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National Rural Health Mission in Meghalaya: A Review of Past Performance and Future Directions

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The present research was undertaken to study the past performance in relation to availability of health institution at the village level, connectivity with all weather roads, free distribution of medicine, impact of health activist at the household level, upgradation of CHC to IPHS, gaiting or availing antenatal and postnatal check up services, services received through mobile medical unit and availability of registered medical practitioner at the village level, etc. The researchers have adopted survey studies based on descriptive cum explorative research methods and selected only one block from West Khasi Hills District through random sampling procedure. 360 rural households from Nongstoin block was chosen through random sampling procedure from 12 villages selecting 30 women respondents from each village. From each household, one female respondent (age group 15-45) was interviewed using purposive sampling method. For analysing and interpreting the data, the investigators adopted simple percentage as statistical technique. The results of the present study clearly demonstrate that majority of the villages were not having health institutions and they were not connected with all weather roads. In relation to free distribution of medicine a very less number of people were benefited and the mobile medical unit is not working properly and there is no registered medical practitioner at the village level. In order to achieve the objectives of the National Rural Health Mission efforts should be made to address these hindrances.

Keywords: NRHM, Performance, Meghalaya, West Khasi Hills District

Introduction

The poor performance of the Indian Public Health System is widely acknowledged. Analysts have attributed this failure to a number of factors, which include almost all the components that make a system functional, that is, infrastructure, human resource, logis-

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tics, and participation of the community. However, some attribute this failure primarily to low and declining public investment in healthcare, and also to structural and managerial weaknesses in the system. After groping with the challenges for decades, the planners have come up with a comprehensive mission-oriented approach to revamp the rural healthcare delivery system, which was aptly named National Rural Health Mission (NRHM). The mission was launched on 12 April 2005. The architectural corrections enshrined in the Preamble of NRHM document primarily comprised of decentralisation, communitisation, organisational structural reforms in health sector, inter sectoral convergence, public private partnership in health sector, mainstreaming Indian system of medicines under Ayurveda, Yoga, Unani, Sidha and Homeopathy (AYUSH), induction of management and financial personnel into health care management and delivery system. The NRHM vision envisaged provision of effective healthcare to rural population throughout the country, to begin with special focus on 18 states in 2005, which had weak public health indicators and weak infrastructure.

NRHM seeks to provide accessible, affordable and quality health care to rural populations, especially vulnerable and underserved population groups in the country. The Mission aims to achieve infant mortality rate (IMR) of 30 per 1000 live births, maternal mortality 100 per 100 thousand live births and total fertility rate of 2.1 by the year 2012. The mission attempts to achieve these goals through a set of core strategies including enhancement in Budgetary Outlays for Public Health, decentralised village and district level health planning and management, appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services, strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels, improved management capacity to organise health systems and services in public health, promoting the non-profit sector to increase social participation, and community empowerment, inter-sectoral convergence, upgradation of the public health facilities to Indian Public Health Standards (IPHS), reduction of infant and maternal mortality through Janani Suraksha Yojana (JSY), etc. (NRHM, 2005; MoHFW, 2007).

A funnel type approach was adopted to ensure the integration of funds for all the national level schemes and thereby the flow of funds to the District Health Mission through the State Health Society. Thus, under the decentralisation scheme the district was supposed to be the hub around which all health and family welfare services were supposed to be planned and managed. The NRHM strategy carefully mentions that the population stabilisation goal needs focused attention on basic health care, and access to quality family welfare services for fertility choice or fertility control, not through coercion or disincentives or inducements. Decentralised planning and communitisation also encompass capacity building in terms of training and sensitisation of ASHAs, Village Health and Sanitation Committee (VHSC) and *Rogi Kalyan Samiti* (RKS) members about their roles and responsibilities towards proper utilisation of Grants and Funds in the best interest of the users. The financial management also entails evaluation of utilisation of untied funds to VHSC, SC, PHC and CHC. The process parameters for the success of the communitisation process can be adjudged in terms of constitution of VHSCs, recruitment and functioning of ASHAs, constitution of registered Rogi Kalyan Samities at District Hospitals (DHs), Sub-Divisional Hospitals (SDHs), Community Health Centres

(CHCs) and Primary Health Centres (PHCs). The Mission strategise decentralisation in the administrative and management of the public health care delivery system to effectively meet the health and family welfare needs of the people in diverse social, economic and cultural settings. The mission also addresses the issue of empowerment of the community to own, manage and control the public health care delivery system.

Rationale of National Rural Health Mission study is to improve availability of and access to quality health care of people, especially for people residing in rural area- poor, women and children. Because health comes under state jurisdiction and NRHM is an effort at building partnership with state to ensure meaningful reform with more resources. Plan of action includes increasing public expenditure of health manpower, decentralisation of district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system and operationalising community health centres into functional hospitals meeting public health standard in each block of the country. In light of the above the research questions are (i) How Government of Meghalaya is implementing the scheme of NRHM? (ii) To what extent NRHM is successful visà-vis achieving its goal by serving people of West Khasi Hills District of Meghalaya.

Review of Literature

M. N. Srinivas' (1979) monograph 'Management of Rural Health Care' reviews the efforts of government in delivery of health care services to rural population since beginning of planed era. He says people living in interior and remote rural areas do not have access to the primary health care. The problem of health care services in rural areas has peculiar characteristics: their concept of health and disease is traditional, apathy towards allopathic medical practitioners, limited capacity to pay the cost of treatment, transport and communication difficulties, unqualified medical practitioners and health centres are under staffed. Doctors and paramedical workers do not want to work in rural areas because of professional, personal and social reasons. Therefore, to remove this problem enhancing the number of primary health centres and the sub-centres is not only the solution, rather to develop the philosophy of providing integrated health care system. For making health services more meaningful to the population of the country, it is necessary to bring about fundamental changes in focus and approach to entire health care delivery system in general and above rural health services in particular.

Indu Mathur (1987), in her study 'Rural Medical Care in a Changing Setting', makes an attempt to observe the functioning of mobile hospitals and health unit in Rajasthan. A close observation revealed certain specific features of social structure and organisations of the camps, which are not present in other treatment situations of the level as follows. The situation is temporary; all staff work as a team; it is depend on patient for success; treatment process does not involve any financial consideration; private practice is not allowed to the staff, and humanistic value is central around which all activities enrols are organised. A comparison of two treatment situations – a hospital and a camp – confirms the observation that people accordingly to the demand of the situation that are constrained by the actions of their co-participants.

K.M. Panikar (1992), in his case study 'Recourses not the Constraints on Health: A

Case study of Kerala', reveals factors contributing to comparatively better achievement of Kerala in health sector. Analysis of data suggests reason for better health in Kerala as it lays much or equal importance to preventive and promotive measures like sanitation, hygiene, immunisation programmes, infant and antenatal care, health education etc. as curative medicine. More over, spread of education, especially among women in rural Kerala is a crucial factor contributing to high degree of awareness of health problems and fuller utilisation of available health care facilities. His study gives proper policies and priorities and argues that lack of resources may not be an impediment in improvement of health status even in low income countries.

Mukherjee (2002) in his paper on Geo-Medical Aspects of Acute Respiratory Infectious Diseases in Meghalaya said that health situation in Meghalaya is more critical due to very poor network of primary health care delivery. Moreover, the working population in Meghalaya is living in close intervention with the already degraded natural environment.

Research Design

In the present descriptive cum explorative study an effort has been made to study the past performance of National Rural Health Mission in relation to availability of health institution at the village level, connectivity with all weather roads, free distribution of medicine, impact of health activist at the household level, upgradation of CHC to IPHS, gaiting or availing antenatal and postnatal check up services, services received through mobile medical unit and availability of registered medical practitioner at the village level etc.

The universe of the study was the West Khasi Hills District of Meghalaya. Keeping in view the purpose and implication of the study, the researchers have adopted "Survey Studies based on Descriptive cum Explorative Research Method" and selected only one block from West Khasi Hills district through random sampling procedure. Exactly 360 rural households from Nongstoin block was chosen through random sampling procedure from 12 villages selecting 30 women respondents from each village. From each household, one female respondent (age group 15-45) was interviewed using purposive sampling method. The following table shell presents the selection of the sample.

Sl. No	Community Development Block	No of villages	Female respondents from each village	Total Respondents
1	Nongstoin	12	30	360
Total	One	12	30	360

Tools for data collection and data analysis

The study was based on both primary and secondary data. Primary data was collected through a structured interview schedule. Besides primary data secondary data from monographs, researches, state gazetteers and journals were consulted and taken into consideration. Apart from interview schedule, observation and discussion methods were also used. For the purpose of analysing the data, the researchers used percentage technique for interpreting of data.

Results and Discussion

This part of the study has been devoted for the purpose of analysis and interpretation of data according to the objectives of the study.

Table 1.0: Availability of Health Institution in the Village

Sl. No.	Option	No. of Villages	Percentage (%)
1.	Yes	3	25
2.	No	9	75
Total		12	100

As regards to the availability of health institution in the villages of the respondents, it was found from the data that 3 villages constituting 25% of the sample were having health institution in their villages, whereas 9 villages constituting 75% of the sample did not have health institution.

Table 1.2: Road Connectivity to Nearest Health Centre

Sl. No.	Types of Road	No. of Villages	Village (%)
1.	Metal road	5	41.67
2.	Katcha road	4	33.33
3.	Walk able road	3SS	25
Total		12	100

As regard to the road connectivity, it has been found from data of the sample that 5 villages constituting to 41.67% of the sample were connected with metalled road, 4 villages constituting to 33.33% of the total sample were connected to Katcha road, and 3 villages constituting 25% of the sample were still facing the hardship with walkable road connectivity only.

Table 1.3: Free Distribution of Medicines

Sl. No.	Options	No. of Respondents	Percentage (%)
1.	Yes	90	25
2.	No	270	75
Total		360	100

As regard to free distribution of medicines, it has been found from the data that 90 respondents constituting 25% of the sample were benefited with free medicines, whereas 270 respondents constituting 75% of the sample were far from getting the benefits of free medicines from the health centers.

Table 1.4: Preference to go for Institutional Treatment

Sl. No.	Health Institutions	No. of Respondents	Percentage (%)
1.	Govt. Health Centre	174	48.33
2.	Pvt. Clinic/Hospital	96	26.66
3.	Traditional Healer	84	23.33
4.	Chemist Shop	6	1.66
5.	AWC (Aganwadi Centre)	0	0.00
6.	Others	0	0.00
Total		360	100

As regard to preference to go for institutional treatment, it has been found from the data that 174 respondents comprising 48.33 % of the sample preferred to go for treatment to government health centres, 96 respondents comprising 26.66 % of the sample preferred to go for treatment to private clinics/hospitals, 84 respondents comprising 23.33% of the sample preferred to go for treatment to the traditional healers, 6 respondents comprising 1.66 % of the sample preferred to go to the chemist shops whereas it was also observed that none of the respondents preferred to go the other health institution including Anganwadi Centres.

Table 1.5: Impact of Health Activist (ASHA) at the Household Level

Sl. No.	Options	No. of Respondents	Percentage (%)
1.	Yes	136	37.77 %
2.	No	224	62.22 %
Total		360	100

As regard to the impact of health activist (ASHA) at the household level of the respondents, it has been found from the data that 136 respondents constituting 37.77% of the sample were having positive impact upon their health status by the services of the accredited social health activist (ASHA) at their household level, whereas 224 respondents constituting 62.22 % of the sample did not receive any services thereby indicating no positive impact of accredited social health activist (ASHA) upon them at their household levels.

Table 1.6: Village Committee Enables

Sl. No.	Options	No. of Respondents			
		Yes (Total)	Percentage (%)	No (total)	Percentage (%)
1.	Better community support	106	29.44	254	70.55
2.	Promoting healthy life style	80	22.24	280	78.55
3.	Reduction in consumption of tobacco	94	26.11	266	73.88
4.	Reduction in consumption of alcohol	122	33.88	238	66.11
5.	Others	-	-	360	100

With respect to the village health committees of the respondents, it has been found from data that 106 respondents constituting 70.55% of the sample did not receive any better community support for RCH, whereas 254 respondents constituting 29.44% of the sample feel that they have better community support now, 80 respondents constituting 22.22% of the sample were found promoting better healthy life style, whereas 280 respondents constituting 78.55% of the respondents were not found promoting better healthy life style by the Village Health Committee, 94 respondents constituting 26.11% of the sample felt that there was reduction in consumption of tobacco, whereas 266 respondents constituting 73.88% of the sample did not show any improvement in tobacco consumption by the intervention of village health committee, and finally 122 respondents constituting 33.88% of the sample have experienced reduction in consumption of alcohol, whereas 238 respondents constituting 66.11% of the sample did not respond to any reduction in consumption of alcohol by the intervention of the village health committee.

Table 1.7: Up gradation of CHC to IPHS

Sl. No.	Options	No. of respondents	Percentage (%)
1.	Yes	-	-
2.	No	126	35 %
3.	Don't know	234	65%
Total		360	100

As regard to upgradation of community health centre to IPHS, it has been found from the data that 126 respondents constituting 35% of the sample were saying that there was no upgradation of community health centre to IPHS took place from 2005-2010, and 234 respondents constituting 65% of the sample were ignorant about the up gradation scheme.

Table 1.8: Availability of Trained Community Health Workers at the Village/ Locality

Sl. No.	Health Workers	Availability	Percentage (%)	Services (utilized)	Percentage (%)
1.	DOTS workers	Yes (90)	25	Yes (90)	25
2.	Aganwadi workers	Yes (190)	52.77	Yes (190)	52.77
3.	Trained Dias	Yes (90)	25	Yes (90)	25
4.	ANM/LHV's	Yes (70)	19.44	Yes (70)	19.44
5.	ASHA	Yes (136)	37.77	Yes (136)	37.77
Total			100		100

As regard to availability of trained community health workers at the village/locality, it has found from the data that 90 respondents constituting 25% of the sample said that DOTS workers were available and they have utilised their services, 190 respondents constituting 52.77% of the sample said about the availability and utilisation of the services of anganwadi workers, 90 respondents constituting 25% of the sample said that they

have availed the services of ANM/LHVs, and 136 respondents constituting 37.77 % of the sample received the presents and also utilised the services of ASHA.

Table1.9: Getting or Availing the Following Services at the Village since 2005-11

Sl. No.	Options	No. of respondents			
		Yes (Total)	Percentage (%)	No (total)	Percentage (%)
1.	Immunization at Community Level	330	91.69	30	8.33
2.	Antenatal check up for mother	70	19.44	290	80.56
3.	Post natal check up for mother	70	19.44	290	80.56
4.	Supplementary nutrition	190	52.77	170	47.23
5.	Free supply of medicines	90	25	270	75
6.	Referral service and transport at CHC/PHC Level	-	-	360	100
7.	Generic drugs for common ailment	8	2.22	352	97.77

As regard to provision for immunization at the community level, it has been found from the data that 330 respondents constituting 91.67% of the sample were of the opinion that they have availed immunization at the community level, whereas 30 respondents constituting 8.33 % of the sample did not avail the facilities of immunization available in the community level. As regards to antenatal check up for mothers, it has been found from the data that 70 respondents constituting 19.44% of the sample availed antenatal care services, whereas 290 respondents constituting 80.56% of the sample did not avail antenatal care services. As regard to post natal check up, it has been found from the data that 70 constituting 19.44% of the sample had avail post natal care services and 290 respondents constituting 80.56% of the sample did not avail post natal care services. As regard to supplementary nutrition, it has been found from the data that 190 respondents constituting 52.77% of the sample received supplementary nutrition materials particularly from anganwadi centres, whereas 170 respondents constituting 47.23% of the sample did not received any supplementary nutrition materials from the anganwadi centres.

Regarding free supply of medicines, it has been found from the data that 90 respondents constituting 25% of the sample benefited from free medicines, whereas 270 respondents constituting 75% of the sample did not received free medicines for their ailments.

In the context of referral services and transport communication at PHC/CHC level, it has been found from the data that no respondents from this sample have availed the said facilities as yet and hence the total number of respondents not yet availed the above said facilities were 360 constituting 100 % of the sample.

Table 1.10: Service Received through Mobile Medicinal Unit at the Village/Locality

Sl. No.	Options	No. of Respondents	Percentage (%)
1.	Yes	-	-
2.	No	360	100
	Total	360	100

As regard to the services received through mobile medicinal unit at the village/locality, it was found that 360 respondents constituting 100 % of the sample did not receive any service through mobile medicinal unit at the village / locality levels.

Table 2.1: Village Health Committee of the Panchayat

Sl. No.	Options	No. of Villages	Percentage (%)
1.	Yes	3	25
2.	No	9	75
Total		12	100

As regard to village health committee of the panchayat of the respondents, it has been found from the data that 3 villages constituting 25% of the sample were having village health committee in their respective villages, whereas 9 villages constituting 75 % of the village were not having village health committee.

Table 2.2: Registered Medical Practitioner (R.M.P) at the Village/Locality

Sl. No.	Options	No. of Villages	Percentage (%)
1.	Yes	-	-
2.	No	12	100
Total		12	100

As regard to the Registered Medical Practitioner (R.M.P) at the village/locality of the respondents, it has been found from the data that all 12 villages constituting 100% of the sample were not having Registered Medical Practitioner (R.M.P) at village/locality level.

Table 2.3: Services of ASHA (Female)

Sl. No.	Options	No. of respondents	Percentage (%)
1.	Yes	136	37.77
2.	No	224	62.23
Total		360	100

As regard to services of ASHA (Female), it has been found from the data that 136 respondents constituting 37.77% of the sample availed the services of ASHA (Female), whereas 224 respondents constituting 62.23% of the sample did not receive any service of ASHA.

Findings

The major findings of the present study are given below:

- As regards to the availability of health institution in the villages, it was found that only 3 villages were having health institution in their villages, whereas 9 villages were not having health institution.
- In relation to the road connectivity, it has been found that 5 villages were connected

with metalled road, 4 villages were connected to Katcha road, and 3 villages were still facing the hardship with walk able road connectivity only.

- As regard to free distribution of medicines, it has been found that only 90 respondents (25%) of the respondents were benefited with free medicines, whereas 270 respondents (75%) were far from getting the benefits of free medicines from health centers.
- From the study it has been found that only 174 respondents (48.33%) of the sample preferred to go for treatment to government health centers.
- As regard to the impact of health activist (ASHA) at the household level, it has been found that 136 respondents (37.77%) were having positive impact upon their health status by the services of the accredited social health activist (ASHA) at their household level, whereas 224 respondents (62.22%) did not receive any services.
- With respect to the village health committees, it has been found that 106 respondents (29.44%) did not receive any better community support for RCH, whereas 254 respondents (70.55%) feel that they have better community support now.
- According to 80 respondents (22.22%) village health committee is promoting better healthy life style, whereas 280 respondents (78.55%) replied that it is not promoting better healthy life style.
- As regard to upgradation of community health centre to IPHS, 126 respondents (35%) replied that no upgradation of community health centre to IPHS took place from 2005-2010, and 234 respondents (65%) of the sample were ignorant about the upgradation scheme.
- As regard to availability of trained community health workers at the village/locality, 90 respondents (25%) said that DOTS workers were available and they have utilised their services.
- As regard to provision for immunization at the community level, it has been found that 330 respondents (91.67%) were availing immunization services at the community level, whereas 30 respondents (8.33%) of the sample did not avail the facilities of immunization available in the Community level.
- Regarding free supply of medicines, it has been found that 90 respondents (25%) benefited from free medicines, whereas 270 respondents (75%) did not received free medicines for their ailments.
- In context of referral services and transport communication at PHC/CHC level, it has been found that no respondents from this sample have availed the said facilities as yet and hence the total number (100%) of respondents not yet availed the above said facilities.
- As regard to the services received through mobile medicinal unit at the village/locality, it was found that 360 respondents (100%) of the sample did not receive any service through mobile medicinal unit at the village/locality levels.
- As regard to village health committee at the panchayat level, it has been found that only 3 villages (25%) were having village health committee in their respective villages, whereas 9 villages (75%) of the village were not having village health committee.
- In relation to the Registered Medical Practitioner (R.M.P) at the village/locality of the respondents, it has been found that all 12 villages (100%) were not having Regis-

tered Medical Practitioner (R.M.P) at village/locality level.

- As regard to services of ASHA (Female), it has been found that 136 respondents (37.77%) availed the services of ASHA (Female), whereas 224 respondents (62.23 %) did not receive any service of ASHA.

Recommendation and Suggestion for Future Intervention

Based on these major findings, the following suggestions may be offered.

- The success of NRHM totally depends on the availability of health institution at the village level but it was found that out of 12 villages only 3 have health institution and these villages are not well connected with roads and due to this all the villages are away from the facilities of mobile medical unit. So, to achieve the maximum output of the programme efforts should be made to establish the heath institution at the village level and road connectivity should be ensured.
- Although the free distribution of medicine is available at the primary and sub-centre level, people are not availing the services because of the misuse of facility or lack of knowledge regarding this. So government intervention is required in this regard.
- It is observed from the study that the antenatal, natal and post natal checkup services are either not available or not utilised by the target groups. So in order to improve the child and mother mortality the availability of services should be ensured.
- The strategy of NRHM is that people should own the responsibility at the grass root level for success of any rural development programme. But in the study it was found that no local institution including the traditional institution has played any role in NRHM to make the programme a success in the district. So, efforts should be made by the government to make the local institution more proactive by providing them training and other requisite facilities.
- With respect to the impact of accredited social health activist (ASHA) at the household level, it was observed that ASHA workers are not working actively. So efforts should be made to bust their motivation.
- The village health committee can provide better community support for the success of NRHM and can promote healthy life style if they work wholeheartedly. The first kind of efforts may be to establish the WHC in those villages where it is not working and secondly motivate them in such a way so that they can work in a more active manner.

Conclusion

National Rural Health Mission (NRHM) yields great response and success in West Khasi Hills District of Meghalaya. It is one of the popular programmes of government of India. But due to unforeseen factors and forces, the programme sometimes faces problems for proper implementation and execution. The objective is to study and analyse success levels as well as bottlenecks of implementation of the programme, if any, for a better health for the people of Meghalaya in near future.

The state of Meghalaya is persistently progressing towards attaining the goals and objectives shared under National Rural Health Mission (NRHM), National Population Policy (NPP) and Millennium Development Goals (MDG). The activities under NRHM are transforming the health care delivery to rural populace with increasing accessibility

to quality services and the opportunity to participate actively in managing these services as well. The state has increased coverage under JSY, improvement in infrastructure, and availability of paramedical and medical personnel.

References

Desai, P.B. (1993): 'Social Dynamics of Health Care', in Ashish Bose and P.B. Desai (ed.). *Studies in Social Dynamics of Health Care*, Delhi: Hindustan.

Dutta, P.C. (1955): *Rural health service in India, Primary Health Centre*, Central Health Education Bureau; D.G.H.S. Ministry of health; Government of India.

Goplan, T. (1987): "National status of some selected tribes of tribes of Western and Central India", *Society of India*, 33: 76-93.

Govt. of India (2001): *Report of the health Survey and planning Committee Government of India*, New Delhi, Ministry of Health.

Mathur, Indhu (1987): "Rural Medical Care in Changed Setting", A paper presented in the seminar on Teaching and Research in Medical Sociology Vol-IV, New Delhi: Vikash Publishing Pvt. Ltd.

National Institute of Nutrition (1971): *Annual Report*, Indian Council of Medical Research, Hyderabad.

Panikar, P. G. K. (1992): "High Cost of Medical Care in Kerala: Tentative Hypothesis", *Economic and Political Weekly*, Vol – XXVII, No. 23, June 06.

Rajpramukh, K. E. (2008): Medical Anthropology a bio-cultural discipline, Ambala Cantt. New Delhi., Report of the health Survey and planning Committee, Government of India, New Delhi; Ministry of Health.

Report on National Rural Health Mission (NRHM): Government Of India, (2005-2012).

Srinivas, M.N. (1987): "Management of Rural Health Care", Social change.

Mukherjee (2002) in his paper on geo-medical aspects of acute respiratory infectious diseases in Meghalaya.