SPEAKING FOR MYSELF

EFFECTIVE IMPLEMENTATION OF NATIONAL HEALTH PROGRAMS: ISSUES AND CHALLENGES

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Dear Sir,

One of the many ways which Government of India has adopted to address health challenges in the country is through implementation of national health programmes. The history of health programmes dates back to 1951, when India became the first country to adopt National Family Welfare Scheme[1]. The center has been promoting programmes for solutions to health problems of national importance by providing financial assistance and broad framework of implementation while the states have the responsibility of implementation of the programme. Effective implementation of national programmes require meticulous planning, pilot phase implementation, financing, proper evaluation of the effectiveness and feasibility of pilot and scaling up. Though India has been implementing health programmes for more than six decades now, the progress towards achieving the millennium development goals is rather slow in most of the areas[2]. Even there is huge interstate disparity in terms of achieving these targets. We are trying to highlight some of the challenges and barriers in implementing national health programmes.

A. Integration of various stakeholders

During programme formulation:

Programme, policies and plans are formed with involvement of many stakeholders like bureaucrats, technocrats, representatives of research organizations, non governmental/community based organizations, bilateral agencies and community representatives. Each one has a specific role to play; hence coordination among the team members is vital for development of an effective and practical plan considering everybody's perspective. Involvement of all stakeholders leads to greater ownership for the programme during implementation. It is important to communicate with each other clearly and specifically regarding the problem at hand. One specific team should be given responsibility of seeing through the programme from inception to implementation at the grass root level.

During programme implementation:

The coordination between policy makers and programme implementers is far from what is desired for effective rolling out of health programmes. Policy and programmes are framed with inadequate knowledge of existing bottlenecks at the field level. Programme implementers who are the key stakeholders in success of a health programme, unfortunately, have little involvement during programme formulation. It is imposed on the implementers most of the times. Moreover, because of limited manpower, programme managers are dealing with multiple programmes simultaneously. So it is desirable to involve state and district programme managers at programme formative stage and give enough flexibility to the states/ districts at implementation stage to adapt the program locally, which are formulated at the centre.

Intersectoral coordination:

India's progress towards achieving Millennium Development Goals has not been very encouraging[3]. However, health services are merely one of the several determinants of health. Hence, blaming the health care sector alone for current status of health indicators is unfortunate. We usually forget that almost majority of the determinants of health lie outside the health service sector; may it be non-communicable disease prevention, diarrhea control or child survival. Addressing these upstream determinants in addition to the downstream ones in causation of the diseases[4] in national programme will be the key to success of any new plan. To achieve overall health of the community, a multisectoral, multipronged approach is needed. This can only be possible once the policy makers of health sector take initiative to sensitize their counterparts in other sectors like education, water and sanitation and social development and seek their involvement to figure out solutions for the existing problems.

B. Lack of Manpower/ support staff

It is observed that our health system is dearth of manpower[5]. There are vacancies at all levels in government health system and existing manpower are overburdened with multitude of work with little extra incentive or benefits. Government health system has failed in providing appropriate facilities to the field staffs in comparison to their corporate counterparts. Although the National Health Policy recommends that 25 percent of the post graduate seats should be reserved for Community Medicine[6]; meeting these norms seems to be a distant reality. The shortage of paramedical staff also compounds the problem[5]. Coupled with lack of manpower there are political and

bureaucratic interferences in recruitment, relocation and job termination of health personnel. This at times lead to manpower-job mismatch, plugging square pegs into round holes.

C. Orienting health practitioner towards public health approach:

Our undergraduate and post graduate curriculum in medical colleges have always emphasized on treatment of diseases than prevention and promotion of health. The health care providers use their own guidelines or obsolete guidelines in stead of the standard prescribed protocols[7]. There are no regular continuing medical education programmes for government doctors; many of them have limited interest in gaining new skills either. Management skills are grossly lacking in health care providers and poor monitoring and supervision have lead to inadequate and ineffective implementation of programmes[8].

D. Developing healthy and committed workforce:

Health care providers in current situation are driven by force rather than interest. Though there may be exception to this statement. Sustainable good performance of national programmes requires commitment from implementer rather than coercion by higher authorities. Motivating the staffs who are actually handling these programmes at different level is a challenge. They are more dedicated towards their private practice which gives them rich dividends. Every little thing requires lots of paper work (*red tapism*) and approvals and there is little room for flexibility, this makes working even more difficult.

E. Evidence based planning:

Mostly health programmes start as small projects under very controlled environment. Observing the success of the projects it is piloted in few selected states based on performance history and needs. Then it is rolled out to other states The problem starts when uniform programme runs in all states having wide variation in the socio-economic status and health system which will implement the programme leading to success story in few states having favourable circumstances and partially successful or failure in majority states having not so favourable circumstances. Programme should be evaluated at formative stage, mid-term and end line and make necessary changes in implementation plans. Without proper evaluation of the health programmes, new programmes are added each year. Integration of related programmes will decrease the burden of the health staff. Before launching any programme, it should be ensured that there is a real need and the system is prepared to implement it.

F. Community participation:

The people for whom these programmes are developed and implemented are not aware of the facilities available and they are never part of the system. Various schemes in place are not known to them. Proper display of facilities available at each center should be highlighted and efforts should be taken to make community aware about these facilities and take an ownership of it.

G. Public Private Partnership:

People are availing services of private practitioner more often than the government one, but these private sectors are rarely part of the programme. Private sectors have no accountability for health system and health programmes. Involvement of private practitioners has improved for some of the programmes like National AIDS Control Programme, RNTCP and Reproductive and Child Health but still there is long way to go to achieve desired support from private players.

H. Integration of national health programmes

WHO envisages that constraints common to multiple health programmes should be tacked in a integrated manner. For example, all the health-related MDGs rely on the existence in a country of a well-functioning workforce of nurses and an efficient pharmaceutical distribution system – it thus makes no sense to tackle the three relevant goals separately. The health programme integration needs to happen both physically and systemically both within facility at different levels of health care and between facility and community.

CONCLUSION

There is a need to integrate all relevant health programmes under one administrative control and ultimately under the overarching umbrella of National Rural Health Mission. The health professional in both government and private sector should try innovative community based projects to generate local solutions.

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