

Sociological Critique of the National Rural Health Mission: Issues and Priorities

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National Rural Health Mission (NRHM- 2005-07) has been viewed as the holistic and democratic mission mode intervention by the state in the field of health. It is based on innovative and comprehensive strategies for providing funds, creating new institutions, decentralization and providing new ideas and resources for health. Assuming the importance of NRHM in improving general health conditions and in particular improvement in IMR and MMR the state has extended it further till 2017. The Twelfth Five Year Plan has also extended NRHM to urban poor, calling it a National Health Mission (NHM) rather than National Rural Health Mission (NRHM). This paper examines the goals and strategies of NRHM and discusses its strengths and weaknesses. At the end it suggests that to make health interventions effective there is a need to strengthen the primary health care system in both rural and urban areas. Weakening of the primary health care system due to multiple priorities and transfer of responsibility to private sector in the new-liberal regime may do a severe damage to the health system.

National Rural Health Mission (NRHM) has been a noble experiment in the direction of improving status of health in the country. As per the Constitution of India, health has been a State subject but the Centre always recognized the need to support State health action to provide equitable and effective services to people belonging to different regions and social groups. This paper aims at critiquing the ideas and practices of NRHM and related health policy matters. Using secondary data and literature it argues that although the aims of objectives of NRHM are holistic and laudable the field practices leave much to be desired. In its present form NRHM has not achieved the stated goals in time and is suffering from many bottlenecks. Concerned about various macro and micro issues, NRHM lacks a focus. The paper argues that although action is

required on several fronts, the most vital need of the project is to strengthen the primary health care system. Due to an overambitious approach on the part of Ministry of Health and Family Welfare a large number of initiatives have been taken but few of them are effectively implemented.

Objectives

The major objectives of this paper are as follows:

1. To examine the goals and strategies of NRHM
2. To discuss the strengths and weaknesses of NRHM
3. To make suggestions for developing effective health interventions
4. To argue for strengthening the primary health care system and that weakening of the primary health care system due to multiple priorities and transfer of responsibility to private sector in the new-liberal regime may do a severe damage to the health system

Prehistory of NRHM

NRHM is a mission of the Ministry of Health and Family Welfare (MHoFW), New Delhi. From the beginning of the post-independence period, MHoFW has planned and promoted a large number of activities at the national level to improve the standards of public health in India, with emphasis on preventive, promotive and curative aspects of health. However, the 21st Century is marked by a paradigm shift in health when a more aggressive, mission mode, approach to health is adopted. In the field of health two important things happened in India in year 2000 itself. For the first time, Indian government announced the National Population Policy (known as NPP 2000), and India became one signatory among the 191 UN Member States to commit to Millennium Development Goals (MDG). The NPP 2000 had the following objectives:

- Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.
- Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.
- Reduce infant mortality rate to below 30 per 1000 live births.

- Reduce maternal mortality ratio to below 100 per 100,000 live births.
- Achieve universal immunization of children against all vaccine preventable diseases.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.
- Achieve universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices.
- Achieve 100 per cent registration of births, deaths, marriage and pregnancy.
- Contain the spread of Acquired Immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organisation.
- Prevent and control communicable diseases.
- Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.
- Promote vigorously the small family norm to achieve replacement levels of TFR.
- Bring about convergence in implementation of related social sector programs so that family welfare becomes a people centred programme.

Under MDG, there are eight goals to be achieved by 2015 which overlap with the stated objectives of the NPP. They are:

- to eradicate extreme poverty and hunger;
- to achieve universal primary education;
- to promote gender equality and empower women;
- to reduce child mortality;
- to improve maternal health;
- to combat HIV/AIDS, malaria, and other diseases;
- to ensure environmental sustainability; and
- to develop a global partnership for development.

Two years later India also announced the National Health Policy – 2002. This policy reflects the concerns of MDGs. The NHP – 2002 may be called the forerunner of NRHM which was to start from 2005. The Eleventh Five Year Plan 2007-12 and the Twelfth Five Year Plan 2012-17 show the similar concerns with fast and inclusive growth, focusing on the lagging sectors and populations.

The Approach of NRHM

The National Rural Health Mission, 2005-07 (NRHM) was launched on 12th April 2005 by the Prime Minister of India to improve the status of health services in India. It has now been extended till 2017. It is based on the understanding that under the prevailing circumstances States required additional funds and technical and institutional support from the Centre to improve the health status of their population. The stated aim of the NRHM was to provide accessible, affordable and accountable quality services to rural population with concentration on 18 ‘Special Focus States’ and the poor. These States include the Empowered Action Group States, States of the North-East, Jammu & Kashmir and Himachal Pradesh (http://www.mohfw.nic.in/NRHM/Documents/NRHM_The_Progress_so_far.pdf).

Sociologically, it is notable that apart from providing financial support several new institutional changes were envisaged. They include communitization of funds, flexible financing, improved management through capacity building, improved monitoring against standards, and innovations in human resource management. Provisions of untied funds, involvement of Panchayati Raj Institutions (PRIs), public-private partnership and convergence of health sector and a wide range of other determinants of health (e.g. water, sanitation, education, nutrition, social and gender equality) were created to develop ‘a fully functional health system at all levels, from the village to the district’ (http://www.mohfw.nic.in/NRHM/Documents/NRHM_Framework_Latest.pdf). Some of the major planks of the NRHM were appointment of Accredited Social Health Activist (ASHA) in each village (one on the population of 1000), health insurance for the poor, and involvement of non-profit sector, especially in underserved regions. The Mission aims at “fostering PPPs; improving equity and reducing out of pocket expenses; introducing effective risk-pooling mechanisms and social health insurance; and taking advantage of local health traditions” (Eleventh Five Year Plan, 2008). Quoting Independence Day speech, 2012, of the Prime Minister of India, the Twelfth Five Plan document notes that the success of the National

Rural Health Mission shows the way for converting NRHM into National Health Mission (NHM) which would cover both rural and urban areas. Thus an impression is created that NRHM has been quite successful in achieving its goals.

NRHM has several new things. To follow Gill (2009) these new things are: creation and up gradation of human and financial resources of health facilities at all levels; revitalising and mainstreaming traditional medical practices; flexible funding; converging health, nutrition, water, sanitation and hygiene activities through District Health Plans; integration of vertical health and family welfare programmes; fostering public-private partnerships with better regulation of the private sector; instituting Indian Public Health Standards; and creation of Janani Suraksha Yojana (JSY), Accredited Social Health Activists (ASHAs), Hospital Development Societies (HDS) or Rogi Kalyan Samitis (RKS) / Village Health and Sanitation Committees (VHSCs);

Evaluation of NRHM: Achievements and Failures

In statement of achievements, 'NRHM – the Progress So Far', Ministry of Health and Family Welfare reports that NRHM has reduced IMR at higher rate than earlier (during 2003-2006), increased institutional deliveries, raised the figures of full immunization, constituted Rogi Kalyan Samitis, appointed and trained ASHAs, constituted Village Health Committees, created village health and nutrition days, provided mobile medical units and co-located AYUSH in a number of health facilities. These are not the mean achievements. Yet, this is not the full story and a thorough examination of cost-benefit analysis of the project is required. This has not been done so far, perhaps because problems abound.

It is practically impossible to evaluate the cost-effectiveness of a national project like NRHM. Health depends on a number of factors such as living and working conditions of people, education, degree of social integration, awareness, belief systems, quality of environment, and access to health facilities, among others. During the last eight years after implementation of NRHM changes have occurred in all the parameters which present significant externalities. Some data are, however, available from both government sources and researchers which are worth observing.

International Institute for Population Sciences (IIPS), Mumbai, has produced a voluminous *Fact Sheet of Concurrent Evaluation of National Rural Health Mission 2009*. This document (IIPS,

2010) establishes that there are pronounced inequalities between States and the achievements are far from being satisfactory. Sample Registration Scheme' Special Bulletin on Maternal Mortality in India 2007-09 (SRS, 2011) showed that MMR varies from 81 in Kerala to 390 in Assam, and maternal mortality rate varies from 4.1 in Kerala to 40.0 in Uttar Pradesh/Uttarakhand. SRS Bulletins also show the continuing differences in IMR and DRs between States and different Union Territories of India. SRS Bulletin of 2009 showed that IMR of India is 53. It is 58 for urban areas and 36 for rural areas. While Goa has a very low IMR which is 10, IMR of Madhya Pradesh is 70. According to October 2012 Bulletin of SRS the IMR of India has come down to 44 but the differences between urban and rural localities and different States have continued. Odisha, Rajasthan, Madhya Pradesh and Uttar Pradesh have IMR above 50.

As per the concurrent evaluation mentioned above (IIPS, 2010), Uttar Pradesh which is one of the High Focus States is characterized by the following:

1. Only 4.5 percent PHCs have piped water supply.
2. Only 3.0 percent PHCs were upgraded as per IPHS norm.
3. 17.9 percent PHCs Rogi Kalyan Samitis (RKS) generated resources.
4. Out of 31 DHs covered in the study only 8 had Neo Natal ICU/ specialized Sick New Born Care unit.
5. Only 6.2 percent ASHAs received incentive for Village Health and Nutrition Days (VHND).
6. Only 13.2 percent ANMs stayed in official residence.
7. 66.5 percent children received full immunization.
8. 28.7 percent of the currently married women (15-49) reported to have exclusively breastfed youngest surviving child for the first six months.

Yet, it may be noted that most of the IPD and OPD patients were satisfied with the services at DH, CHC, and PHC. More or less similar is the situation in Bihar and other High Focus States. To me this means that for those who come to avail services in government health facilities these facilities are of great value, if for one reason that they have no other alternative.

Among the latest sources of data, Annual Health Surveys have shown: (a) full ANC (i.e. three or more ANC, one TT injection and IFA for 100 days or more) varies from 3.9 percent in Uttar Pradesh to 19.5 percent in Chhattisgarh; (b) during 2007-09 one in four marriages of girls in Bihar and one in five in Rajasthan and Jharkhand occurred below the age of 18; (c) in Chhattisgarh only 34.9 percent deliveries are institutional; and Bihar and Uttar Pradesh continue to have high TFR. On the positive side there has been no polio case in India after 13 Jan. 2011 (NRHM Newsletter, 2012). Observations from the Fifth Common Review Mission reports are also useful and insightful. The Uttar Pradesh report shows that the newly constructed PHCs are lying locked due to non-availability of Staff; equipments needing minor repairs are lying dysfunctional; district priorities for infrastructure are not reflected in State PIP; there is a severe shortage of Specialist/MOs/Nurses/MPWs; the conventional methods of recruitments/outsourcing are not producing the desired results; there is a serious lack of priority to training; there is a shortage of training institutions; the quality of training is not good which affects delivery of health services; biomedical waste management is grossly inadequate; and quality assurance mechanisms are not established.

Eleventh Five Year Plan document itself recognizes that there are several drawbacks of the public health systems. They are: (a) centralized planning instead of decentralized planning and using locally relevant strategies; (b) institutions based on population norms rather than habitations; (c) fragmented disease specific approach rather than comprehensive health care; (d) inflexible financing and limited scope for innovations; (e) semi-used or dysfunctional health infrastructure; (f) inadequate provision of human resources; (g) no prescribed standards of quality; (h) inability of system to mobilize action in areas of safe water, sanitation, hygiene, and nutrition (key determinants of health in the context of our country)—lack of convergence; and (i) inability to mobilize AYUSH and RMPs and other locally available human resources. The same document mentions about the review of NRHM leading to following conclusions:

- 17318 Village Health and Sanitation Committees (VHSCs) have been constituted against the target of 1.80 lakh by 2007.
- No untied grants have been released to VHSCs pending opening of bank accounts by the Committees.

- Against the target of 3 lakh fully trained Accredited Social Health Activists (ASHAs) by 2007, the initial phase of training (first module) has been imparted to 2.55 lakh. ASHAs in position with drug kits are 5030 in number.
- Out of the 52500 Sub-centres (SCs) expected to be functional with 2 Auxiliary Nurse Midwives (ANMs) by 2007, only 7877 had the same.
- 9000 Primary Health Centres (PHCs) are expected to be functional with three staff nurses by 2007. This has been achieved at 2297 PHCs.
- There has been a shortfall of 9413 (60.19%) specialists at the CHCs. As against the 1950 CHCs expected to be functional with 7 specialists and 9 staff nurses by 2007, none have reached that level.
- CHCs have not been released untied or annual maintenance grant envisaged under the NRHM as they have not reached up to the expected level.
- Number of districts where annual integrated action plan under NRHM have been prepared for 2006–07 are 211.

While discussing the strategies of NRHM the Eleventh Five Year Plan admits that there are formidable problems. For example, the Centre has focused on reducing MMR the most. From the top to bottom, efforts are made to minimize maternal deaths in the country which still has an unusually high rate of maternal mortality. Janani Suraksha Yojana is precisely about this. At the same time the Plan recognizes that encouraging women to go to health facilities for delivery alone cannot reduce maternal mortality to zero. It accepts that the country does not have adequate institutional capacity to receive all women giving birth each year and that half of the maternal deaths occur outside delivery, i.e., during pregnancy, abortions and postpartum complications. The problem is mixed up with several issues such as lack of concern for women's health, malnutrition, lack of proper transport facilities, lack of awareness of danger signs, lack of full ANC, and lack of stress management.

Planning Commission's Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012-2017) presents the policy framework of NRHM in the Twelfth Five Year Plan. Among the new provisions under NRHM the role of ASHA workers is considered to be very significant. Therefore it is revealing what the review of ASHA scheme shows. Quoting from *Which way forward?: An Evaluation of the ASHA Programme* in

Eight States, a study conducted by National Health Systems Resource Center in 2010, the report says:

A recent large scale evaluation of the programme in a sample of 16 districts across eight states, offers important evidence on the functionality and effectiveness of the ASHA. The finding that about 74% of women with a child up to 6 months and about 71% of women with a child under two who had an episode of illness in the past month, reported receiving services from ASHA indicates that nearly 30% of the population is still not reached. The second significant finding is that ASHAs were very active and effective in promoting institutional delivery and immunization and to some extent access to sterilisation, because the support system was geared to promoting exclusively these aspects. The ASHAs were therefore less functional and effective in tasks related to community level counselling, care provision and in mobilisational work and the lesser effectiveness is correlated to the inadequate emphasis on skills in the training curriculum and lack of support systems for ongoing mentoring, support and supervision. Thus at this stage though we are getting outcomes related to improved institutional delivery and increased attendance at immunisation, the role of the ASHA in child survival has only been strengthened recently with issue of guidelines on Home Based New born Care and introduction of 6th and 7th Module training. These deficiencies have since been corrected and the last year of the plan has brought considerable focus on skills and home based newborn care as envisaged so clearly in the eleventh five year plan. This plan would need to persist for at least three years before acceleration in child survival can be seen.

In a balanced article Jacob (2011) said that the NRHM needs to face a number of challenges to deliver effectively. Two of them are of special interest. First of all, the proposed system of health insurance may take away a huge amount of funding from the health care delivery in the rural areas and weaken the government system. Secondly, it is difficult to place the trained doctors in remote rural areas which lack in basic amenities and services at the health center as well as the locality. So therefore, there is a need for “differential payments to health care staff who work in remote situations and difficult contexts”.

Our experience of working among rural and tribal populations shows that for the rural (and also for the urban) poor the first place to think of for health needs is the government hospital (in rural areas PHCs and CHCs too are called hospitals). As long as they can work, they work; only when a disease or illness affects their roles and they perceive a threat to their functionality they look for the most convenient treatment (often by a quack at the nearest point). Failure of quack's treatment makes them go to 'hospital' which is a costlier choice for many. Hospital doctors are considered to be certainly more competent. If there is a functioning health facility in the vicinity

and the treatment is accessible and affordable there is no reason why people go to quacks now. Magical practices of very very remote areas are only an exception. It is also a fact that doctors who are known for their concern about people are the most trustworthy elite and people will listen to them about making choices, immunization, nutrition and behaviour change.

In the new-liberal regime the primary health care system seems to be weakening despite the creation of Aanganwadi Workers (AWs), ASHAs, and emergence of health insurance for the poor. There are many reasons behind this which are well documented in the Plan drafts. It cannot be substituted by democratization, transfer of responsibility to private sector, and multiple actions to involve AYUSH, CBOs, NGOs and PRIs in health delivery. Indeed it may do a severe damage to the health system for the poor.

Major Challenges of NRHM

The Chapter on Health in the third volume of Twelfth Five Year Plan is a very well written draft. It takes a holistic view of health, includes all conceivable ways of improving health of people and identifies twelve issues to ponder, ranging from maternal and child health to ethical issues in research. Yet, they lack the field view of health. Literature shows that there are several determinants of people's health: structure of society; conditions of living and working; values and beliefs; life styles and choices; and availability of health facilities. Commenting on the higher mortality of working class in the nineteenth century Engels (1845) attributed this to unhygienic living condition, unhealthy working condition, poverty, lack of proper diet, non-availability of proper medical facilities due to inability to pay high fees of English doctors, and cheap charlatans and quack remedies which do more harm than good. His ideas are still quite relevant. To improve health at the national level requires that the poor are also provided clean water, sanitation, quality employment, education, housing and nutritious diet. Research has shown that equality in both economic and social senses is vital to improvement of life expectancy (Wilknsn, 2005). Presenting the sociology of health perspective White (2011) argues that diseases are socially produced and distributed and class, gender and ethnicity are three major factors which shape them.

Without going into the issues of social structure, which are more important in case of public health though, there are nine major questions:

1. What should be the targets?

I am most perplexed by the target setting under NRHM. In the field of health why targets for IMR, MMR, anemia etc. should differ from State to State? Why should they not be zero? Why should we be happy if Bihar has the MMR of 177 or UP and Uttarakhand of 163 and Kerala of 37? Regionally differentiated approaches to health make sense but why should targets also differ? Should the goal not be to reduce them to the lowest possible levels (say around 3-5) for all States and social groups?

2. How can health governance be improved?

Are mechanisms to regulate food items in place? Are rules regarding private medical practice effective and in practice? Are there negative and positive sanctions in place for performance of staff? Can health governance be dissociated from general governance? UP has a fraud of Rs. 3000 crores under NRHM. What does it mean in terms of governance of the State? In the new paradigm transfer of power to PRIs is believed to be of great significance in running the programmes effectively. However, investigations have shown that PRIs are not always the epitome of democracy and decentralization. PRIs do not exist in vacuum and are part of the larger socio-economic and cultural milieu (Raghunandan, 2012).

3. What are feedback mechanisms and how does programme respond to feedback from ASHAs and AWs?

There are serious issues not only with background, training, motivation and overburdening of grassroots workers but there are also issues regarding feedback from them and response of the system to their feedback. There is very little thinking about motivational and reward strategies among grassroots workers and volunteers.

4. If the staff position and facilities cannot be improved should they not be limited to certain regions and sections of society only, specially the poor?

This issue has to be given a careful thought. As long as limited services are thrown open to all, there is a higher chance that they will be expropriated by the local elite and not reach the neediest people. On the other hand, it would be unethical to deny public health services to some local people because they do not meet the economic or social eligibility criteria.

5. How does AYUSH help in strengthening health services, in improving the quality of services at the local level, and in changing belief systems of the people?

For a long time in the country modern medical science has been presented as having the monopoly over truth and all traditional practices for which there is no scientific evidence have been rejected. This has been true of discourses among experts and lay persons. Sharatchandra's (2008) famous story 'Bilasi' emphatically conveys the emptiness of certain traditional knowledge claims. Now what do we achieve by including AYUSH in government health facilities? Are we to take an official stand that both science and non-science are on equal footing as long as they prove to be of any utility? How do we select some traditional practices from all? How to winnow truth from false beliefs? Although the presence of AYUSH in the health facilities is only token (Twelfth Plan outlay on AYUSH is 3.3 percent of the total MoHFW outlay), this is having serious implications for the perspectives on health. Twelfth plan too says that for involving AYUSH graduates in the primary health system the legal framework has to be amended. The new provisions have to authorize the practice of modern medicine by practitioners of Indian medical systems. Does it mean that while the elite classes go for allopathic medicine the rural poor are provided AYUSH because they cannot be given allopathic medicine? To quote from the Twelfth Plan chapter on health (p.38): "Associations of allopathic practitioners are generally opposed to AYUSH practitioners being allowed to prescribe allopathic medicines; they will have to be persuaded to yield in the national interest of serving the masses, particularly the rural population and the urban poor. Suitably trained, AYUSH graduates can provide primary health care and help fill in the human resource gaps in rural areas."

Then can't we think of providing the same training to Jholachhap doctors (untrained allopathic practitioners) and involve them in the programme? Evolved on the pattern of training of traditional birth attendants, training of existing village practitioners could be of immense value in primary care.

6. What optimum strategies are developed for health education and behavioural change communication? In other words the issue is: What needs to be done to improve use of safe water, advantages of early breastfeeding, compliance in cases of tuberculosis and other diseases, and health diet?

7. Is there any stigma against certain communities/minorities which discourage them from availing services?

Our experience in the field shows several instances of minorities not going to health facilities for delivery, family planning and other services due to a perceived stigma against them among the state providers. Something has to be done about this and about building trust relationship with the minorities and excluded groups.

8. Why are mental health and palliative care not given adequate attention?

With aging of population and epidemiologic transition (Omran, 1971), non-communicable, degenerative diseases are going to have a greater disease burden. Already there is evidence that prevalence of mental illness may be higher than assumed and suicide deaths are more than the total maternal deaths, tuberculosis, deaths due to cardiovascular diseases, and deaths due to accidents (Patel et al., 2012).

9. Where should the priority lie?

From our point of view a multipronged approach is undoubtedly required to improve health. Yet, within the constraints of logistics, limited funds and limited resources we cannot achieve everything. To us there is only one most important concern and that is strengthening the primary health system. This is within the capabilities of Ministry of Health. Yet, within the constraints of logistics, limited funds and limited resources we cannot achieve everything. The maximum priority must be assigned to strengthening the primary health system. If the primary health services are strong it helps in many ways: (a) it raises trust of people in services at block, panchayat and hamlet levels; (b) those who do not have any other alternative (rural poor) they too can have preventive and curative services; (c) it makes health services more efficient and effective; (d) it reduces the load on specialists (in both public and private facilities); (e) it leads to inclusive development; and (f) it can make strategies of behavior change communication more effective. Empowered and independent medical officers at these facilities can also play an important role in regulation of food and drugs, and control of pollution. It is heartening to learn from the Secretary, Health and Family Welfare, that “The district hospitals would be strengthened to provide advanced level secondary and tertiary care to help reduce the private out-of-pocket expenditure on health. However, the focus on primary care would continue and not be diluted” (Pradhan, 2012).

The whole NRHM seems to be based on a number of weak assumptions:

1. Health is most vital to people.
2. Individuals follow an instrumentally rational approach to health (This assumption ignores habitus and interactive situations).
3. Several current practices ignored in the programme (AYUSH) are rational, efficient and effective.
4. People differ primarily in terms of economic capital or financial resources only.
5. State is in full command of other fields – religious, community, values, social systems.
6. State is effective.
7. With small incentives members of civil society can act as effective agents of state.
8. Non-beneficiaries of the state programmes including NRHM are random groups.

Using Smith, one may argue that the above assumptions reflect the rules of ruling, i.e. the objectified ideology of the ruling classes and there is an utmost need to examine the whole question of health management from the standpoint of poor clients (Smith, 1992). Sociological literature is replete with facts and arguments that the above assumptions regarding people may not be true and that social capital is an important factor in returns on human capital. Social capital not only determines directly the health status of a population it also contributes to coping and treatment (Coleman, 1994; Coleman, 1988; Ottebjer, 2005). This particularly relates to 8 that non-beneficiaries of the state programme including health are random groups. As a matter of fact they are most often the most marginalized groups lacking in trust in the state programmes. A strong PHC can help a lot in removing the distrust and misconceptions among these groups in society.

Recommendations

This paper examines the prehistory and the approaches of National Rural Health Mission (NRHM). Based on available material, achievements and limitations are also discussed. The paper raises nine questions about the approaches and strategies of NRHM and suggests that the most effective way to attain goals of NRHM is to strengthen the primary health care system

rather than taking up a large number of things simultaneously without any focus. This is not to denigrate the importance of other measures and we recognize that to improve public health standards in the population a multipronged approach is indeed required but a fully functioning primary health care system is a necessary condition for other goals to be achieved.

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