.in/nrhm | MOHFW. (2010). District level households survey (DLHS). New Delhi: Ministry of health & FW. | MOHFW. (2005). Framework of Implementation of NRHM. Retrieved December 8, 2011, from Ministry of Health & FW, GOI: www.mohfw.nic.in/nrhm | MOHFW. (2005). Institutional Arrangements Under NRHM.pdf. New Delhi: Health Ministry, Government of India. | MOHFW. (2005, April). Mission documents on NRHM. Retrieved January 10, 2011, from www.mohfw.nic.in | MOHFW. (2010). Rural Health Survey periodical bulletins. Retrieved January 3, 2012, from Ministry of health and family welfare, Government of India: www.mohfw.nic.in/rhs | Registrar General India. (2010). Sample Registration System Bulletin. Retrieved March 2010, from Registrar General of India: www.rgi.nic.in | WHO. (2005). World health organization countries ststistics India. Retrieved November 5, 2011, from World Health Organization: www.who.org/india