IMPACT OF NATIONAL RURAL HEALTH MISSION (NRHM) ON THE HEALTH SECTOR IN HARYANA

Pritam
Research Scholar
Department of Physical Education
Maharshi Dayanand University, Rohtak, Haryana, India.

Abstract: The main aim of the present study to find out the impact of National Rural Health Mission (NRHM) on the health sector in Haryana. The National Rural Mission (NRHM) was launched by the Hon’ble Prime Minister Dr. Man Mohan Singh on 12th April 2005, to provide accessible, affordable, equitable and quality health services to the poorest households in the rural region of the country. The NRHM covers the entire country with special focus on 18 states where the challenges if strengthening poor public health system. National Rural Health Mission (NRHM) is not a first programme on rural health in independent India, even than the enthusiasm and attention of the heath personnel and people towards the programme is phenomenal. The attempts to improve rural health through various programmes were started as early as in 1940, when the British government in India set up ‘Bhore Committee’ to find out the way to improve the health of people. This was followed by a number of other committees and programme i.e. Balwant Rai Mahta Committee, community Development programme and Basic need programme.

I. INTRODUCTION

Health is necessity to the nation progress. Nothing could be greater significant than the health of people in terms of resources for socio-economic development. In spite of this realization, the people living in have little or no access to modern medical and health care. This results in high rate of morbidity and mortality from diseases (Goel, S.L., 1980). In India, the health care services and facilities available are highly haphazard in nature. Some areas have more health facilities, available than the need of that particular area whereas majorities of areas have more demands for services. Thus, there exist disparities not only in rural and urban areas but also within rural and urban areas of different states of India (Mayer, I.A., 2008, p.133). The reality of easily accessible quality health care in rural India remains a myth. There are 74% of rural women are suffer from anemic even today. Only 21 percent of rural population has access of safe and sustained source of drinking water (Kumar, R., 2007, p.58). Development of health care sector is a great challenge to India, since this is a vital sector and faces several problems, which includes vast population, paucity of resources and non- availability of affordable health care to the poor. Improvement in health status of people has been one of the major thrust areas for the social development progress of the country. Article 47 of Indian Constitution states that the “the State shall regard raising the level of nutrition and standard of living of its people and improvement in public health among its primary duties.” (Article 47, Constitution of India, 1950).

Good health is a major resource for social, economic and personal development and an important dimension of quality of life (International Union for Health Promotion and Education, 2000). In recent years, there has been considerable concern about human development and among other factors; health is a vital indicator of human development. Article 25 of the Universal Declaration of Human Rights unequivocally states that the preservation and promotion of health is one of the basic human rights. India, despite being a signatory the Alma Ata Declaration (1978), which aimed at “Health for All” by 2000. The Indian government started many programme to provide healthcare facility to all. The National Rural Health Mission is also one of them. The Government of India launched this programme National Rural Health Mission (NRHM) on 12th April 2005; to provide comprehensive and effective primary health care to the unprivileged and vulnerable sections of the society especially women and children by improving access availability and quality of public health services. The key strategies of the mission includes ensure intra and intersectoral convergence ,strengthening public health infrastructure , increasing community participation, creating a village level cadre of health workers, fostering public-private partnerships, emphasizing quality services and enhanced programme management inputs. The plan of action of the Rural Health Mission aims at reducing regional health imbalance in health outcomes by relating health to determinants of good health. Further the mission aims at increasing the outreach...
of the health system from the sub-centre level to village level by providing a trained and Accredited Social Health Activist (ASHA) per thousand population as in Anganwadi set up. The present system of health planning and management is uniform for state level. The National Rural Health Mission (NRHM) seeks to provide effective health care to rural population throughout the country with special focus on 18 states, which have weak public health indicators weak infrastructure. These 18 states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.

II. Meaning and Definition of Health

There is no agreed definition of health; In fact, there have been many definitions. To the laymen, health implies a sound mind in sound body, in a sound family, in a sound environment. The widely accepted definition of health is that given by the World Health Organization (1948) which states: “Health is a state of complete physical, mental and social well-being not merely an absence of diseases or infirmity”. In 1986, the WHO, in the Ottawa Charter for Health Promotion, said that health is “a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical resources”. The Health Survey and Development Committee (1946) rightly points out that “the term health implies more than absence of sickness in the individual and indicates a state of harmonious functioning of the body and mind in relation to his physical and social environment, so as to enable him to enjoy life to the fullest possible extent and to reach his maximum level of productive capacity”.

III. Commissions and Committees on Health in India

Although a number of commissions and committees have been set up in India since the mid nineteenth century to survey the existing conditions and health organization and to make recommendations for their future development but up to what extent they have been succeeded in their tasks, can only be known by going through them. An attempt has been made to throw some light on the major committees and commissions regarding the health care facility.

Health Survey and Development Committee (Bhore Committee) 1946: The Government of India appointed this committee in 1943 to survey the then existing health conditions and health organization in the country and to make recommendations for future development. It was Bhore committee also known as Health Survey and Development committee. The main recommendations of the Bhore committee were:-

1. No individual should fail to serve adequate medical care because of his inability to pay for it.
2. The health services when fully developed should provide facility necessary for the proper diagnosis and treatment of diseases and for its presentation.
3. In order to provide widest possible integrated health services to the people, the committee put forward valuable recommendations on subject like environmental sanitation, personal health, community health, control of communicable diseases, mental health, vital statistics, professional education and research on health.

Mudaliar Committee (1962): In 1959, the Government of India instituted a “Health Survey and Planning Committee” collect the Mudaliar committee to survey the progress made in the field of health since submission of the Bhore committee’s report to make recommendations for future development and expansion of health services. The Mudaliar committee found that quality of services provided by primary health centres inadequate and stressed the need to strengthen the existing primary health centre’s before new centres are created. The main recommendations of the Mudaliar committee were:-

1. Rural medical care problem cannot be solved by merely establishing primary health centre without proper staff and equipment.
2. For control of communicable particularly water borne diseases.
3. On the question of medical education emphasis should be more on the quality than the quantity.

Chadha Committee (1963): Chadha committee was appointed under chairmanship of Dr. M.S. Chadha the then Director General of Health Services, to advise about the necessary arrangement for the maintenance phase of National Malaria Eradication Programme. The committee suggest that the vigilance activity in the NMEP should be carried out by basic health worker (one per 10,000 population), who would function as multipurpose workers and would perform, in addition to malaria work, the duties of family planning and vital statistics data collection under supervision of family planning health assistants.

Mukherjee Committee (1965): The committee was appointed by the Government of India to review the strategy for the family planning programme. The major recommendations of the committee were:-

1. There should be separate staff for family planning programme and the family planning assistants should look after planning work exclusively.
2. The basic health worker should not be utilized for the family planning programme.

Jungalwalla Committee (1967): This committee known as “Committee on Integration of Health Services” was set up in 1964 under the chairmanship of Dr. N. Jungalwalla, the then Director of the National Institute of
Health Administration and Education (currently NIHFHW). It was asked to look into varies problem related to integration of health services, and the service condition of Doctors. The committee defined “Integrated health services” as:-

1. A service with a unified approach for all problems instead of segment approach for difficult problems.
2. Medical care and public health programme should be put under change of a single administrator at all level of hierarchy.

Following steps were recommended for the integration at all levels of health organization in the country.

1. Unified Cadre
2. Common Seniority
3. Recognition of extra qualification
4. Equal pay for equal work
5. Special pay for special work
6. Abolition of private practice by government doctors
7. Improvement in their service condition.

**Kartar Singh Committee (1973): Kartar Singh** Committee popularly known as committee on Multipurpose workers under Health and Planning. The recommendations were:-

1. The structure for integrated services at the peripheral level.
2. Creation of multipurpose worker and supervisors both male and female to work at the peripheral level for providing integrated medical public health and family planning services to the people.

**The Srivastava Committee (1975):** This Committee was appointed by Government of India in 1974 under the chairmanship of Dr. J.B. Srivastava, the then Director General of Health Services. The committee located the basic ills of our health policy and medical education. A major contribution of the Srivastava Committee was the involvement of community health workers. There were about 1.40 lakh community workers in the field as on 1st April 1980; by 1985 the government of India expected to raise them to 3.60 lakh community health volunteers.

**The Ramalingaswami Committee (1980):** The Committee reports correctly note that in the last thirty years, the capacity for change and progress was wrongly equated in India without capacity to reproduce the western style of institutions services and values. The Committee suggested that health for all cannot be achieved through a liner expansion of the existing system and even by tinkering with it through minor reforms. The committee advocated nothing short of a radical change and called for a comprehensive national policy for health.

**Bajaj committee (1986):** An “Expert Committee for Health Manpower Planning, Production and Management” was constituted in 1985 under Dr. J.S. Bajaj, the then professor at AIIMS. Major recommendations were:-

a. Formulation of national Medical & Health Education Policy.
b. Formulation of National Health Manpower Policy
c. Establishment of an Educational Commission for Health Sciences (ECHS) on the lines of UGC.
d. Establishment of Health Science Universities in various States and Union Territories.
e. Establishment of health manpower cells at Centre and in the States.
f. Vocationalisation of education at 10+2 levels as regards health related fields with appropriate incentives, so that good quality paramedical personnel may be available in adequate numbers.
g. Carrying out a realistic health manpower survey.

**IV. STUDY AREA- HARYANA**

Haryana state is selected as a study area for research work. It is located between the 27°37' North to 30°55' Northern latitude and 74° 28' East to 77° 36' Eastern longitude. Haryana state was formed on 1 November 1966, on the recommendation of the **Sardar Hukam Singh** Parliamentary Committee. The formation of this committee was announced in the Parliament on 23 September 1965. On 23 April 1966, acting on the recommendation of the Hukam Singh Committee, the Indian government set up the Shah Commission under the chairmanship of Justice J. C. Shah, to divide and set up the boundaries of Punjab and Haryana giving consideration to the language spoken by the people. The commission gave its report on 31 May 1966. According to this report the the districts of Hissar, Mahendragarh, Gurgaon, Rohtak, and Karnal were to be a part of the new state of Haryana. Further, the tehsils of Jind (district Sangrur), Narwana (district Sangrur), Naraingarh, Ambala and Jagadhari were also to be included. Geographically it is one of the smallest states of India spread over 44212 KM² area and accounts 1.37 percent of country’s total area. According to 2001 census state account 21 million person populations. Both states share a common capital Chandigarh, which is a union territory also. At present state have 21 districts, 47 sub divisions, 67 tehsil, 45 sub tehsil and 116 blocks. The state has 81 cities and 6759 villages.

**V. SIGNIFICANCE OF THE STUDY**

Health problem in a developing country like India is paramount. India is second most populous country of the world. In India, the majority of people living in rural areas, are poorly served and at best receive only
rudimentary healthcare. Above 70 percent population of India is living in rural areas but about 75 percent of healthcare infrastructure, medical manpower and other health resources are concentrated in urban areas where 27 percent of population live. Contiguous, infections and waterborne disease such as diarrhoea, typhoid, infectious hepatitis, worm infestations measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. The health status of Indians, is still a cause for grave concern, especially that of rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100000 live births).

According to the latest report of the National Sample Survey Organisation (NSSO) 2005 report, three out of every thousand rural households do not get enough to eat. The report added that at all India level three rural households per thousand do not get enough to eat in any month of year (Ojha, 2006:29). There is also shortage of medical personnel in rural areas. A regional disparity in health institution is a big problem in rural India. Due to lack of health infrastructure in rural area, there is high infant mortality rate and high crude death rate in India compare to developed countries. In India, Public expenditure on health is low. Pandey (2007) pointed out that the government spending .9% of GDP on public health. This expenditure is fifth lowest in the world after Nigeria, Sudan, Indonesia and Myanmar.

Haryana state is also poor in terms to provide good health quality to rural areas. In Haryana 71 percent population is inhabited in rural areas. Infant mortality Rate (SRS 2008) is high in Haryana than the national average. Health infrastructure is not growing as requirement. According to RHS Bulletin March, 2008, there is shortfall in health Infrastructures like Sub-centre, Primary Health Centre, MPH/W/ANM, Doctor at PHCs, Physicians, Pharmacist, mid-wife etc. Many programme and policy started to improve health quality of people those live in rural area. The Government of India launched the National Rural Health Mission (NRHM) on 12th April, 2005 to provide comprehensive and effective primary healthcare to the unprivileged and vulnerable section of the society especially women and children by improving access availability and quality of public health services. The significance of this study to improve health quality in rural area and remove the regional disparities of health care facilities in Haryana. Above review of literatures reveals that there is no research has been done on its merits and demerits of above mission at micro level, meso or macro level. However, an attempt has been made to analyse how NRHM has helped to improving health facility in rural Haryana.

Haryana state has a small size with 1.37 percent of area of the total geographical area of the country and it has 1.97 percent population of the country. It is located between the 27° 37' north to 30° 55' Northern latitude and 74° 28' east to 77° 36' Eastern longitude. The sex ratio recorded is 861 females per 1000 males, inhabited in 6,955 villages and 106 towns spread over 42,212 sq. km. The density of population recorded as 477 persons per sq. Km. There are 67.9 persons are literate. Nearly 122.25 lakh persons are literate and educated from 11,235 primary schools, 2,170 Middle schools, 4,494 Senior Secondary schools, 237 degree colleges and 5 Universities. Haryana has mostly plain surface except some hills in northern part which is part of Shiwalik and some fragmented hills of Arawali range are found in southern part of state. The climate of the state is similar to other states of India which are situated in northern plain. The climate is arid to semi-arid monsoon type with the annual rainfall of 45 centimetres. In the south western part of the state semi deserted climate is also found. Temperature in this region varies from season to season. In winter season December and January temperature is found very low, sometime it found below the freezing point. But in summer season region become very hot and sometime temperature found above 45° C. There is a large deposits of alluvial soil found in the region. But the sub-mountainous area is generally hilly in nature; the soil cover over hills is very thin. In the southern part of the state, soil is sandy and deserted topography. Sand dunes are found in the south-western districts of the state and in the middle part soil is very fertile. Economically Haryana state is very advanced; it is one of the highest per capita income’s states of the country. There is a general picture of National Rural Health Mission (NRHM) in India. This study discussed about the National Rural Health Mission on all India level. This study shows the categorization of the state under different category like; high focus non-North Eastern States, High focus North Eastern States, Non-focus Large States and Non-focus Small states and Union Territories. This study also discussed about the three tier system of health centre in rural areas of India like; Sub-centre (SC), Primary Health Centre (PHC), and Community Health Centre (CHC). This study also discussed about the objective of National Rural Health Mission in India and the coverage under National Rural Health Mission. National Rural Health Mission cover 74 crore population, approximately 14.8 crore households, 1, 75,000 sub-health centers, 27,000 primary health centres, 7,000 community health centres, 1,800 sub- divisional hospitals, 600 district hospitals, 3,50 lakh auxiliary nurse midwives (ANMs), 1,44,000 staff nurses and 4 to 5 lakh accredited social health activist (ASHAs). This chapter also describes about the strategies of National Rural Health Mission, Infrastructure under National Rural Health Mission, Financing of national Rural Health Mission.

VI. Objectives

Objectives of present study are:-
(1) To find out difference in healthcare facilities before and after NRHM.
(2) To find out the impact of NRHM on healthcare facilities.
sources, apart from this, various publications like statistical work which helps in scientific descriptive and explanation of reality. A systematic approach has been followed. Various statistical techniques have been adopted to represent the data; mean, standard deviation and choropleth maps.

Major Findings: The major findings of the study are as follows:-

- Arurvedic, Yoga, Unani, Siddha and Homeopathic (AYUSH) institution on per lakh population decrease from 2000-01 to 2008-09. Fatehabad was in the high category in 2000-01 but it came down in moderate category in 2008-09. There were 10.53 percent districts under low category of AYUSH Institution on per lakh population in 2000-01 but there are 20 percent districts under low category of AYUSH Institution on per lakh population in 2008-09. Thus there is no progress of AYUSH Institution under National Rural Health Mission.

- Number of AYUSH Medical Personnel on per lakh population are slowly increasing from 2000-01 to 2008-09. There is increase of medical personnel on per lakh population in Rohtak and Panchkula district. There were 10.53 district were under high category of AYUSH medical personnel on per lakh population in 2000-01and now in 2008-09 there are 15 percent districts under the high category.

- Doctors and specialist on per lakh population increase from 2000-01 to 2008-09. There were 84.21 districts under low category of doctors and specialists on per lakh population in 2000-01 and in 2008-09 only 20 percent district are under low category. On the other hand there were only 5.26 percent district in high category but in 2008-09 there are 15 percent districts under high category. Thus, there is impact of National Rural Health Mission on doctors and specialists on per lakh population.

- Staff nurses and auxiliary nurse midwives (ANMs) on per lakh population also increase from 2000-01 to 2008-09. There were 26.31 percent district under low category in 2000-01 and in 2008-09 there are only 10 percent districts under this category. On the other hand 36.84 percent districts were under the moderate category in 2000-01 and in 2008-09 there are 55 percent districts under this category. So there is noticeable impact of NRHM on staff nurses and ANMs on per lakh population.

- There is no improvement in beds on per lakh population from 2000-01 to 2008-09. There were 63.15 district were under low category of beds on per lakh population in 2000-01 and in 2008-09 there are 70 percent districts under this category . Districts also decrease from the high category of beds on per lakh population. There were 10.52districts under high category in 2000-01 but in 2008-09 there is only 5 percent district under this category. So, we can say that National Rural Health Mission has no significant impact on beds on per lakh population.

- There is no progress in increase of medical institution on per lakh population from 2000-01 to 2008-09, rather it decrease from 2000-01 to 2008-09. There were 31.57 district were under low category of medical institution on per lakh population in 2000-01 and in 2008-09 there are 40 percent district under low category .There were 47.36 percent districts under high category in 2000-01 and in 2008-09 but in 2008-09 there is only 10 percent district under high category of medical institution on per lakh population.

- There is some progress in area covered by per institution from 2000-01 to 2008-09. There were 36.84 percent district under low category of area covered by per institution in 2000-01 but there are 55 percent district are under this category in 2008-09 .Thus we can say that National Rural Health Mission has some impact on area covered by per institution.

- Study found that National Rural Health Mission has significant impact on AYUSH medical personnel on per lakh population, doctors and specialist on per lakh population, staff nurses and ANMs on per lakh population and on area covered by per medical institution.

- Study shows that NRHM has no impact on the AYUSH institution on per lakh population, Medical institution on per lakh population and Beds on per lakh population.

- Study found that there is progress under National Rural Health Mission in man power in health sector like; doctors and specialist, staff nurse ANMs, and AYUSH medical personnel but there is no
progress in construction of new medical institution, new AYUSH institution and no progress to facilitate new beds to medical institution.

**Suggestion:**
- There should be more AYUSH Institution in rural area for good health care facilities in rural areas.
- There should be more medical institution on per lakh population. Construction of new medical institution should be in progress.
- To remove the regional disparities in health sector government should give good facility like road, doctor residents, and hospitals to backwards districts also.
- Government should fill the vacant post of doctors and nurses in medical Institutions.
- Districts like Mewat, Sirsa, Bhiwani and Mahendragarh have low facility of road, doctor residence, and medical institution; there should be constructed new medical institution and should fill up the vacant post of doctors and staff nurses.
- There should also be a proper transfer system of doctors and nurses from developed district to backward district. Because of this, they (Doctors and Nurses) have to go in districts like Mewat, Bhiwani, Sirsa and Mahendragarh.
- Government should assists who build medical institution/hospital in the district like Mewat, Bhiwani, Sirsa and Mahendragarh.
- The problems of unavailability of doctors can be redressed if we depute doctors who are trained under Indian system of medicine.
- Adequate funds should be allocated for the construction of residential quarter for doctors and other medical staff with basic minimum facilities.
- Govt. should improve co-ordination with NGOs and private sector organisation.
- Public expenditure on health should be increased to improve the health care facility.
- Doctors should be encouraged to provide their services in rural areas by providing some incentives.
- Priority should be given deprived districts to minimize regional imbalances in the health care services.

In the last it may be concluded that there is a little and marginal impact of National Rural Health Mission on health care facilities even after 5 years of implementation. It has also been noticed that there is some progress in manpower like; doctors, specialist, staff nurse, auxiliary nurse midwife (ANMs) and AYUSH medical personnel but there is no progress in construction of new medical institution and other facility like; beds, laboratory and residential quarters etc. under national Rural Health Mission.

**Bibliography**