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A Critical Assessment of National Rural Health Mission (NRHM) for Rural Health Security in Uttar Pradesh

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ABSTRACT

India has registered significant progress in improving health condition of the people over the last few decades. In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. National Rural Health Mission (NRHM) has launched in 2005 to improve the health system and the health status of the rural people. However, studies have revealed that the lack of awareness about this programme, depriving the potential benefits to the people. So the present study entitled "National Rural Health Mission (NRHM) for rural health security: a critical assessment" was undertaken to assess the programme effectiveness in terms of peoples' awareness, participation, satisfaction and constraints faced by them in harnessing the benefits from the programmes. The study was conducted in Kashi Vidyapeeth block of Varanasi district of Uttar Pradesh. The findings of the study revealed that 66.67% of respondents has medium level of awareness and 55.83 per cent of the respondents had expressed their satisfaction about the services rendered by NRHM.

Keywords NRHM, Awareness, Participation, Satisfaction, Constraints, Medicating Facilities and Rural People

INTRODUCTION

Health System in India is oriented towards curative Health. Despite the five decades of unprecedented progress in the health sector and health indicators, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition.,

In order to promote the interventions to bring sustained change in the behaviour of the community, the National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005. The mission intended to adopt synergistic approach by relating Health to determinants of good health viz. nutrition, sanitation, hygiene and safe drinking water. The Mission seeks to provide accessible, affordable and quality health care to rural populations, especially vulnerable and underserved population groups in the Country.

So keeping in view the the important contribution of NRHM to the well being of the people, the present study entitled ***"National Rural Health Mission for rural health security: a critical assessment"*** was undertaken to assess the peoples' awareness, participation, satisfaction and constraints faced by them in harnessing the benefits from the programmes.

METHODOLOGY

The study was conducted in purposively selected CD (Community Development) block, Kashi Vidyapeeth in the Varanasi district of Uttar Pradesh, India. There are 8 blocks in Varanasi district. Kashi Vidyapeeth block was selected purposively for the study because the NRHM are successfully implemented in this block for benefiting the rural population. There are 130 Villages in the Kashi Vidyapeeth Block of Varanasi district. Eight Villages namely *Gajadharpur, Madhopur, Tikari, Bhitari, Chitauni, Maheshpur, Bishunpur and Harpalpur* were randomly selected. Through proportionate random sampling techniques 15

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per cent of beneficiaries were selected from each village. Thus a total of 120 respondents were selected for the purpose of study. Action research was applied. To see the effectiveness of interventions an interface between Block officials and villagers were organized in the selected villages. Printed literatures related to the developmental programmes was prepared and distributed to the villagers. Effect of interventions was measured in terms of awareness by applying before after experimental design among respondents about developmental programmes. The required information was collected through structured interview schedule. Collected data was tabulated and analyzed by using statistical techniques like frequency, percentage, mean, standard deviation and correlation. Some important statistical details related to demography and available health infrastructures of the sample area have been presented in Table 3.

RESULTS AND DISCUSSION

Level of awareness of people about National Rural Health Mission

A perusal of Table 1 revealed that 66.67 per cent of the beneficiaries belonged to medium level category before the interventions followed by low level (24.16%) and 9.17 high level of awareness and after interventions, 77.50 per cent of the respondents possessed medium level of awareness whereas 22.50% of the respondents were having low level of awareness indicating that interventions significantly influenced the awareness level of respondents.

Table 1 Distribution of respondents according to their level of awareness about various developmental programmes

Category	Awareness level (Mean ± SD)	Frequency	Percentage
BI* NRHM			
	Low (Below 3.23)	29	24.16
	Medium (Between 3.23-11.23)	80	66.67
	High (Above 11.23)	11	9.17
AI NRHM**			
	Low (Below 6.64)	27	22.50
	Medium (Between 6.64-15.64)	93	77.50
	High (Above 15.64)	00	00.00

(NRHM) BI* = Before Interventions Mean =7.23, SD = 4.00
(NRHM) AI** After Interventions Mean =11.14, SD = 4.50

Findings related to awareness about various aspects of NRHM have been presented under Table 2 reflects that majority of the respondents were aware about the general aspects of the programme but they were little aware about the specific aspects necessitating the government interventions to create awareness among the people residing in rural areas/remote areas to promote, restore or maintain the health status through meticulously designed policy, plan and programme.

Table 2 Respondents awareness about various aspects of NRHM programmes

Awareness components	Awareness percentage			
	BI*		AI**	
	F	%	F	%
NRHM programme was enacted in 2005 by Central government	83	69.20	108	90.00
The main goal of this programme is to provide universal access of qualitative health services to the rural people in an affordable manner.	66	55.00	86	71.67
The main objective of the NRHM is to reduce Infant/maternal mortality Rate (IMR/MMR), Prevention and control of communicable and non communicable diseases among rural households.	59	49.20	92	76.67
NRHM give special attention on 18 States which have weak public health indicator/infrastructure.	15	12.50	86	71.67
ASHA would acts as interface between community and public health system and responsible to provide health facilities at door steps to rural people.	93	77.50	103	85.83
Every habitat that has population of 1000, there is a provisi on of one trained ASHA to vigil and serves the health facilities.	14	11.67	64	53.33
Under this programme there is a provision of establishing a Rogi Kalyan Samiti for rural community.	65	54.20	85	70.83
District health implementation plan are prepared at district level.	39	32.50	78	65.00
NRHM strengthen the PHCs, CHCs through adequate and regular supply of modern essential quality drugs and equipments.	89	74.20	102	85.00
NRHM helps in strengthening and implementing the other disease control programmes.	93	77.50	102	85.00
Under NRHM there is a provision of Mobile medical Unit (MMU) in each district.	29	24.16	72	60.00
This programme assumes to reduce 50% Malaria mortality Rate by 2010 and 60 % by 2012.	69	57.50	101	84.17
Village He alth and Ayush Committee are responsible for preparing the village health plan.	38	31.70	88	73.33
All health related developmental plan that are prepared at district level are implemented at village level	88	73.30	98	81.67
The central government allocate budget directly to state level agency.	29	24.20	76	63.33

BI= Before Interventions, AI= After Interventions, F= Frequency, %= Percentage

Level of participation

Level of participation was measured through structured interview-schedule. The result reflects that active and empowering participation were lacking among the respondents.

Table 3 Distribution of respondents according to their level of participation

Level of Participation	Frequency	%
Nominal participation	34	28.33
Passive participation	27	22.50
Consultative participation	23	19.17
Activity- specific participation	18	15.00
Active participation	10	8.33
Interactive(empowering) participation	08	6.67
Total	**120**	**100**

Satisfaction of respondents about NRHM

Findings with regard to the level of satisfaction of respondents with various aspects of NREGA have been presented in Table 4. It is clearly reflected that 55.83 per cent expressed their satisfaction from NRHM. Out of that 15.83 per cent were highly satisfied and 40 per cent were satisfied. The main reason of their satisfaction was services rendered by ASHA and Rogi Kalyan Samiti; attempts to rejuvenate the traditional health care practices and facilities provided under NRHM. This finding is partially supported by **Bora & Baruah (2012)** and **Saraswati *et al.* (2008).** The respondents showed their dissatisfaction on facilities provided through MMUs (Mobile Medical Units); medication served under PPPs (Ponnusamy, 2013); work performed by Village Health Committee (VHCs); efforts are being made for preventing/ controlling the communicable/ non communicable diseases and medication facilities provided under single window system. In this regard it is suggested that NRHM officials should pay their attention on above issues so that the needy people can easily receive the benefits from NRHM.

Table 4 Distribution of respondents according to their level of satisfaction from NRHM

Level of satisfaction	Frequency(F)	Percentage (%)
Highly satisfied	19	15.83
Satisfied	48	40.00
Not satisfied	53	44.17

Perceived constraints in NRHM

It is evident from the Table 5 that respondents experienced constraints relating to Mobile Medical Unit, proper sanitation in villages even after establishment of Rural Health and Sanitation Samiti under NRHM, lack of appropriate information dissemination process regarding population control measures and lack of appropriate medication facilities available to prevent/ control the spreading of communicable diseases. The incentives given to ASHAs were very meager and it generated a bias in their work activities and has shifted to the attention of these community health workers from the community to the health service system (Joshi and George, 2012). Majority of the respondents had perceived constraints towards services provided under NRHM. Therefore, adequate remedial measures should be undertaken to promote, restore or maintain the health status of its population through meticulously designed policy by effectively implementing, monitoring and evaluating them to yield targeted results in respect of health care mechanisms (Ponnusamy et al., 2017). It can be suggested that some more Primary Health Centers must be established in rural areas equipped with modern medicating facilities to provide better services to the people belonging to BPL.

Table 5 Distribution of respondents according to their perceived constraints towards NRHM

Constraints	F	%*	%**
Women Health Activists (WHA) does not perform their duties properly and not do not visit village frequently	83	9.06	69.2
Lack of proper sanitation in villages even after establishment of Rural Health and Sanitation Samiti under NRHM	112	12.36	93.3
Hijack of the benefit of Janani Suraksha Yojana by upper class family	77	8.50	64.2
Lack of Infant care facilities at PHCs	67	7.40	55.8
Lack of 24×7 Medical facilities at village level	106	11.70	88.3
Mobile Medical Unit (MMUs) does not reach to diseased person	118	13.02	98.3
Appointed Doctors do not perform their duty properly and devote their maximum time in private hospitals	91	10.04	75.8
The appropriate medication facilities are not available to prevent/ control the spreading of communicable diseases	86	9.49	71.7
Lives saving drugs at Primary Health Centers (PHCs) are not available in required quantities	77	8.50	64.2
Lack of appropriate information dissemination process regarding population control measures	89	9.82	74.2

*Percentage of multiple responses (N=906),
**Percentage of respondents (N=120)

CONCLUSION

NRHM encompasses the principle of *'health for all'* and after its launching, people residing in remote areas could access basic health care and led to multiple effects on the society. In order to further encourage and ensure full community participation, effective propagation of relevant information along with both preventive and curative strategies and mobilization of additional resources are needed. Increase in literacy and development of the necessary institutional arrangements like public private partnership through which individual, family and community can assume responsibility for their health and well being. Capacity building of health staff needs to be initiated at the earliest and multi skilling of doctors need to be given high priority.

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