Chapter –III

Health Care in Rural India

In previous chapter I discussed and developed framework of study. In this chapter I try to highlight health care in rural India in view of measures of successive governments to improve health of rural people and change after NRHM intervention.

Health Care During Ancient India

Health care in traditional ancient India was primarily governed by *Veda* and *Shastra*. Ancient medicine in India from *Atharvavedic* period is characterised by supremacy of magico-religious practice[1]. During that time people believed on sin, disgrace of god and goddess, demon, evil spirit and magic behind cause of disease and illness. Ancient-traditional India being highly hierarchical, disease was implied with ascription and other kinds of traditional attributes. Mind of people was almost static as religious dogma governed them to large extent. In fact people of ancient India thought disease occurred due to sin committed by some or his/her ancestor. Gods and goddesses disgrace and curse on violation of karma and dharma also prevalent in mind of people. As

[1] Edward Wasgburn Hopkins, The Religion of India, Munshiram Monoharlal Publishers Pvt. Ltd., 1977, New Delhi Pp 151-160

a response to action of god and goddess, devil and evil spirit or force, magical activity and religious practices were followed by ancient people[2].

Besides magico-religious practice in traditional India, ayurvedic and herbal medicine were also used for treatment of different kind of diseases. Regardless of their positive impact and cure of disease, people of old society blindly or superstitiously believed magico-religious pattern of treatment. Owing to gradual enlarged hierarchy and stratification of Hindu domination, ayurveda and herbal medicine use attained pure religious colour. Use of traditional medicine by saint, *muni*, *rishi* and *yogi* justify how people of ancient India availed health care practice. For them disease and health were associated with food, life and activities. To be specific all of them promulgated social taboo to uphold their hegemony among people on health. These four kinds of religious specialist sanctioned or imposed medicine of their own kind to mesmerise people. Alongside *tantra, mantra*, *guni* and *garedi* were used by rural folk to heal their disease and wound. For example for snake bite or any immediate problem in heath was attended through *guni* and *garedi*. But extent of use of such medicine was limited. Irony was over passage of time dogmatic religious practice imposed by such people became hallmark of reference for future generation. In different socio-cultural setting of rural India, folk healer used

[2]Jaggi O. P. History of Science and Technology in India. Vol.3. Folk Medicine. Atma Ram and Sons, Delhi, page 1-100, 1973.

ayurvedic medicine to some extent along with magico-religious practices to serve tribal and village population[3]. Hence it is well understood that ancient India only nurtured traditional magico-religious practice and most people accepted the same as medical science was not available before rigid Hindu social structure.

Health Care during Medieval India

In medieval period ayurvedic medicine lost its popularity in small town and urban centre, because of change in nature of governance and rule. Since medieval age remained in paw of Pathan and Mughal with successive invasion, earlier practice of indigenous medicine underwent change. In fact change occurred in very nature of practice in religion and in such process medieval India became more rigid in religious sanction. *Unani* became major source of medicine for Muslim rulers. Hence so called indigenous pattern of medicine and treatment was replaced by introduction of Unani medicine and Unani medicine was most popular in medieval India[4].

Successive rulers including emperor, king and their estates spread medical facility in town and periphery during medieval India. They established hospitals and appointed medical practitioners who were experts in Unani

[3] Ibid Pp 40-77

[4]JaggiO. P, History of Science and Technology in India, Vol 8, Medicine in Medieval India, Atma Ram and Sons, Delhi. Pp 49-216, 1977

medicine. People irrespective of religion and caste were treated in these health centres. Poor people availed free medical facility at that time[5].

Sultans and Sayyids after capturing throne at Delhi started to expand Unani medicine. They established hospitals and appointed physicians for rapid expansion of Unani medicine. Muhammad Bin Tughlaq (1325-1352 A.D.), second ruler of Delhi Sultanate, established seventy hospitals at Delhi and appointed around twelve hundred physicians[6].

During Mughal period a combination of Indian and Persian medicine was introduced in greater part of India. Knowledge of Ayurvedic medicine was also borrowed by scholars to make Unani medicine more suitable in Indian context. During reign of Babur, Humayun and Akbar many Unani physicians (*Hakims)* migrated to India from Persia and central Asian countries. They maintained private clinic besides royal service. Poor people irrespective of religion and caste were treated free of cost in their clinics[7].

Both Shah Jahan and his son Aurangzeb followed their predecessors to spread health care throughout the country. Several hospitals were constructed in length and breadth of country to make medical facilities available for common

[5]IbidPp 20-140
[6] Ibid Pp 22-138
[7] Ibid Pp 25-138

people. Apart from spread of medicine, medical education was also patronised during their regime. Medical schools were attached to hospitals. Some of the eminent Unani physicians opened private medical schools during that period[8].

In fact health care in some selected locations of India got much attention and support from medieval rulers. Unani medicine slowly percolated down towards countryside. Rural people normally accepted Unani medicine due to its popularity. But neither Unani physician nor medicine was freely available to all corners of rural India. People irrespective of caste, language and religion depended on traditional folk medicine and magico-religious practice. Health culture of people of medieval India was influenced by religious belief and practices too. For critical diseases they had to move toward hospital located in far off town and city[9].

Health Care during British Rule

After decline of Mughal Empire in India, British introduced its own system of medicine known to be allopathic. Western medicine was introduced by British in India to serve a selected population, who were engaged in service of British

[8] Madhu Nagla, Sociology of Medical Profession, Rawat Publications, Jaipur, Pp 26-54, 1997

[9] Ibid Pp 34-40

government. Initially health and medical service of British was of army orientation. In early period like from 1605 till consolidation of British imperialism till Buxar war British attitude towards health was quite nascent, unintentional and ill-equipped. Rather mixture of earlier indigenous and Unani health care continued in a very shaky condition. Such an alarming trend in health existed for a long period of time[10].

British East India company along with Christian missionary brought allopathic doctors from west to their own territory to serve their people. French and Portuguese also patronised spread of modern medicine in India. Portuguese established a hospital in India in 1648 and a medical school at Goa in 1687. French government also spent huge money to establish modern medicine. Introduction of modern medicine in India by Portuguese, French and British discouraged practice of Ayurved and Unani in towns and cities. But rural people stuck to indigenous medicine like Folk, Ayurveda and Unani due to unavailability, affordability and lack of knowledge on modern medicine[11].

There was no systematic health policy in India, adopted by British, until transfer of colonial power from East India Company to British Crown. In 1859

[10] Ibid Pp 35-42
[11] Ibid Pp 35-44

royal commission was appointed to investigate sanitation and health of British army in India. Sanitary commission was set up in 1863 to protect British people from attack of endemic and communicable disease. But no massive initiative was taken by them to prevent endemic disease from India[12].

After government of India Act 1935, decentralisation in public health under new constitution was introduced by British. Government spent money to expand health care in India. Medical college was established in cities like Calcutta, Madras, Bombay, Chandigarh, Indore and Hyderabad. Hospitals were established in different provinces. Despite of all these measures taken by British, public health did not get much support from government[13].

Health situation in pre-independence India was very poor. A variety of communicable, endemic and infectious diseases prevailed in the country. Majority of Indian people, being poor and illiterate, suffered poverty, malnutrition and health hazard. Death due to infectious diseases like cholera, chicken pox, plague and other infectious diseases were also alarming.

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[12] Ibid Pp 36-48

[13]Muhammad Umair Musthaq. Public Health in British India : a brief history of medical services and disease prevention in colonial India, Indian Journal of Community Medicine, January 2009, 34 (1), Pp 6-14

Maternal and infant mortality rate throughout the country was very high along with low life expectancy of both male and female[14].

Traditional method of treatment was dominant throughout the country which did not have any preventive measure to control endemic disease. Moreover, traditional medicine prevailing at that time was not much effective. Though modern medicine was introduced by British but its coverage was limited. Number of medical professional, paramedical staff and health care institution were very limited and vast mass in countryside were out of reach of modern medicine[15].

Health Care after Independence

After independence government of India adopted British model of health care. Process of spreading modern medicine started slowly after 1947throughout the country. As per recommendation of Bhore committee, government of independent India spread modern scientific medicine as a dominant system of medicine. Government gave special concern for developing health situation of deprived rural people[16].

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[14]Ibid Pp 7-9

[15]M. Harrison, Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914, Cambridge: Cambridge University Press. 1994 Pp 120-160 and 227-234

[16]S. P.Ranga Rao, Administration of Primary Health Centre in India, Mittal Publications, New Delhi. 1993.Pp 20-24

As a part of wider community development programme, government of India established Primary Health Centre (PHC) for providing integrated health service to rural people. Provision of both curative and preventive services was part of primary health centre[17].

In successive plan period, government set up various committees to review health scenario and took initiative to improve health status. Chadah Committee in 1963 and Mukharjee Committee in 1965 set up by government to review health scenario with special emphasis upon control of communicable disease and family planning[18].

In 1975 government set up Srivasthava Committee which recommended nation-wide network of health service. The committee also recommended for creation of Para professionals and semi-professionals to provide simple protective and curative service as per requirement of society. The committee suggested for presence of male and female health workers to serve every 5,000 population. Despite of earlier measures taken by government, it was felt during 1970's that health service in India particularly in rural India is not adequate as per need of people[19].

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[17]Ibid, Pp 21-22

[18]Madhu Nagla, Sociology of Medical Profession, Rawat Publications, Jaipur, Pp 60-92, 1997

[19]Rabi Duggal, Evolution of Health Policy in India, 2001,Pp 29-56 downloaded from www.cehet.org, accessed on 23.12.2011

National health policy in 1981 is taken by government to provide door to door primary health service. Government restructured health policy for preventive, promotive and rehabilitative aspects of health care and planned to establish a need based comprehensive health service for all covering remotest part of country[20].

Since poverty is closely associated with health in India, minimum need programme initiated by government helped to coordinate activity of comprehensive health service. Safe drinking water is very essential to maintain good health. Therefore, government initiated rural drinking water mission in 1980 to provide safe drinking water to rural people. Government of various states also adopted initiative to provide safe drinking water and sanitation to rural people during these periods. For improvement of nutritional status of people government took various initiatives during same plan period too[21].

Health Care and National Rural Health Mission

National rural health mission is launched in India in April 12, 2005 with a view to improve health care of rural India through an accessible and affordable primary health care. Mission aims to provide health care to rural

[20]Ibid, Pp 40-55
[21]Madhu Nagla, Sociology of Medical Profession, Rawat Publications, Jaipur, Pp 60-92, 1997

people of India with special emphasis on eighteen states having poor health care facility[22].

Eighteen states covered under national rural health mission are Assam, Arunachal Pradesh, Bihar, Chhattisgarh, Jharkhand, Himachal Pradesh, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Rajasthan, Orissa, Sikkim, Tripura, Uttaranchal and Uttar Pradesh[23].

The mission is designed to articulate government's commitment made on national common minimum programme to increase public expenditure on health from 0.9% to 2%-3% of gross domestic product. One key component of the programme is to keep provision for a female health activist in every village[24].

Major objectives of National Rural Health Mission are

1. To reduce infant mortality rate (IMR) and maternal mortality ratio (MMR).
2. To ensure universal access to public health service.

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[22]Park K. Park's Text Book of Preventive and Social Medicine, Banarsidas Banat. Jabalpur, Pp 366-372, 2007
[23]Ibid, Pp 368-370
[24]R. Kumar, Health and Human Development, Deep and Deep Publications Pvt. Ltd. New Delhi. 2011. Pp 119-150

3. To prevent and control communicable and non-communicable disease.
4. To ensure access of people to integrated comprehensive primary health care.
5. To ensure population stabilisation, gender and demographic balance.
6. To revitalise local health tradition through AYUSH.
7. To promote healthy life styles of all people irrespective of caste, class, gender, region and religion.
8. To strengthen community participation in health care delivery system.

With a view to fulfill objective of community participation in health care, NRHM aims to create accredited social health activist (ASHA). ASHA is supposed to make awareness and provide information to community people. She indeed acts as a bridge between community people and health care service. She is entrusted with responsibility to mobilise community and facilitates them to get access to health care service. She needs to connect every household to health care facility provided by government. One principal function of ASHA is to look after maternity and child health of community[25].

Primary health centres and sub-centres stand to boost increasing number of medical professional, para-medical staff and health worker by providing

[25] Ibid. Pp 125-135

adequate infrastructure required for primary care including supply of essential drug and equipment[26].

Mission aims to introduce AYUSH (ayurveda, yoga, Unani, siddha and homeopathy) as a corollary to allopathic medicine to primary health centre throughout India. The mission further aims to design health care in rural India with preventive, promotive, curative, supervisory and outreach service become possible for health centre and sub-centre[27].

Special attention is given to eighteen states of India including all North-Eastern states. Entire India is divided into four categories of states like high focus non-North-Eastern state, high focus North-Eastern states, non-high focus large state and non- high focus small state and union territory[28].

High focus non North-Eastern states are Bihar, Chhattishgarh, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand. High focus Northeast states are Assam, Manipur, Arunachal Pradesh, Meghalaya, Mizoram, Tripura, Nagaland and Sikkim[29].

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[26] Ibid, Pp 160-170

[27] Park K. Park's Text Book of Preventive and Social Medicine, Banarsidas Banat, Jabalpur, Pp 366-372, 2007

[28] Ibid, Pp 8-15

[29] Ibid, Pp, 9-20

Table III.2

Health centres in high focus NE states by 2005-2012

Name of States	Sub-centres		Percent Increase	PHC		Percent Increase
	2005	2012		2005	2012	
Arunachal Pradesh	379	286	-24.50%	85	97	14.10%
Assam	5109	4604	-9.90%	610	975	63.10%
Meghalaya	401	397	-0.99%	101	109	7.90%
Manipur	420	420	00	72	80	11.10%
Mizoram	366	370	1.10%	57	57	00
Nagaland	394	396	0.50%	87	126	44.80%
Tripura	539	719	33.40%	73	79	8.20%
Sikkim	147	147	00	24	24	00
Total	7755	7411	-4.40%	1109	1547	39.50%

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi

Table III.2 highlights health centres in high focus North-East state. Negative growth is seen in average increase of sub-centre from 2005 to 2012. This negative growth may be due to up-gradation of sub-centre to primary health centre. In Assam 385 sub centres are upgraded to primary health centre from 2005-2012. Tripura makes a significant increase (33.40%) in number of sub-centre. In all high focus North-East states, except Arunachal Pradesh, Assam and Meghalaya, there is increase in number of sub-centres after implementation of national rural health mission.

Primary health centre of the region is increased after implementation of national rural health mission. Assam has significantly increased number of primary health centre by 63.10% followed by Nagaland 44.80% after implementation of national rural health mission. It is observed from the table that increase of primary health centre in other states are not significant

Mizoram and Sikkim are unable to increase number of primary health centre and sub-centre. Only four sub centres are increased in Mizoram after implementation of national rural health mission. No increase of sub centre and primary health centre is found in Sikkim from 2005 to 2012.

Table III.3

Health centre in non-high focus large states by 2005-2012

Name of States	Sub- centres		Per cent Increase	PHC		Per cent Increase
				2005	2012	
Andhra Pradesh	12522	12522	00	1570	1624	3.40%
Goa	172	205	19.20%	19	19	00
Gujarat	7274	7274	00	1070	1158	8.20%
Haryana	2433	2520	3.60%	408	447	9.55%
Karnataka	8143	8871	8.90%	1661	2310	39%
Kerala	5094	4575	-10.20%	911	809	-11.20%
Maharashtra	10453	10580	1.20%	1780	1811	1.75%
Punjab	2858	2951	3.25%	484	449	-7.20%
Tamil Nadu	8682	8706	0.30%	1380	1227	-11%
West Bengal	10356	10356	00	1173	909	-22.50%
Total	57631	68560	19%	10536	10763	2.15%

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi

Table III.3 reveals that non high focus large states have made significant increase in number of sub-centre and primary health centre after implementation of national rural health mission. Total increase of sub-centres during 2005 to 2012 is 19% and total increase of primary health centres is 2.15%. Decrease in number of sub-centre and primary centre are found in states like Kerala, Punjab, Tamil Nadu and West Bengal during 2005 to 2012.

Reason for growth of sub-centre and primary health centre in Kerala and primary health centre in Punjab, Tamil Nadu and West Bengal is not available.

Table III.4

Health centres in non-high focus small states & UTs by 2010

Name of States	Sub-centres		Percent Increase	PHC		Percent Increase
	2005	2012		2005	2012	
A & N Island	107	119	11.20%	20	22	10%
Chandigarh	13	16	23%	0	0	00
D & N Haveli	38	50	31.60%	6	6	00
Daman & Diu	21	26	23.80%	3	3	00
Delhi	41	41	00	8	5	-37.50%
Lakshadweep	14	14	00	4	4	00
Puducherry	76	51	-32.90%	39	24	-38.45%
Total	310	317	2.25%	80	64	-20%

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi

Table III.4 focuses non-high focus state and union territory have increased number of sub-centres up to 2.25% after implementation of national rural health mission. But these states and union territories are unable to increase number of primary health centres from 2005 to 2012. Some of the non-high focus states like Delhi and Puducherry has grown.

Table III.5
CHC in India from 2005-2012

Category of State	No. Of CHC		Percent Increase
	2005	2012	
High Focus Non Ne State	1616	2233	38.20%
High Focus Ne State	209	246	17.70%
Non high Focus large States	1501	2338	56.70%
Non High Focus Small state & UTs	14	16	14.30%
Total	3340	4833	44.70%

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi

Table III.5 simplifies number of community health centre increased throughout India after implementation of national rural health mission. Average 38.20% increase in number of community health centre occurred in between 2005 to 2012 in high focus non-Northeast states of Bihar, Chhattisgarh, Madhya Pradesh, Jammu & Kashmir, Jharkhand, Himachal Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand. The highest growth in community health centre is in Jharkhand (300%) followed by 63.20% in Odisha, 45.41% in Madhya Pradesh. All other high focus non-Northeast states significantly grow except Bihar.

High focus North-Eastern state like Assam, Meghalaya, Manipur, Mizoram, Tripura, Nagaland, Arunachal Pradesh and Sikkim grow collectively in number of community health centre from 2005 to 2012. Similar is case of non

high focus large state and non high focus small states and union territories. Both categories of states have grown by 56.70% and 14.30% respectively.

Table III.6

Shortfall of PHC in India on 2012

Category of States	PHC		Shortfall
	Existing	Requirement	
High Focus Non-Ne State	12075	16721	4646
High Focus Ne State	1547	1471	56
Non high Focus large States	10763	12429	2655
Non High Focus Small state & UTs	64	44	10
Total	24,449	30,665	7367

Source: Rural Health Statistics, 2012, MoHFW, GOI, New Delhi

Table III.6 highlights number of community health centre is not available in all four categories of state. In high focus non-Northeast state number of existing primary health centre is 12,075 against requirement of 16,721. There is still shortfall of 4,646 primary health centre in these states. All states of high focus non-Northeast have shortfall except Himachal Pradesh.

High focus North-East states except Tripura, Manipur and Meghalaya have primary health centre more than requirement. Assam has 975 primary health centres against requirement of 953. Mizoram, Sikkim, Arunachal Pradesh and Nagaland have primary health centre more than requirement. Non high focus large states have shortfall of primary health centre except Goa, Karnataka and Kerala. In Goa, Karnataka and Kerala primary health centres are established more than requirement. In all non-high focus small states and union territories

except Delhi and Dadra and Nagar Haveli primary health centres are more than requirement. However, Chandigarh does not have requirement of primary health centre.

Table III.7
Shortfall of Sub-centre in India on 2012

Category of States	Sub centre		Shortfall
	Existing	Requirement	
High Focus Non NE State	72140	103579	22809
High Focus NE State	7339	9384	2208
Non high Focus large States	68,560	76,310	9885
Non High Focus Small state & UTs	317	288	73
Total	1,48,356	1,89,561	34,975

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi

Table III.7 shows requirement of sub-centre throughout India could not be fulfilled at end of 2012. Total number of 34,975 sub-centre need to be established to fulfill requirement of India. High focus non North-East states have shortfall of sub-centre except Chhattishgarh and Himachal Pradesh. These two states have number of sub-centre more than their requirement. High focus North-East states have shortfall of sub-centres except Mizoram as the state has 370 sub centres against requirement of 176. Non high focus large states have shortfall of sub-centre too except Goa and Kerala, where sub-centres are more than requirement. In non high focus small states and union territories shortfall of sub-centre is seen except Andaman and Nicobar Islands, Daman and Dew, Lakshadweep and Chandigarh.

Table III.8
Expenditure for Infrastructure Maintenance from 2005-2012

Category of States	Expenditure		Percent Increase
	2005	2012	
High Focus Non NE State	869.88	2047.76	135.40%
High Focus NE State	136.44	215.76	58.15%
Non high Focus large States	900.39	1988.56	1088.20%
Non High Focus Small state & UTs	6.71	17.73	164.20%
Total	1913.40	4269.91	123.15%

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi

Table III.9 reveals government of India provides adequate fund for infrastructure development for community health centre, primary health centre and sub-centre. At end of 2012 expenditure of Infrastructure increased to 123.15% and same is seen in all states.

As a result of allocation of fund for infrastructure maintenance, number of community health centre in government building increased significantly in 2012 as compared to 2005. Percentage of community health centre in government building increased 91.6% to 97% in 2012. Percentage of primary health centre in government building increased 78% in 2005 to 90.2% in 2012. Percentage of sub-centres in government building also increased 50% in 5005 to 60.4% in 2012[32].

[32]Rural Health Statistics in India 2012, MoHFW, GOI, New Delhi, downloaded from www.mohfw.nic.in, accessed on 28.7.2013

Table III.9

Doctor and ANM in high focus non NE states in 2012

Name of State	Doctors in PHC			ANMs in PHCs & Sub-centre		
	E	R	S	E	R	S
Bihar	3532	1863	0	16,943	11,559	0
Chhattisgarh	435	755	320	5468	5886	398
Himachal Pradesh	436	472	36	1951	2537	586
Jammu & Kashmir	845	396	0	3941	2303	0
Jharkhand	407	330	0	6574	4288	0
Madhya Pradesh	814	1156	342	10204	10025	0
Odisha	1069	1226	157	8211	7914	0
Rajasthan	1755	1528	0	17638	13015	0
Uttar Pradesh	2861	3692	831	22464	24223	1749
Uttarakhand	205	257	52	2016	2105	89
Total	12,359	11,675	3817	95,410	83,855	2822

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi
NB: E- existing, R- requirement and S- shortfall

National rural health mission aims to increase number of doctor, nurse and other paramedical and non-paramedical staff in health centre starting from sub-centre to district level hospital. Table III.9 shows status in increase of doctor and ANM in sub-centre and primary health centre in the country. It is found states like Bihar, Rajasthan, Jharkhand and Jammu and Kashmir fulfill their requirement of doctor in primary health centre. Himachal Pradesh and Uttarakhand are closer to their requirement. Uttar Pradesh, Madhya Pradesh, Chhattisgarh and Odisha could not reach to their target to fulfill doctor in primary health centres after implementation of national rural health mission.

Table III.9 highlights Bihar, Rajasthan, Jammu and Kashmir, Madhya Pradesh, Odisha and Jharkhand reached more than their target for increasing number of auxiliary nurse midwives in primary health centre and sub-centre after implementation of national rural health mission. Uttar Pradesh is lagging behind by 1749 auxiliary nurse midwives than its requirement. Himachal Pradesh, Chhattisgarh and Uttarakhand too could not fulfill their requirement after implementation of national rural health mission. Himachal Pradesh has 586 auxiliary nurse midwives less than its requirement followed by Chhattisgarh 398 and Uttarakhand 89. Entire high focus non North-East states have a shortfall of 2822 auxiliary nurse midwives in primary health centre and sub-centre.

Table III.10
Doctor and ANM in high focus NE states in 2012

Name of States	Doctors in PHCs			ANMs in PHCs & Sub centres		
	E	R	S	E	R	S
Arunachal Pradesh	92	97	5	395	383	0
Assam	1478	975	0	8723	5579	0
Meghalaya	104	109	5	787	506	0
Mizoram	49	57	8	650	427	0
Manipur	80	170	68	975	500	0
Nagaland	99	126	27	867	522	0
Tripura	119	79	0	798	1169	0
Sikkim	32	24	0	291	171	0
Total	2053	1637	113	13,486	9257	0

Source: Rural Health Statistics 2012, MoHFW, GOI, New Delhi
NB: E- existing, R- requirement and S- shortfall

Table III.10 shows high focus Northeast states performed well to increase number of doctors in primary health centre after implementation of national rural health mission. In North-East India against total requirement of 1637 doctors, 2053 are employed after implementation of national rural health mission. Assam, Tripura and Sikkim have doctors more than requirement in primary health centre. Manipur requires 68 more doctors in primary health centre followed by Nagaland twenty seven doctors, Mizoram 8 doctors, Arunachal Pradesh and Meghalaya 5 doctors. All states of North-East India have auxiliary nurse midwives more than requirement.

After completion of seven years of implementation of national rural health mission still shortfall is found in specialist doctors in referral health centre like community health centre and district hospital throughout entire India. Studies show 64% shortfall in specialist doctors in community health centre in India in 2011. In Jharkhand 91% shortfall followed by Chhattisgarh 86%, Madhya Pradesh 83%, Odisha 71% and Rajasthan 62%. Shortfall of specialist in community health centre of non high focus states like Gujarat is 94% followed by Haryana 89%, West Bengal 87%, Andhra Pradesh 64%, Maharashtra 59% and Punjab 42%[33].

[33] Performance Appraisal of National Rural Health Mission, August 2013, downloaded from www. counterview. net accessed, on 10.10.2013

Overall shortfall of ANM exists in India about 3.8% of total requirement as on March 2012 and 10.3% shortfall in allopathic doctor as per Indian Public Health Standard norm. 3.8% sub-centres are without a female health worker, 51.6% of sub-centres are without a male health worker, 2.7% sub-centres are without both male and female health worker, 4% of primary health centre are without doctor, 36.5% primary health centre are without lab technician and 23.1% primary health centre are without pharmacist as on March 2012. In community health centre, out of total requirement of 4833 radiographers only 2314 are available[34].

Table III.11

Number of ASHAs Selected up to 2010

Year	India	HFS non NE	HFS NE	NHFSL	NHFS S&UT
2005-06	1,30,135	1,19,662	10,673	0	0
2006-07	3,00,699	2,52,454	29,639	18,606	0
2007-08	1,71,931	58,270	5,718	1,07,702	241
2008-09	1,22,048	19,383	4,238	95,838	2589
2009-10	24,447	11,401	2,733	10,313	0
Total	7,49,440	4,61,150	53,001	2,32,459	2830

Source: Executive summary, NRHM, MoHFW, GOI, Jan. 2010 downloaded from www. Mohfw. Nic.in, accessed on 11.12.2012

NB: HFS non-NE- high focus state non- Northeast, HFS Ne- high focus state Northeast, NHFSL- non high focus state large, NHFS S & UT- non high focus state small and union territories.

[34] Rural Health Statistics 2012, MoHFW, GOI, New Delhi, Pp 1-80, downloaded from www.mohfw.nic.in, accessed on 28.12 2013

Table III.10 reveals 7.49 lakh ASHA are selected in between 2005-06 to 2009-10. In high focus non North-East states number of ASHA selected in 2005-06 to 2009-10 is 4,61,150 followed by 53,001 in high focus North-East states, 2,32,495 in non-high focus large states and 2820 in non-high focus small state and union territories.

Table III.12

ASHAs Received Training and Drug Kits (in percent)

Training	India	HFS non NE	HFS NE	NHFSL	NHFS S&UT
1ST module	94.1	95.7	94.4	91.2	83.1
2nd module	80.8	81.2	91.3	77.6	83.1
3rd module	78.5	80.9	90.7	70.7	83.1
4th module	75.5	78.5	89.4	66.2	83.1
5th module	26.6	18.3	69.5	33.8	3.1
Drug kit	69.4	75.8	90.8	51.6	84.9

Source: Executive summary, NRHM, MoHFW, GOI, Jan 2010 downloaded from www. Mohfw.nic.in, accede on 11.12.2012,
NB: HFS non-Ne high focus state non-Northeast, HFS NE- high focus state Northeast, NHFSL- non high focus state large, NHFS S & UT-non high focus state small and union territories.

Table pinpoints 94.1% of ASHA in India received first module of training but up to fifth module the same come down to26.6%. In high focus non North-East states 95.7% ASHA received first module of training but such percentage is come down t018.3% in fifth module. The case is not similar in high focus North-East state, where 94.4% received first module of training and 69.5%

received training up to fifth module training. In non high focus large states 91.2% received first module of training but it come down to 33.8% in fifth schedule of training. In non high focus small states and union territories 83.1% ASHA received training in first module and per cent suddenly come down to 3.1% in fifth module of training. It is observed from the table 69.4% ASHA received drug kit in India. In high focus non North-East states, 75.8% ASHA received drug kit followed by 90.8% in high focus North-East states, 51.6% in non high focus large states and 84.9% in non high focus small states and union territories.

In 2005-06 to 2009-10 around 90% of villages are covered by ASHA. Norm of recruitment of ASHA in various states is not transparent. In many cases recruitment is done on political and other conditions. In Madhya Pradesh, majority of ASHA belong to influential family and selection criteria such as educational attainment, willingness to serve community and family background of candidates are not considered. Even, in some cases, wife of community health worker is selected, but duty is undertaken by husband (Hussain, 2011)[35].

[35]Zakir Hussain, Health of National Rural Health Mission. Economic and Political Weekly, Vol. XLVI. No.4, January 2011, Pp 53-60

National rural health mission takes initiatives to provide various health services throughout India. In primary health centre, 24X7 service is initiated to provide twenty four hour health service to people. In 2013-13 the service is supposed to cover 500 primary health centres throughout India, but 215 primary health centres are operationalise up to September 2013. Government planned to provide first referral service to 200 community health centres, but 240 community health centres are equipped to provide first referral service. Mission planned to appoint 900 specialist, 900 staff nurse and 900 paramedical staff, but 92 specialist, 542 staff nurse and 887 paramedical staff are appointed in 2012-13. Along with such services, mobile medical unit is supposed to be operationalised. The mission aimed to provide mobile medical unit to 50 districts against which 45 districts are only covered. Moreover, 80 emergency referral vehicles are provided in 2012-13[36].

Besides programme and policy implementation, national rural health mission planned to hold village health and nutrition day in every village. There was a plan to hold 55 lakh village health and nutrition day against which 34.2 lakh village health and nutrition day are held during 2012-13. For eradication of polio, the mission planned to provide polio drop to 7million children during each national immunisation round and 86 million children during sub-national

[36]National Rural Health Mission, Review of Performance 2012-13, MoHFW, GOI, Pp 1-112, downloaded from www.mohfw.nic.in, accessed on 21.10. 2013

immunisation round. Three sub-national immunisation round was completed in June, July and November 2012[37].

Routine immunisation is done during implementation of national rural health mission. The mission planned to increase full immunisation up to 70% by end of 2012-13. As per record, it is found that BCG coverage is 72.5% during 2012-13, DPT3 coverage is 66.09%, OPV3 66.27%, and Measles 71.27%, full immunisation is 68.46% as on November 2012. Performance of immunisation was satisfactory in 2011 too. In 2011 BCG performance was 90.93% followed by DTP3 86.33%, OPV3 82.33% , Measles 85.57% and full immunisation 84.02%[38].

National rural health mission successively aims to provide maternity and child care throughout the country. Government aims to promote maternal care through *Janani SurakshaYojana* (JSY). 50.54 lakh beneficiaries are covered under this scheme during April-September 2012. Steps are also taken for enrolment of JSY beneficiaries under *aadhaar* scheme. Steps are also taken by government to promote institutional delivery, to eliminate out pocket expense, prompt referral service with free and zero expense treatment, free drug and consumable, free diagnosis, free provision of blood, free transport from home

[37]Ibid, Pp 46-68
[38] Ibid Pp 68-72

to health institution, free transport in case of referral, free drop back from institution to home and exemption from all kinds of user charge[39].

National rural health mission aims to provide better new born care. For better child health service, it provides training to health personal. 88422 health personal is trained in NSSK till October 2012 and 399 SNCU, 1542 NBSU, 11,508 NBCC have been set up to address sick new born care in October 2012. National rural health mission takes initiatives to establish NRC for control of malnutrition.

National rural health mission also aims to initiate family planning. For family planning the mission produces 367 million pieces of condom, 230 cycle of oral pill, 88.76 lakh pieces of IUD, 39.03 lakh pairs of tubal ring and 75.799 lakh packs of ECP during 2012-13 and procure to states for free distribution. The mission sent 2, 22, 18,600 lakh pregnancy test kits to sub-centre up to September 2012[40].

Mission also has initiative programme to control vector born disease, leprosy eradication programme, tuberculosis control programme, national programme for control of blindness, integrated disease surveillance programme, national

[39]Ibid, Pp 74-78
[40]National Rural Health Mission, Review of Performance 2012-13, MoHFW, GOI, Pp 1-112, downloaded from www.mohfw.nic.in, accessed on 21.10. 2013

cancer control programme, national tobacco control programme, national mental health programme etc[41].

National rural health mission is yet to reach to its target for specific health indicators like maternal mortality ratio, infant mortality rate and total fertility rate. In 2005, infant mortality rate in India was 58 which came down to 42 in 2012. But at end of 2012, mission is unable to reduce infant mortality rate to its desired goal of below thirty[42].

Maternal mortality ratio in India was higher in 2005. Before implementation of national rural health mission, maternal mortality ratio was 254 which came down to 212 in 2011. Still India has not achieved its target for maternal mortality ratio. Government of India proposes to reduce maternal mortality ratio below 100 after implementation of national rural health mission[43].

Total fertility rate of India in 2005 was 2.9. Government India set target to reduce total fertility rate to 2.1 after implementation of national rural health mission. But till 2011 total fertility rate came down to 2.5. Gap between target

[41]Ibid. Pp 76-88
[42]Sample Registration System, Govt. of India. bulletin. Vol. 47, September 2013, Page 207.
[43]Ibid, Pp 182

and achievement exists now. Data on total fertility rate is not found after 2011[44].

Birth rate in India in 2005 was 23.8 which came down to 21.6 in 2012. Death rate in India in 2005 was 7.6 which came down to 7.0 in 2012. Natural growth rate in India was 16.2 in 2005 which came down to 14.5 at end of 2012[45].

Studies show rural health programme management unit and health information system is better in high focus states. Overall situation of programme management in district level of high focus states is satisfactory. But at block level and PHC level, programme management is not satisfactory. In PHC and SC, register is not maintained properly and those maintained are not updated regularly or not maintained in accordance with format provided to them[46].

Conclusion: National rural health mission started its journey in 2005 with a view to improve health of rural people. Government of India is providing financial support to every state and union territory to implement the programme. Success of the programme solely depends upon involvement and cooperation of state government to utilise funds properly in time.

Starting from 2005 to 2010, the mission though could not achieve its target in all dimensions, somehow approaching to provide improve health service to

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[44]Ibid, Pp 182
[45]Ibid, Pp182
[46]Zakir Hussain, Health of National Rural Health Mission, Economic and Political Weekly, Vol. XLVI, No.4, January 2011, Pp 59

rural people. Significant increase is observed in number of primary health centres in states of Andhra Pradesh, Assam, Bihar, Chhattishgarh, Gujarat, Haryana, Jammu and Kashmir, Karnataka, Maharashtra, Nagaland, Uttarakhand and Uttar Pradesh. Significant increase is also taken place in number of sub-centres in states of Chhattisgarh, Haryana, Jammu and Kashmir, Karnataka, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Tripura and Uttarakhand. Significant increase in community health centre is also seen in some of states like Andhra Pradesh, Arunachal Pradesh, Chhattishgarh, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Kerala, Madhya Pradesh, Odisha, Punjab, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh and West Bengal.

Some states in India like Karnataka, Kerala perform well. High focus states started well but success of programme in high focus states depends on role of respective state government for proper utilisation of fund toward achieving target set by national rural health mission.