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RESEARCH ARTICLE

MISSING THE BUS ON HEALTH-RELATED MDGS IN INDIA: PROGRESS OF NATIONAL RURAL HEALTH MISSION

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ABSTRACT

Millennium Development Goals (MDGs) were adopted in September 2001 by 147 countries including India. Out of 8 MDGs, 3 MDGs were directly related to the health and under the framework of MDGs, Government of India set ambitious targets for reduction in maternal and child mortality by 2015. In 2005, Government of India launched, National Rural Health Mission (NRHM) to strengthen the health infrastructure & services in rural areas, particularly in 18 high priority states. NRHM was expected to make significant contribution in achievement of MDGs. Though NRHM made significant contribution in strengthening of health infrastructure in rural areas of focused states, however the key targets in-terms of reduction in MMR, IMR and TFR were not achieved.In 2015, world has accepted Sustainable Development Goals (SDGs) to address global development challenges and facilitate sustainable development across the countries. However, in order to ensure that the health-related SDGs doesn't meet the same fate as that of MDGs in the country, it is vital that lessons are learnt from the non-achievement of health related MDG goals and are incorporated in the relevant policies & programmes.

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INTRODUCTION

After getting independence in 1947, though a vast network of public health facilities were setup in the India, but there were large gaps in meeting the health need of the people particularly in rural areas (Kapil & Choudhury, 2005). Even after significant improvement in reduction of maternal and infant mortality, it still remains quite high (Agarwal, 2005). Globally, India contributes around 22.2% of total under five mortality and 25.7% of maternal mortality (Agarwal, 2005) which shows the urgent need of taking actions to strengthen the public health system in the country and to reduce the high under five & maternal mortalities. Millennium Development Goals (MDGs) were endorsedin September 2001 by 147 heads of states. Out of 8 MDGs, 3 MDGs were directly related to the health with focus on reducing child mortality, improving maternal health and combating HIV/AIDS, malaria & other diseases (World Bank, 2004).

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Under the framework of MDGs, goals for reducing the burden of different diseases were fixed including target of reducing the maternal mortality to 109 per 1,00,000 live birth (437 per 100,000 live birth in 1990), infant mortality to27 per 1,00,000 live birth (80 per 100,000 live birth in 1990) and under 5 mortality to 42 per 1000 live births (125 per 100,000 live birth in 1990) was set (Government of India, 2015).

Launch of National Rural Health Mission (NRHM)

In order to strengthen the health infrastructure & services in rural areas, particularly in 18 high priority states (states with higher poverty and poor socio-economic indications) and to achieve the MDG goals, National Rural Health Mission (NRHM) was launched in 2005 by Government of India (Kapil & Choudhury, 2005). The key strategies proposed under the NRHM were increasing the Government's funding on health from 0.9% of GDP to 2-3% of GDP; provision of female health worker in each village; strengthening the existing health facilities and construction of new health facilities as per the population norms set in the Indian Public Health Standards (IPHS); integration of different disease control, reproductive

health and family welfare programmes; improving community's involvement in planning and monitoring of health services; providing additional human resources in the health facilities as per the client load (NRHM mission document, 2005). Though health is a State subject in India however NRHM was primarily funded by Central Government and Centre contributed 75% of total budget & States contributed rest of the 25% budget (Sarma & Bhattacharyya, 2015). The key outcomes which were planned to achieve by 2012 were reduction in infant mortality rate (IMR) to 30/1000 live births, reduction in maternal mortality ratio (MMR) to 100/100,000 live births and reduction in total fertility rate (TFR) to 2.1 (NRHM mission document, 2005). NRHM was initially launched for 8 years from 2005 to 2012 however after 2012, it was extended to cover urban areas too and was renamed as National Health Mission (Government of India, 2012).

METHODS

A desk review of the progress of the NRHM in the country was undertaken using the available data from different sources including National Family Health Surveys (NFHS), Sample Registration Surveys (SRS) and Annual Health Surveys (AHS). Besides that, interaction with Senior Health Officials were done at national, state & district levels to understand their perspective and issues related to implementation of NRHM in the country.

RESULTS

Progress under NRHM in the Country

During the period of 2000-2015 and specially after launch of NRHM in 2005, there has been significant improvement in availability and uptake of health services in the country. The launch of NRHM made significant contribution in strengthening health infrastructure in the rural areas in the country and in improving uptake of health services. This is also reflected in improvement of indicators related to maternal and infant mortality for the country (Government of India, 2015). A mid-term assessment done in 2010 by Government of India shows that around 7.50 lakh field level female health workers, 75000 nursing staffs, 15000 paramedic staffs and 19000 doctors were supported through NRHM in the States. Also, around 10,500 health facilities were newly constructed and 12,500 health facilities were renovated across the country. Besides that, in order to improve the community's participation around 4.5 lakh village health level health & sanitation committees were formed. An analysis done by Narwal & Gram (2013), shows that after launch of NRHM, the average annual reduction rate of IMR in rural areas improved to 3.4% in comparison to 2.8% in pre-NRHM period.

In terms of achievement of target set, under the framework of MDGs, related to maternal mortality and child mortality, the maternal mortality reduced to 167 in 2011-13 and as per the trend, it was expected to reduce to 140 per 1,00,000 live births by 2015 (Government of India, 2015), but still it was 31 points more than the target of 109 maternal deaths per 1,00,000 live births expected to be achieved by 2015. Similarly, in terms of achievement of target related to under five mortality among children, India was found lacking and under five mortality reduced to 50 per 1000 live births in 2015-16 (NFHS-4) and it was 8 points more than the target of 42 deaths per 1000 live births expected to be achieved by 2015. Also, the IMR reduced to 41 per 1000 live births in 2015-16 (NFHS-4) against the target of 27 per 1000 live births. However, India did better in terms of achieving the goals set under MDG 6 regarding the halting and reversing the spread of HIV/AIDS, malaria & other diseases. The prevalence of HIV/AIDS and malaria has shown a continuous decline over the period 2000-2015 (Government of India, 2015).

DISCUSSION

Reasons for Slow progress towards achievement of Health related MDGs in India

Launch of NRHM was an ambitious step by Government of India to overhaul the public health system in rural India and it was able to make significant contribution in improving availability & uptake of health services. It also led to increase in rate of decline of maternal and under five mortality in the country. However, it was unable to achieve some of the key goals set in the NRHM's mission document (GoI, 2005) including of reduction in IMR to 30/1000 live births, MMR to 100/100,000 live births and Total fertility rate (TFR) to 2.1. As per the Government of India (2015), MMR in the period 2011-13 was 167, IMR in 2015-16 was 41 (NFHS-4) and TFR in 2015-16 was 2.2 (NFHS-4). The achievement of goals related to decline of maternal and child mortality, under the framework of MDG, were missed. Some of the key challenges related to implementation of public health programme, which hindered the achievement of the MDGs were -

Lack of required financial resources: One of the key requirement for achieving any policy objective is ensuring availability of required financial resources. The NRHM's mission document (GoI, 2005) set the target of increasing government's spending on health, as proportion of GDP, to 2-3%, which is still much lower than expenditures on health by developed countries & some developing countries like Brazil (GoI, 2015). However as per the Economic Survey of India (2012–13), government's spending on health, as proportion of GDP, has only increased from 1.27% to 1.36%, during the period 2007-13. The shortage in funding had negative impact on the programme implementation at all level and hampered the ability of implementers to achieve the set goals.

Infrastructure gaps: Availability of sufficient infrastructure is one of the basic requirement for any large-scale initiative. After the launch of NRHM, though there has been significant increase in the number of the health facilities however the availability of basic facilities and quality of services in some of these facilities remains a challenge (rural health statistics, 2012). Around 12% of Primary Health Centres (established at the population of 25000) and 28% of sub-centres (established at the population of 5000) doesn't have regular water supply; besides that, 14% and 29%, respectively also lacks electricity and 8% of both the facilities lacks all weather, motor-able approach road (Duran et al, 2014). As sub-centres and primary health centres are the primary contact point for the rural population, hence, lack of basic facilities in these centres severely hampered the provision of quality health services among the rural masses.

Shortage of human resources: Another major challenge faced in the provision of quality health care under NRHM was severe shortage of human resources specially at specialist's level. As

per the rural health statistics (Government of India, 2014), 26% positions of doctors in primary health centres were vacant and in community health centres against the requirement of 21,452 specialists (Paediatricians, Physicians, Obstetricians & Gynaecologists and Surgeons), only 4,091 specialists were in-position, hence the gap was as high as 81%. Also the data from rural health statistics (2014), shows that there is significant variation among the states and the situation is far worse in the tribal (indigenous people) areas. This resulted in lack of quality health care services in many parts of rural India and also in facilities were positions were partially vacant, existing staffs were overburdened which contributed in lowering the quality of services.

Lack of inter-sectoral coordination: The issue of child survival or reducing maternal mortality requires coordination between different sectors and department including education, health, sanitation & nutrition. The effective coordination between different concerned departments was very important to facilitate effective implementation of NRHM at field level. However, in India the coordination between the concerned departments are severely lacking and it has also contributed in non-achievement of goals in terms of reduction in IMR and MMR (Lenka & Kar, 2012). This has also contributed in failure of NRHM to achieve the desired goal set in the mission document.

Corruption: Rampant corruption is also a major issue which affects the availability and quality of services. It leads to either leakage of resources or additional out of pocket expenditure from patient or even both. As per the Transparency International, India was ranked 95th among the 183 countries surveyed on a corruption perception index. As per a study, Lokayukta (a constitutional post established to deal with corruption) in Karnataka has estimated that around one-quarter of the total state's health budget is siphoned off because of rampant corruption at different levels (Sudarshan & Prashanth, 2011). These gaps led to non-achievement of most of the gorals related to MDGs which country expected to achieve after launch of NRHM. These gaps led to the constraint in delivering services & failure in ensuring optimum utilization of resources.

Conclusion

Though there has been significant decline in maternal & childmortality in the country, the above mentioned implementation issues have resulted in non-achievement of MDGs & key milestones set at the time of launch of NRHM. In 2015, world has accepted Sustainable Development Goals (SDGs) to address global development challenges and facilitate sustainable development across the countries. However, in order to ensure that the health-related SDGs doesn't meet the same fate as that of MDGs, it is vital that lessons are learnt from the non-achievement of health related MDG goals and are incorporated in the relevant policies & programmes. In order to facilitate universal coverage of health in India, it is very important that existing gaps in planning and implementation of health programmes are addressed. This would require ensuring availability of sufficient physical and human resources &effective implementation with commitment from all stakeholders.

REFERENCES

Agarwal SP. 2005. Towards Achieving Millennium Development Goals in the Health Sector in India. Journal Indian Academy of Clinical Medicine;6 (4): 268-74.

Duran A, Kutzin J, Menabde N. 2014. Universal coverage challenges require health system approaches; the case of India. Health Policy.,114: 269–77.

Government of India. Constitution of India - Part IV: Directive principles of state policy; 1950 [cited 25th July 2016]. Available from: http://india.gov.in/govt/constitutions of india.php

Government of India. Millennium Development Goals: India Country Report. Social Statistics Division, Ministry of Statistics and Programme Implementation 2015.

Government of India. National Rural Health Mission - meeting people's health needs in partnership with States, the journey so far. Ministry of Health & Family Welfare 2010.

Government of India. Special Bulletin on Maternal Mortality in India 2010-12. Sample Registration System, Office of Registrar General 2013.

Government of India. SRS Bulletin. Sample Registration System, Registrar General, India 2013; 48(2).

Kapil U. Choudhury P. 2005. National Rural Health Mission (NRHM): Will it make a difference?. Indian Paediatrics; 42: 783-86.

Lenka S R, Kar SS. 2012. Effective Implementation of National Health Programs: Issues and Challenges. National Journal of Medical Research, 2 (4); 528-29.

Narwal R. Gram L. 2013. Has the Rate of Reduction in Infant Mortality Increased in India Since the Launch of National Rural Health Mission? Analysis of Time Trends 2000-2009 with Projection to 2015. International Journal of MCH and AIDS; 2 (1): 139-52.

Sen G. 2012. Universal Health Coverage in India; a long and winding road. Economic and Political Weekly; 46 (2): 45–52.

Sudarshan H, Prashanth NS. Good governance in health care: the Karnataka experience. Lancet 2011; 377(9768):790-92.

World Bank. 2004. The Millennium Development Goals for Health: Rising to the Challenges.

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