Letter to the Editor

National Rural Health Mission : Training of Health Functionaries

Sir,

The National Rural Health Mission (2005-12) has been launched on 12th April 2005 by the Government of India (GOI). The NRHM will cover all the villages in 18 States through, approximately, 2.5 lakh village-based "Accredited Social Health Activists" (ASHA) who would act as a link between the health centers and the villagers. New components have been added to the existing Primary Health Care delivery system in the country, like supply of AYUSH drugs, horizontal integration of vertical national health programs, annual grant of Rs. 10,000 per sub-center, integrated disease surveillance programme, provision of 24-hour service through mainstreaming AYUSH manpower etc. Hence, training of the health functionaries at various levels is envisaged.[1]

According to the projections made for a unit of 100 ASHAs, which would be in each block of 100,000 population, the total cost of training ASHA will be Rs. 7,41,500; and in a district with 12-15 blocks, about 1 crore of rupees will be spent/available for training ASHA honorary functionaries.

For logical reasons, the NRHM will start with the activities of selection and training of ASHA. The national, state, and district levels trainers will be trained to make them aware of the different new components of the NRHM. Earlier there were similar training activities in the entire country with initiation of expanded programme of immunization (EPI) in the early eighties; universal immunization programme (UIP) during the Seventh plan (1985-90); child survival and safe motherhood programme (CSSM) during the eighth plan (1992-97); reproductive and child health (RCH) programme in the ninth plan (1997-2002). During the late nineties there was also a country-wide training programs for "Target Free Approach" / "Community Need Assessment Approach". Health infrastructure has experienced a system of organizing training activities from national level to the most peripheral block level. In the past, there have been examples of national programs and initiatives which started with training and closed with trainings activities, and no evaluation of these programs was conducted (UIP, CSSM) to assess their success[2].

The conducting of training is convenient both to the trainers and trainees, as the one gets money for speaking and other gets money for listening. Also the lodging and boarding are free to both. There are also flexible funds available with each training program. The funding agency of the program also need an objective data to show how many persons were trained against the funds spent. In the past, there are instances where program duration was already over but the training continued; for example the CSSM program tenure was for 5 yrs (1992-97) but the training continued till march 1999 so that the training funds sanctioned to the states could be utilised.

The training disrupts the implementation of the routine health care services by the health functionaries as they attend the training courses away from ther place of duty. A large country like ours cannot afford the frequent training courses which are often time-consuming, and at times not required. There is a need for horizontal and vertical convergence of training activities of various national programs like RCH, IMNCI, NRHM etc, which are presently or likely to be implemented. One of the possible options is to include all the different types of training activities in the pre-placement course for the various levels of functionaries (new recruits) before they are posted. These pre-placement training courses can be conducted by network of health and family welfare training centers in the country. The training of 2.5 lakhs ASHAs will also be time-consuming. All efforts should be made to ensure that training of ASHA is completed within first two years of NRHM so that they have five years to perform and, if required, mid-course correction can be undertaken in NRHM implementation

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REFERENCES

1. National Rural Health Mission 2005-2012, Mission document, Ministry of Health and Family welfare, Government of India 2005
2. Kapil U. After RCH program be ready for IMCI strategy. *Indian Pediatr* 1999; 11 : 1177-1178.