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# NRHM - the panacea for rural health in India: a critique

Vikas Bajpai*, Anoop Saraya**

*PhD Scholar, Centre for Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.
** Prof Dept. of Human Nutrition and Gastroenterology, All India Institute of Medical Sciences, New Delhi.

ABSTRACT

There has been news of the Central Government's flag ship rural health care scheme - National Rural Health Mission (NRHM) being given an extension till 2015; albeit there is little talk of what we have learned from the experiences of NRHM till now so as to remove the bottle necks in its implementation. After seven years of implementation NRHM has failed to achieve its stated objectives. This calls for a scrutiny of this failure. This article analyzes fundamental conceptual dilemmas inherent to the Mission to draw lessons for future. The most important lesson that ought to be learnt is that 'the health of the people is not a standalone phenomenon that can be improved through healthcare alone. It requires a comprehensive action plan encompassing food security, employment and poverty alleviation as well.'

**Key words:** NRHM, Mission, ASHA, NGO, health

Corresponding Author: Vikas Bajpai, PhD Scholar, Centre for Social Medicine and Community Health

Jawaharlal Nehru University, New Delhi.

Contact: drvikasbajpai@gmail.com

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## Introduction

There have been reports of late to the effect that the Central Government's flag ship program to improve rural health in India – the 'National Rural Health Mission' has got an extended lease of life until 2015.[1] Surprisingly enough, there has been little public discussion as regards the achievements of NRHM – 1 in alleviating the health of rural India, let alone the lessons drawn for future health planning. It seems that the lack of enthusiasm on extension of NRHM is not after all without reason. One need only compare the achievements of NRHM against what the mission set out to achieve, to figure out the this absence of enthusiasm.

## Taking Account of the Goals and Achievements

### Achievements versus Targets

The health planners in the country set out to turn around the health of the rural India through NRHM. However, for all practical purposes the mission's thrust was on ensuring substantial improvement in the Reproductive and Child Health (RCH) indicators. Accordingly then the entire public health machinery was geared towards ensuring the success of 'Janani Suraksha Yojna' (safe birth scheme) that aimed for increasing the institutional deliveries as the key strategy for achieving the set targets for the RCH indicators – the maternal and infant mortality; as also better adoption of family planning interventions to reduce the total fertility rate (TFR). The underlying presumption was that Institutional deliveries are "safe" deliveries both for the mother and the child and hence are expedient in reducing maternal mortality and the crucial neonatal mortality, thus impacting on the infant mortality rate. The self assured nature of this strategy can be judged from table 1 which lists the achievements against the targets for the important RCH parameters. [2]

This however, is only a small part of the picture. The larger picture is that the Empowered Action Group

(EAG) States of Assam, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttrakhand, which have had the worst public health outcomes, seem to have benefited much less from NRHM.[3] Rather than the prophecy come true, the gap in public health indicators of EAG States and the better performing States of South India and Maharashtra has either remained static or has actually increased, as can be seen from table 2.

It can be seen from table 2 that even as the gap between EAG States and the better performing States (as judged by the ratio between the two) has only marginally declined for the MMR, while that for TFR has remained the same. The most alarming finding is that the gap (ratio) for IMR between the EAG States and the better performing States has actually increased.

**Infrastructure Deficits**

Figures 1a to 1c give an account of the status of rural health infrastructure as on March 2010. This infrastructure is as against the required 2001 census population norms. Naturally, by March 2010 the actual required strength of infrastructure as per the increased population is much higher than the existing infrastructure.

It can be seen from figure 1a that the deficit in the number of sub-centers in Bihar, Jharkhand and Uttar Pradesh is close to as much as a fourth of the required strength. In figure 1b Bihar, Jharkhand and Madhya Pradesh have more than 25% shortfall of PHCs, with Uttar Pradesh also have a crucial shortfall of 16%. The shortfall of PHCs for Jharkhand is as high as 59%. It is noteworthy that with such crucial deficit in health infrastructure, Jharkhand still managed an IMR less than its parent State Bihar in 2010 (see notes of table 2). There can be genuine doubts regarding the authenticity of such estimates of health parameters.

For the CHCs the shortfall for Assam and Uttar Pradesh is around 50%, while that for Bihar is a whopping 89%. On all India basis and the targets set to be achieved by NRHM, the present infrastructure is way off the required strength. Likewise existing strength of sub-divisional hospitals throughout India is approximately 50% short of the NRHM target. It is prudent to remember that the excess number of facilities observed for some of the States might be excess only with respect to the 2001 population norms; however, when judged by the 2011 population norms, this surplus could easily disappear.

Three things need be specified here; one, the kind of deficits in infrastructure observed for large States like Bihar and Uttar Pradesh, can easily pull down the all India averages for the health outcomes given the sheer size of the population of these States. Secondly, it need be remembered that deficit in one type of facility cannot be overcome with larger number of another kind of facility because the functions and roles of sub-centers, PHCs and the CHCs have been devised in a manner as to serve as a referral system with the higher level of facility supporting the functioning and supervision of the lower level facilities.

Thirdly, physical existence of a facility alone does not ensure its successful functioning in the absence of adequate facilities and manpower. For example, the proportion of sub-centers without electricity and running water facility was 28.5% and 27.8% respectively as on March 2010. The respective proportion for PHCs was 14.2% and 12.4%. The number of PHCs and CHCs not working as per the IPHS (Indian Public Health Standards) norms was 11.8% and 16.6%. This proportion is of the existing PHCs and CHCs and not that of the required strength, which means that de facto number of functioning PHCs and CHCs gets further reduced by 11.8% and 16.6%.

**Manpower Deficit**

Needless to say that the shortage in all grades of manpower (medical and paramedical) remains acute in the rural health set up in India. Doctors are supposed to be the team leaders of the peripheral health care workers vested with the responsibility of guiding, supervising and monitoring the health care work in the peripheral areas.

As on March 2010, there were 42,584 allopathic doctors (M.B.B.S / M.D. / M.S. / B.D.S) working in the rural health institutions in India. As per the Medical Council of India, as in 2010, 335 medical colleges in the country produced a total of 40,525 (medical graduates, M.B.B.S) every year, [10] while the number of dental graduates passing out from 213 dental colleges, as in 2007, is approximately 17,320. [11] Hence, as per the available estimates the country produces a total of 57,845 allopathic medical graduates (M.B.B.S and B.D.S) every year.

The rural population in the country stood at 833 million as per the 2011 census. This implies that there were only 42,584 doctors (much less than the number of medical graduates passing each year) available through the peripheral health services to ensure the health of 833 million Indians living in the rural areas. This amounts to a doctor – patient ratio of 1: 19561.4 for the rural areas as compared to the overall doctor patient ratio for the country that stood at 1: 2000. [12] The latter is further deterioration of the doctor patient ratio of 1: 1722 in 2005. [13] This deterioration of the doctor patient ratio itself is a comment on the impact of

NRHM in health care delivery.

The deficit in infrastructure and manpower raises legitimate doubts regarding the quality of services provided. As per government of India's own admission, of the 8473 24 X 7 PHCs, only 44 % provide the three essential services of managing normal deliveries, common obstetric complications and essential new born care, while the number of FRUs providing full complement of obstetric services is only 39%. [2]

Based on the aforementioned facts, the question naturally arises - was NRHM a package capable of rejuvenating rural health care in India? If not, then where are the fault lines?

**Table 1: Achievements in major RCH indicators against the targets set in NRHM.**

| RCH II Goal Indicator | All India Figure (source of data) | | | RCH II NRHM Goal (2012) |
|---|---|---|---|---|
| **Maternal Mortality Ratio (MMR)** | 398 (SRS 1997-98) | 301 (SRS 2001-03) | 254 (SRS 2004-06) | < 100 |
| **Infant Mortality Rate (IMR)** | 71 (SRS 1997) | 60 (SRS 2003) | 55 (SRS 2007) | < 30 |
| **Total Fertility Rate (TFR)** | 3.3 (SRS 1997) | 3.0 (SRS 2003) | 2.7 (SRS 2007) | 2.1 |

Source: NRHM 6th Joint Review Mission.

**Table 2: RCH indicators – the EAG States versus the better performing States.**

| Indicator | Year | Assam | Bihar | M.P. | Odisha | Rajas. | U.P. | Maha. | T.N. | Kerala |
|---|---|---|---|---|---|---|---|---|---|---|
| MMR | 2005 | 480 (4.3) | 312 (2.8) | 335 (3) | 303 (2.8) | 388 (3.5) | 440 (4) | 130 | 111 | 95 |
| | 2007-09 | 390 (4) | 261 (2.7) | 269 (2.8) | 258 (2.7) | 318 (3.3) | 359 (3.7) | 104 | 97 | 81 |
| IMR | 2005 | 68 (1.7) | 61* (1.6) | 76* (2) | 75 (1.9) | 68 (1.7) | 73* (1.9) | 36 | 39 | 14 |
| | 2010 | 58 (2.4) | 48** (2) | 62** (2.67) | 61 (2.6) | 55 (2.3) | 61** (2.6) | 28 | 24 | 13 |
| TFR | 2008 | 2.6 (1.5) | 3.9 (2.3) | 3.3 (1.9) | 2.4 (1.4) | 3.3 (1.9) | 3.8 (2.2) | 2 | 1.7 | 1.7 |
| | 2010 | 2.5 (1.5) | 3.7 (2.2) | 3.2 (1.9) | 2.3 (1.4) | 3.1 (1.8) | 3.5 (2.1) | 1.9 | 1.7 | 1.8 |

Note: The figures in parenthesis are ratio of the MMR / IMR / TFR of the concerned State and the corresponding value for the State of Tamil Nadu, taking the figure for Tamil Nadu as the mean of better performing States. With respect to MMR the figures for Bihar, Madhya Pradesh and Uttar Pradesh for the years 2005 and 2007-09 include those for the States of Jharkhand, Chhattisgarh and Uttrakhand respectively. *The IMRs for Bihar, Madhya Pradesh and Uttar Pradesh for 2005 include the IMR for the States of Jharkhand, Chhattisgarh and Uttrakhand respectively as separate statistics for 2005 are not available. **The IMR of Bihar, Madhya Pradesh and Uttar Pradesh for the year 2010 do not include the figures for Jharkhand, Chhattisgarh and Uttrakhand that were carved out of these States respectively. This may increase ratio (EAG State/Tamil Nadu) as the new States of Jharkhand, Chhattisgarh and Uttrakhand had slightly lower IMR (42, 51 & 38 respectively) than their parent States for the year 2010. Nonetheless, the respective ratios for the other three States show an unambiguous increase.

Source: MMR for the year 2005 is from 'National Health Profile, 2009 – Demographic Indicators [4], while those for the year 2007-09 have been obtained from 'Special Bulletin on Maternal Mortality in India 2007-09. [5]. The State wise IMRs for the year 2005 have been obtained from 'Economic Survey 2007-08' [6], while those for the year 2010 have been obtained from SRS Bulletin, Vol. 46(1): 3. [7]

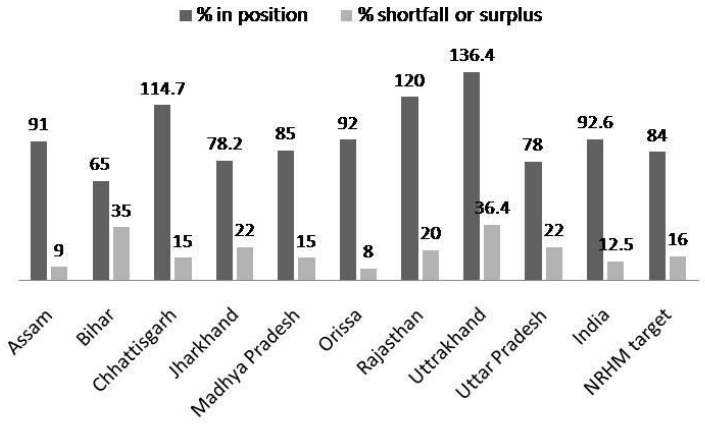
The required number of sub-centers, PHCs and CHCs as per the 2001 population norms are given in the tables shown along with the figures. The bars for in position facilities denoting figures of more than 100 indicate surplus over and above the required number. Accordingly then the shorter bar indicates the proportion of surplus facilities.

## NRHM IN THE CONTEXT OF PRIVATIZED HEALTH CARE

Health policies and health care systems cannot be divorced from the larger socioeconomic and political environment of the day. It is this environment which defines the value system and the moral underpinning of societal institutions that shape the construct of policy paradigm and its implementation.

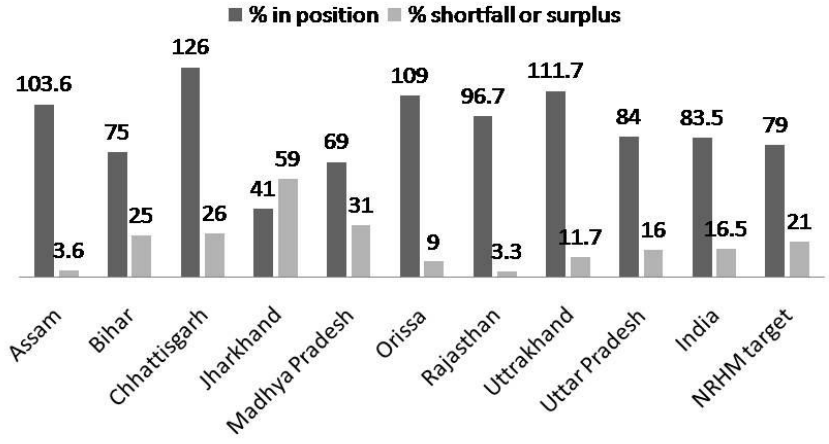
This holds equally true of NRHM.NRHM was launched at a time when 'Neo-liberal' policy paradigm constituted the dominant economic and social thinking of the day. The policy regimen emphasizing policies of privatization, liberalization and globalization,

**Fig 1a: Sub-centers: In position and shortfall /surplus as on March 2010**



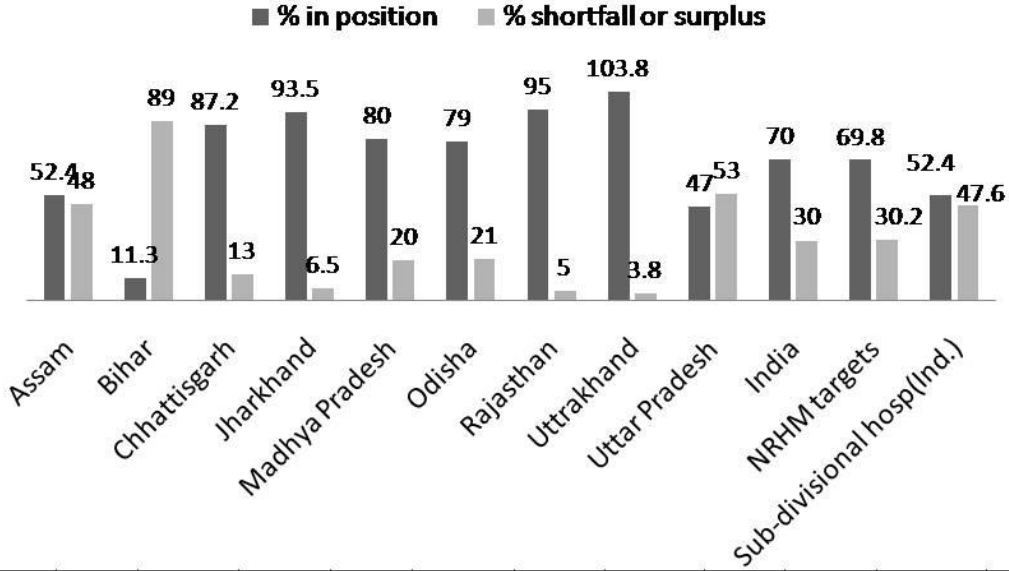

| | Assam | Bihar | Chhat-tisgarh | Jhar-khand | M.P. | Odisha | Rajas. | Uttra-khand | U.P. | India | NRHM target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No. req. | 5,063 | 14,959 | 4,164 | 5,057 | 10,402 | 7,283 | 9,554 | 1,294 | 26,344 | 1,58,792 * | 1,75,000 |

**Fig 1b: PHCs: In position and shortfall /surplus as on March 2010**




| | Assam | Bihar | Chhat-tisgarh | Jhar-khand | M.P. | Odisha | Rajas. | Uttra-khand | U.P. | India | NRHM target |
|---|---|---|---|---|---|---|---|---|---|---|---|
| No. req. | 826 | 2,489 | 569 | 806 | 1,670 | 1,171 | 1,555 | 214 | 4,390 | 1,58,792 | 1,75,000 |

**Fig 1c: CHCs & Sub-divisional hosp (All India): In position and shortfall /surplus as on March 2010**




| | Assam | Bihar | Chhat-tisgarh | Jhar-khand | M.P. | Odisha | Rajas-than | Uttra-khand | U.P. | India | NRHM target | Sub-div Hosp (India) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. req. | 206 | 622 | 164 | 201 | 417 | 292 | 388 | 53 | 1,097 | 6,491 | 6,500 | 1,800 |

Source: All statistics for the figures except NRHM targets have been compiled from Rural Health Statistics in India 2010, Ministry of Health and Family Welfare. [8] NRHM targets have been obtained from Ministry of Health and

Family Welfare. 'National Rural Health Mission: Meeting people's health needs in rural areas, Framework for Implementation 2005-2012. [9]

Note: * In figure 1a there is discrepancy in the total number of sub-centers in position in India and the shortfall in the number of sub-centers. However, the proportions of in position and shortfall are based on the figures provided in table 11 of the Rural Health Statistics in India, 2010. The figures given for the number of sub-centers required, those in position and the shortfall in the referenced table are 158792, 147069 and 19590 respectively.

referred to as 'New Economic Policies' (NEP), that has reigned supreme over the last two decades, increasingly legitimized healthcare as a source of profit rather than a welfare obligation of the State towards the people. It is not that private healthcare came into being with the initiation of these policies. Indeed, the preeminent healthcare institutions constituted of the publically funded government medical colleges in the country directly fed into the large pool of private healthcare practitioners rather than recruit or train them for managing the rural healthcare system of the country. [14] This process had been going on since the time of the transfer of power in the country in 1947 and by the decade of the 80s had led the private healthcare constituted of the individual practitioners, small nursing homes and the few trust managed tertiary care

hospitals and a vast number of the non-formal practitioners to become the dominant part of the healthcare delivery system in the country. [14] However, private healthcare still remained the domain of small scale individual entrepreneurs.

It is NEP that created the environment conducive for large scale corporate investments in healthcare, directly aided and abetted by the government in the form of publically funded subsidies and public-private partnerships under the guise of making these corporate hospitals to service public health objectives, especially for the poor. That these corporate hospitals have blatantly flouted their public health obligations has been documented by the government's own committees. [15] Additionally, the NEP have resulted in large public healthcare institutions losing their position of preeminence to the large corporate hospitals in the metros and some other big cities to the effect that corporate sector has gained considerable influence in shaping health policy.

It is well recognized that the healthcare system in the country long suffered from the curative-preventive and the urban-rural divide where in curative care required by the better off was privileged over the preventive / promotive care required more by the poor. This resulted in the curative care being largely concentrated in the towns and the cities with the rural folk having to access it at considerable cost in these towns and cities. [16] Consolidation of profit motive in healthcare has only fortified these fault lines, for profit can only come from provision of costly curative care to those who can afford to pay; who invariably are located in cities. This precisely is what the corporate health sector is interested in rather than pitching in for achieving the larger 'public good' to be achieved through strengthening public health.

It could not but be that NRHM was tempered in the harsh ethics of commercialized health care. Public-private partnerships, contracting out service provision to the NGOs and private sector and providing monetary incentives to ASHAs (Accredited Social Health Activist) particularly for pushing up the RCH related goals were integral part of NRHM. Government launched the 'Rashtriya Swasthya Beema Yojna' (RSBY) (National Health Insurance Scheme) for the poor, which leveraged service provisioning by the private sector at the cost of public financing. Not that there is any convincing evidence of these schemes leading to alleviating the health condition of the poor on a wider scale, but they certainly have the potential for insidiously spreading the culture of commercialization down to the most peripheral healthcare institutions. In the process, public health, which rests on the principles of social justice, human rights, equity and a strong welfare commitment devoid of profit motive, was the loser.

This lays down for us the context in which to analyze the fundamental fallacies of the 'mission'.

## FUNDAMENTAL FLAWS IN THE CONCEPTUALIZATION OF THE MISSION

At its inception itself, numerous critiques of the Mission had seriously questioned the basis of the various strategies of the Mission. [17] [18] [19] [20] [21] Profound lack of an epidemiological approach to health planning was at the core of these critiques. Neither the NRHM mission document nor the NRHM Framework for Implementation 2005-2012 provide an analysis of the problems of rural health care in India; neither is there a discussion on past experiences, nor any clue to the evidence base for the various strategies enumerated in the mission documents.

Different National Family Health Surveys (NFHS) and the National Sample Survey Organization (NSSO)

surveys have highlighted wide variations in health outcomes by caste, expenditure categories and gender. Barring passing reference to gender, there was little appreciation of stratification of the rural society by caste or class. It is borne out by experience that the benefits of various development sector schemes and programs have invariably been cornered by the dominant sections of the society. Oversight of the specific needs of the marginalized sections undermined effective implementation of NRHM. For example, rather than put out fancy schemes like the RSBY for accessing high end curative care, the more fundamental health need of the impoverished sections is that of food, clean drinking water and efficient and effective primary health care.

The Mission sought to provide – "Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization". [21] However, the core and the supplementary strategies of the Mission concerned primarily with the health service provision and their financial management. There was neither a mention of the strategies to ensure food security and nutrition of the people, nor any targets to measure their progress. NRHM did talk of total sanitation mission, but remained casual on measuring its progress.

NRHM recognized that poverty is the biggest barrier to access health services and equity in health. Lack of regular employment is an important cause for poverty and together they undermine people's food security and thereby their health. Good health is essential to mitigate the effects of socio-economic inequities. Absence of effective strategies to tackle issues like unemployment, poverty and food security resulted in one sided emphasis on purely technological medical interventions to achieve the desired outcomes of NRHM. This strategy proved to be intrinsically self defeating.

"Communitization", "Community Ownership", "Community Participation" and "Accountability to the Community" – these themes are often raised in the NRHM documents. However, NRHM has been blissfully ignorant of the needs of the marginalized sections of the rural society. This begets the question – can the marginalized and those with little voice in the society command accountability unless actively supported by the system?

Patterns of disease are socially produced and those at the lower rungs of the society suffer more from ill-health. Hence, an attempt to improve the health of the masses has to be imbued with a vision for 'social justice', backed by efforts to change the unjust socioeconomic realities. [22] [23] [24] Nobody expected NRHM to bring about a radical redistribution of resources in the society, but implementation of comprehensive rural employment guarantee programs and food security for the people by restructuring PDS (Public Distribution System) to reduce their dependence on the propertied classes for their existential needs was certainly possible. For example the United Progressive Alliance (UPA) - I government could unroll NRHM, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) and Food Security Bill together, with the objective of making them complement eachother. This could have delivered some empowerment of sections like the landless agricultural laborers, the scheduled castes, scheduled tribes and the women, thereby enabling them to seek accountability and exercise control over the health services.

But doing so requires a political vision and political will. Experience of the implementation of NREGA and NRHM and now the debate around the Food Security Bill, betray a lack of such political will on part of the government. Add to this the impact of the widespread agrarian distress due to the economic policies that have spelt the ruination of small, marginal and even middle peasants, thereby further aggravating social inequalities. In the absence of concerns for social equity, economic growth and public health interventions could easily end up aggravating, not ameliorating, social inequalities in health if such economic growth increases economic inequality. [25]

## INHERENT CONTRADICTIONS IN THE MISSION'S IMPLEMENTATION STRATEGIES

Public private partnerships (PPPs) in health sector emerged as another sine qua non of NRHM. They become a convenient alibi to outsource a variety of services and personnel ranging from class four staff to even doctors. Outsourcing of services under different names like 'Janani' in Bihar and 'Yeshaswani' Trust in Karnataka became a byword for innovation.

However, the Mission was clueless about resolving the essentially antagonistic motives of the private sector to provide care for profit and that of the public sector to provide healthcare irrespective of the people's capacity to pay. The suggested middle path is that of engaging the not for profit civil society organizations as partners for achieving public health goals. The report of the task force on PPPs says – "A very innovative experimentation is currently under progress in Arunachal Pradesh with the help of NGOs like the Voluntary Health Association of India and Karuna Trust. Such a window for partnerships with NGOs for service

delivery, in remote regions or at public facilities where for some reason the Government delivery structure is not able to provide those service guarantees, would be an useful way to reach out services where they are needed". [26]

It would have been fruitful if the report had elaborated on the 'reasons' for which the government, inspite of its immense administrative, financial and logistical capabilities fails to provide 'service guarantees' in remote areas and the factors that enable the NGOs, to deliver these services, such that appropriate lessons can be drawn to remedy government action. In the long run it is desirable that health care in such difficult areas be provided by the government rather than being left to the nebulous capabilities of NGOs. After all if the government provides healthcare for the armed forces in the remotest areas, why should that not be possible for civilians?

215 mother NGOs had been identified under the Mission to assist in the implementation of disease control programs, RCH – II, routine immunization, pulse polio and Janani Suraksha Yojna etc. in some 300 districts. [9] The 'framework of implementation' for NRHM states – "Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas and aspects, working together with community organizations and Panchayati Raj institutions, and contributing to monitoring the right to health care and service guarantees from the public health institutions. The effort will be to support / facilitate action by NGO networks in the country which would contribute to the sustainability of innovations and people's participation in NRHM." [9]

NRHM thus prescribed large scale "NGO-ization" of government in the delivery of health services. This has important consequences. There is no mention of any country experiences where sustainable improvement in the health of the people has been possible through large scale outsourcing of government functions to NGOs. This is but a way of introducing intermediaries between the government and the people in the delivery of health services; thereby absolving the government of any direct answerability to the people. NGOs on the other hand, are answerable only to their funding agencies on which they depend for their sustenance, while answerability to the people remains optional. Rather, the notion of 'selfless service' that is cultivated around NGOs, gives an impression that people should be grateful for their 'selflessness' rather than be assertive in seeking accountability / services.

The control of the funding agencies over the NGOs has potentially dangerous implications for the country. It is entirely possible that a large NGO involved in the implementation of a vital health program, which is funded by USAID or DFID would be more answerable to the embassies of US or Britain than to Health Ministry in New Delhi. Involvement of PATH; an International NGO, in the controversial human papilloma vaccine trials in India, is a case in the point. [27]

While provision of services through NGOs is encouraged on one hand, on the other NRHM visualizes an important role for them in 'community monitoring' [28] i.e. that NGOs will sit in judgment over their own trial. This is vulgarization of the concept of community monitoring which essentially is a political process facilitated by socio-economic empowerment of the people rather than being an NGO processed reform.

**SOME OBSERVATIONS ON THE ASHA SCHEME**

ASHAs are the fulcrum on which the entire balance NRHM rests. There is a fundamental flaw in the conceptualization of an 'activist'. An activist is a person who is a vigorous advocate of a cause and whose primary motivation is the realization of the cause without regard to any other incentive. We need to understand the conditions under which a person would be willing to be such an activist.

People have many needs. The life of the poor in rural areas revolves primarily around the struggle for their daily bread, dictated by the objective conditions of their life. Once this most fundamental want is satisfied, their attention goes to satisfying other basic needs like clothing, housing or the education of the children. Even under the best of circumstances, it is nothing short of extraordinary that a poor rural household manages to fulfill these needs. Under such conditions people can be motivated for an activist role only under two situations – one, if people become politically organized and motivated by higher ideals to change the societal conditions, or if the government implements such programs which initiate an all round development in the lives of the people, giving them this conviction that they must ensure the success of these policies for fulfillment of their basic needs. In both these conditions the struggle for the basic existential needs and the struggle for overall social development become one.

In other words unless a program also addresses the basic existential needs (bread, butter and employment) of the people, it cannot invoke any spirit of activism in them. The NRHM planners on their part seem to have

been aware of this; that is why they embedded monetary incentives into the ASHA scheme itself; and ASHAs have performed best where the incentives lie i.e. in shoring up the rates of institutional deliveries under the Janani Suraksha Yojna. This is a far cry from what was envisaged of her.

## IMPORTANT LESSONS FROM THE MISSION

NRHM had come into being at a very important historical juncture – a time when the country had already witnessed nearly two decades of economic reforms and structural adjustment policies. Despite the unprecedented high economic growth rates that the country has witnessed, there has been stagnation in the human development indicators of the country. Worldwide there is an increasing resistance to globalization. Some of the earlier votaries of globalization – former chief World Bank economist Joseph Stiglitz and Amartya Sen presented their own critiques of globalization which urged for globalization with a human face. In the midst of all this the splendid 'Shining India' campaign of the BJP led NDA government failed to return it to power. The writing on the wall was thus clear for the ruling classes. It was under such conjuncture of circumstances that the new coalition at the Centre; the UPA I came up with social welfare programs like the NRHM, NREGA and the farm loan waiver.

Even though necessitated by compelling circumstances, these programs were not borne out of any kind of self realization on part of the ruling elite; they were more in the nature of mollifying the people. Resultantly, NRHM was a very poorly conceived program. As we have noticed above, there continue to remain vital gaps in NRHM that have ensured the non-achievability of the Mission's objectives. Concepts of 'decentralized planning', devolution of powers, 'community control and monitoring' and inter-sectoral coordination remain notional rather than substantive.

The most appropriate lesson to draw would be that health of the people is not a standalone phenomenon that can be improved by making arrangements for provision of healthcare alone. Improving the health of the people involves a comprehensive action plan that encompasses areas like food security, employment and poverty alleviation as well. Healthcare is a continuing process; it may be too late to redeem the present version of NRHM. All we can hope is that the lessons drawn here from shall feed into the future planning for health and that the policy planners shall be wiser by their mistakes. However, the prospects of this happening anytime soon appear to be remote.

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