PROGRESS OF HEALTH CARE IN RURAL INDIA: A STUDY ON NATIONAL RURAL HEALTH MISSION

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Abstract

National Rural Health Mission (NRHM) was initiated in the year 2005 in Eleventh Five Year Plan, with the objective of providing quality health care services to the rural population. The mission brought out salient strategies by involving various sectors and forging partnerships with various organizations to unify health and family welfare services into a single window. Though the mission strived for a sustainable health care system, it did not envisage certain challenges in implementation. The public health system in India could take off from the foundations laid by the NRHM to overcome these challenges, in order to achieve various goals of health and development and put India on the road map of healthful development NRHM has been a mammoth effort by the Union Government to build the public health infrastructure of the nation. The mission deserves its credit for empowering the rural India in health care, especially in States with poor health related indicators. NRHM has been a pioneer in reiterating the need for community participation, coupled with intersectoral convergence, to bring about a paradigm shift in the indicators, which has been reasonably achieved in most of the States. Taking forward the foundations laid by the NRHM, it is essential for the forthcoming policies and plans to focus on capacity building, not only on the infrastructure and technical aspects, but also on streamlining the health workforce, which is crucial to sustaining the public health infrastructure. The public health system in India should take off from the foundations laid by the NRHM. There is an imminent need to focus on forging a sustainable public private partnership, which will deliver quality services, and not compromise on the principles and identity of the public health system of the country, in its pursuit to achieve universal health coverage and sustainable development goals.

Keywords: *Health Programme, Family Welfare, NRHM, Rural Health*

Introduction

The NRHM was launched in 2005 to provide accessible, affordable and accountable quality health services to rural areas with emphasis onpoor persons and remote areas. It is being operationalized throughout the country, with special focus on 18 states, which include eight empowered action group states (Bihar, Jharkhand, Madya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Odisha an Rajasthan, the eight north-eastern States, Himachal Pradesh and Jammu & Kashmir. Among major innovations of the NRHM are the creation of a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization at district level to improve intra and intersectroal convergence and effective utilization of resources through PRIs, NGOs and the community in general. The NRHM further aims to provide an overarching umbrella to the existing programmes including the reproductive Child Health Project (RCH – II), Integrated Disease Surveillance and other programmes for treatment of malaria, blindness, iodine deficiency, filarial, kalaazar, TB and leprosy by strengthenging the public health delivery system at all levels the SCs, PHCs and CHCs are proposed to be revitalized through better human resource management including provision of additional man-power, clear quality standards, revamping of existing medical infrastructure, better community support and untied funds to facilitate local planning and action so as to achieve the goals laid down in the National Population Policy 2000. Further, the Mission, in a sector-wide approach addressing sanitation and hygiene nutrition and safe drinking water as basic determinants of good health seeks greater convergence among the related social, sector departments, i.e., AYUSH, Women and Child Development, Sanitation, Elementary Education, Panchayati Raj and Rural Development. The expected out-comes of the Mission include reduction of IMR to below 30 per 1000 live births, MMR to below 100 per 1,00,000 live births and TFR to 2.1 by 2012

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Environmental Pollution

The world pollution, having its origin in the Latin word pollutionem (means to defile or make dirty), is the act of polluting the environment. Environmental pollution is defined as the unfavourable alteration of our surroundings wholly as a by product of man's activities, through direct or indirect effects of changes in the physical, chemical and biological characteristics of the land, air or water that harmfully affect human life or any desirable living thing. Human population explosion, rapid industrialization, deforestation, unplanned urbanisation, scientific and technological advancement, etc., are the major causes of environmental pollution.

Classification of Pollution

Pollution may be classified in different ways as follows:

According to the Source: It may be classified as natural May also result in the diminished number of blood cells (cyopenia) and even total none morrow loss. Benzene exposure is said to introduce genetic changes in extreme cases.

Indiscriminate use of fertilisers and pesticides, other health hazards, has already started showing its negative results. According to a study, more than 140 varieties of pesticides are currently in use in the country. The levels of DDT in the bone tissue to an average Indian is the highest in the world- averaging really 20 times that of an Australian, a Canadian and a British national.

Accumulation of Harmful Substances in Food Chain: Experiments and empirical evidence reveals of chemical substances tend to concentrate at each successive trophic level with the result that an animal placed at the highest trophic level has the highest quantity of chemical substances in its body. For example DDT, an insecticide, has highest concentrations in humans who are placed at the end of the foodchain.

Catalytic Converters: catalytic converters convert the carbon monoxide to relatively onon-toxic carbon dioxide, water vapour and nitrogen. It may be emphasised that carbon dioxide is normally not an atmospheric pollutant except under very high concentration. Catalytic converters, thus help bring down pollution caused by the vehicle emissions.

Gas Masks: The gas masks worm in the polluted places use the common adsorbents –a mixture of activated charcoal with reactive chemicals, caustic soda fused with pumice stone, fused calcium chloride and silicia gel. They help remove most kinds of fumes and toxic gas from the air.

Ultra-Low-Sulphur Diesel: Also known as ULSD, it contains 0.005 per cent sulpur - nearly 100 times lower than the sulphur content in diesel being used in india. Near elimination of the sulphur content is not only technically difficult but a very costly affair. Indian refineries need, as per one estimate, more that Rs.15,000 crores to bring about an improvement in the quality of petrol and diesel to meet stringent emission norms.

Water Pollution

With the advancement of civilisation man used large volumes of agricultural and industrial materials, most of which end up as waste products in the rivers and ocean and thus affects aquatic life of both plants and animals. Main water pollutants are mercury, lead, D.D.T., chlorinated hydrocar-bons, radioactries, city sewage etc.

Minerals and organic wastes are carried to the rivers, streams, lakes and the seas from agricultural fields where fertilisers, pesticides and herbicides are given throughout the year. Drinking of such water by cattle and human beings causes serious diseases. Industrial discharges also contain heavy metals like copper, chromium, cadmium, mercury and lead which get transformed into more toxic compounds. Industrial wastes and sewage disposal are the biggest contributors to water pollution. Due to industrial water pollution, there is oxygen depletion in water which kills the aquatic animals and sewage water pollution spreads a number of epidemic diseases, e.g. cholera, dysentery, diarrhoea, infectious hepatitis and jaundice.

Soil Pollution

With the increase of population, there is more requirement of food and thus extensive cultivation of land. For higher productivity, more chemical fertilisers are used. Different kinds of pesticideds and insescticides are used to protect crops, which lead to loss of productivity of soil in long run.

Indiscriminate Use of Fertilisers Leads to Groundwater Contamination

What happen is that when fertilisers are added to the soil, the plants absorb not only the extra nitrogen, phosphorous and potassium from the fertilisers but also proportionately increased levels of micro-nutrients, (zinc, iron & copper) from the soil. Over a period of time, the soil becomes deficient in these macronutrients. This deficiency in turn retards the plant's capacity to absorb the fertilisers. To make up the shortfall, more and more fertiliser is added to the soil. This excessive use leaches into the ground water contaminating it.

According to one study, more that 18,500 million litres of water gets polluted in India every day. Of this only 400 million litres I streated and the rest finds its way to the

streams, lakes and water bodies to further contaminate aquatic resources.

Therefore increased agricultural activity has created an imbalance in nature. Soil erosion, unplanned irrigation, overgrazing, deforestation and other defective agricultural practices lead to formation of deserts.

Phytoremediation: The process of cleaning up heavy metal contamination by the use to plants is called phytoremediation. Plants store the metals in their body or convert them into volatile form that can be released into the air. The process is made up of three components: photoextraction, where the plant roots and shoot accumulate heavy metals; rhizofiltration, where roots absorb heavy metals and phyto-stabilisation, where the plants immobilise contaminants in the soil and ground water. The plants that are used to absorb the contamination are finally cut-off from the problem areas and burned or composited to recycle the elements.

Noise Pollution

Various kinds of undesirable loud sounds, which disturb the environment are called noise pollutants. Noise pollution is produced by loud sounds of various machine, loudly played transistor, radio, thundering of jet plane, automobiles etc. Noise has an adverse effect on the mind, health and behaviour of a man. It increase nervous tension, blood pressure and heart trouble. Noise also cause physical discomfort and temporary or permanent damage to our hearing capacity.

The Objective of NRHM Mission

The main objectives of NRHM was to provide accessible, affordable, effective, accountable, and reliable health care to the entire rural population in the country with special focus on 18 states (8 North Eastern states + 8 empowered action group (EAG) states [socioeconomically backward states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh] + 2 Hilly states (Himachal Pradesh, Jammu & Kashmir) which have weak public health indicators.

The Objectives of NRHM

- Reduction in the Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR).
- Universal access to public health services such as women's health, child health, water, sanitation & hygiene, immunization, and nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH. 7. Promotion of healthy life styles.

National Rural Health Mission (NRHM)

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State of 'Public Health' Prior to NRHM

The public health expenditure in India had declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Government's contribution to public health expenditure was 15% and the State's contribution was 85%. The National Health Accounts (NHA) 2004-05 data shows that at the State level, 38% of health expenditure is spend on primary health care, 18.67 % on secondary

health care, 21.84 % on tertiary health care and rest on direction and administration and other services.

This has not been changed substantially by 2008-09 as per the National Health Systems Resource Centre (NHSRC) budget tracking report. The share of State expenditure (TN) on primary health care services, secondary health care and tertiary health care were at 38%, 39% and 8%. As per the budget tracking study done by NHSRC, the increase in own share of health budget over the previous year was 5%.5

Most states spend around 4 to 5 % of the state budgetary outlay on health and less than 1% of the GSDP on health which is insufficient to meet the NRHM goals. The total public expenditure on health in the country as a percent of GDP stands at around 1.1% in 2009-10 from 0.96% in 2005–06. The current public spending is roughly 1% of the GDP and there is an urgent need for rising to 2-3% of the GDP. 4 The twelfth five year plans needed to address these constraints creatively–especially the central problem of efficiency in resource allocation to districts and within districts. Having said that it needs to provide a much larger resource envelope to all states for them to be able to achieve their goals of the total health expenditure, the share of private sector was the highest with 78.05%, public sector at 19.67% and the external flows contributed 2.28%. Out-of-pocket spending accounts for over 95% of total private health spending and 71.13 % percent of total health spending in India, which is one of the highest, even amongst lowincome countries. The high out-of-pocket expenditure on health care forms a barrier to accessing care and can cause households to incur catastrophic expenditures, which in turn can push them into indebtedness and poverty.

According to a recent article published in Lancet, health expenditures account for more than half of Indian households falling into poverty, with about 39 million Indian people (30.6 million in rural areas and 8•4 million in urban areas) being pushed into poverty every year due to health costs. Also, the curative services were in favour of the non-poor and over 40% of the hospitalized individuals borrow heavily or sell their assets to cover the hospitalization costs.

The other key issue was the lack of community ownership of public health programmes, which had impacted the efficiency, accountability and effectiveness in implementation of these programmes. Moreover, vertical health and family welfare programmes had limited synergisation at implementation levels. There was a strong need to synchronize several preventive and curative public health services such as sanitation, hygiene, nutrition and drinking water. Above all, population still remained a challenge, especially in states with poor demographic indicators.

The Implementation of NRHM

The implementation of NRHM was planned by strengthening the following components by working inco-ordination with the State Governments, Panchayati Raj institutions and NGOs.

- Training Accredited Social Health Activist (ASHA) to bridge the health care providers and the community.
- Strengthening sub centers with provision of untied fund and essential drugs
- Strengthening primary health centers to provide 24 hours services with standard treatment guidelines and protocols
- Strengthening community health centers as first referral units (FRU) by promoting Rogi Kalyan Samiti
- District health plan
- Converging sanitation and hygiene under NRHM g) Strengthening disease control programmes
- Public private partnerships (PPP) for public health goals and regulation of private sector
- New health financing mechanisms
- Re-orientation of medical education (ROME)

Conclusion

NRHM has been a mammoth effort by the union government to build the public health infrastructure of the nation. the mission deserves its credit for empowering the rural India in health care, especially in States with poor health related indicators. NRHM has been a pioneer in reiterating the need for community participation, coupled with intersectoral convergence, to bring about a paradigm shift in the indicators, which has been reasonably achieved in most of the States.

Taking forward the foundations laid by the NRHM, it is essential for the forthcoming policies and plans to focus on capacity building, not only on the infrastructure and technical aspects, but also on streamlining the health workforce, which is crucial to sustaining the public health infrastructure. There is also an imminent need to focus on forging a sustainable public private partnership, which will deliver quality services, and not compromise on the principles and identity of the public health system of the country in its pursuit to achieve universal health coverage and sustainable development goals.

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