HUMAN SECURITY IN INDIA ESPECIALLY IN UTTAR PRADESH THROUGH NRHM IN THE ERA OF GLOBAL GOVERNANCE: ACHIEVEMENTS AND CHALLENGES

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INTRODUCTION

In the era of globalization, human security is a global phenomenon. It is relevant to people everywhere in developed and developing countries because of both old and new security threats - from chronic and persistent poverty to ethnic violence, human trafficking, climate change, health pandemics, international terrorism, and sudden economic and financial downturns are interrelated. Such threats tent to acquire transnational dimensions and move beyond traditional notions of security that focus on external military aggressions alone. So many human securities related issues are discussed worldwide. For example, in September 2000, 191 UN member states including India agreed to try to achieve Millennium Development Goals by 2015. Hence to get human security especially health security, National Rural Health Mission(NRHM) was launched on 12th April 2005 in India.

THE ORIGIN OF HUMAN SECURITY

The concept of human security emerged as part of the holistic parading of human Development cultivated at UNDP by Mahbub-Ul-Haq with economist Amartya Sen. HDR of 2004 was the First major international document to articulated human security in conceptual terms with proposal for policy and action.

The North South Roundtable, which is called the "Economic of peace", held in Costa Rica in January 1990, produced a clear statement that the post-cold war world needed "a new concept of global security is concerned for overall security of Individuals from Social, violence, economic distress and environment degradation the report placed there challenges in the Context of the post-cold war world along with an emphasis on reducing military spending and creating a peace dividend to ensure greater human development and case economic and environmental imbalances-

Hence, the global HDR became broader concept of security. It includes the safety of individuals and groups from such threats as hunger Disease and political instability and protection from sudden and hurtful disruptions in patterns of daily life.

Later, Oscar Arias, former President of Costa Rica and winner of the Nobel Peace Prize, Liked human security with proposal for a Global Delimitation fund. After 1994, the concept of human security became a central theme of a number of governments through their foreign and defiancepolicies. The Canadian, Japanese and Norwegian government led the way in institutionalizing human security. According to Canadian government report, "Human security means safety for people from both violent and non-violent threats. It is a condition or State of being characterized by freedom from pervasive threats to people's rights, their safety or even their lives.

The Commission on Human Security chaired by Nobel Laureate Amarty Sen and Sadako Ogata, in their report (2003) noted that human security complemented Sated security because its concern was focused on the individuals and the community.

WHAT IS HUMAN SECURITY?

Human security is a broad concept. According to Mahhub-Ul-Haq (1995), Human security is not a concern with weapons. It is a concern with human dignity. In the last analysis, it is a child who did not die, a disease that did not spread, and ethnic tension that did not explode, a dissident who was not silenced, a human spirit that was not crushed.'

The Commission on Human Security, in final report Human Security Now, defines human security as to protect the vital core of all human lives in ways that enhance human freedoms and human fulfillment. Human security means protecting people from critical (severe) and pervasive (widespread) threats and situations. It means using processes that build on people's strengths and aspirations. It means creating political, social, environmental, economic, military, and cultural systems that together give people the building blocks of survival, livelihood and dignity."

Human Development Report of 1994, issued by the United Nations Development Programme, defined the scope of Human Security to include seven areas:

- Economic security e.g. Persistent poverty
- Food Security e.g. Famine
- Health Security e.g. Deadly infectious diseases
- Environmental Security e.g. Pollution
- Personal Security e.g. Crime
- Community Security e.g. Inter-ethnic
- Political Security e.g. Human Rights abuses

Japanese Foreign Ministry official (2000) defined Human security as the preservation and protection of the life and dignity of individual human beings. Japan holds the view, as do many other countries that human security can be ensured only when the individual is confident of a life free of fear and free of want.'

Above analysis it is clear that Human security brings together the human elements of Security, rights and development. It is people centeredmulti sectorial. Comprehensive, Context specific and prevention oriented.

HUMAN SECURITY AND HEALTH SECURITY

Health Security is a part of Human Security. It is also concern with trade. Tread in health services is a trillion-dollar industry ruled by the GATT. Mode 4 of GAAT includes the globalization of health services.Several epidemic and infectious diseases can not only spread faster, but also they appear to be emerging more quickly that ever than ever before since the 1975. New diseases have been identified at theunprecedented rate of one or more per year. There are new at least 40 diseases that were unknown a generation ago. In addition, during the last five years, WHO has verified more than 1100 epidemicevents?(World Health Report 2007). Hence health diseased emerged new threats for human security. This is the reason that health security is necessary for human beings.

HEALTH SECURITY IN WORLDWIDE

Health Security is a global phenomenon. Human capabilities, resources, security and Social-economic development depend on health security. Health security has been not only described in India in its national health policy 2002, but also in many international and regional declarations. The universal declaration of Human Rights (UDHR) was adopted by the United Nations General Assembly in 1948, in which article 25 provides rights to health.

According to Article 25-

(i) Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing, and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widow, old age or other lack of livelihood in circumstances beyond his control.

(ii) Motherhood and childhood are entitled to special care and assistance all children, whether born in or out of wedlock, shall enjoy the same social protection.

The preamble to the constitution of the World Health Organization (WHO) says that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distraction of race, religion, and political belief, economic or social condition.

In the Human Development Report of 1994, issued by the UNDP, health security includes the scope of human security.According to world health report 2007. Health security includes both proactive and reactive to minimize vulnerability to acute public health events that endanger to collective health of national population. Health security is also defined in UNDD's HDR 1997. According to this report health security means to guarantee a minimum protection from diseases and unhealthy lifestyles. Hence, health security includes equitable, affordable, accountable, and effective health care services. It also includes rights to health.

Present time to meet the target of health security, Several countries adopted the concept of Universal health care (UHC)'as a citizen's right in 2005, but their Health Care models are different many countries have adopted a tax – financed model, while other have adopted an insurance based mode. Some countries deliver care through salaried public providers other have adopted capitation as the preferred model for payment for outpatient care and fee-for service for in patient care. For Example in Canada Medicare is a regionally administered Universal Public insurance programme, publicity financed through federal and provincial tax revenue while in New Zealand. National Health Service is publicly financed through general tax revenue. Other hand in Germany, statutory, Health Insurance is funded by 180 "sickness funds. In Sri Lanka, Universal Health Coverage scheme is tax financed and Government operated.

HEALTH SECURITY IN INDIA A SPECIALLY REFERENCE TO UTTAR PRADESH:

Uttar Pradesh population is 19.96 crore (census 2011), which is 16.49% out of total population of India. Decadal Growth rate of population of U.P. is 20.09% (census 2011) compared with 17.64% for India and 4.86% for Kerala and 15.87% for Karnataka. The sex Ratio in U.P is 908 per 1000 males compared with 943 for India and 1081 for Kerala and 968 for Karnataka. Compared figure of major health and demographic indicators are as follows:-

Comparative health infrastructure indicators of India & States

Table-01

Indicator	India	Kerala	Karnataka	U.P
Decadal Growth (%) (census 2011)	17.64	4.86	15.67	20.09
Infant Mortality Rate (SRS 2011)	44	12	35	57
Maternal Mortality Rate (SRS 2007-2009)	212	81	178	359
Total fertility Rate (SRS 2011)	2.4	1.8	1.9	3.4
Crude Birth Rate (SRS 2011)	21.8	15.2	18.8	27.8
Crude Death Rate (SRS 2011)	7.1	7.0	7.1	7.9
Natural Growth Rate (SRS 2011)	14.7	8.2	11.7	20.0
Sex Ratio (census 2011)	943	1084	968	908
Child sex ratio (census 2011)	914	959	943	899
Total population (in crore) (census 2011)	121.01	3.33	6.11	19.96

(Source: RHS Bulletin, March 2012, M/O Health and F.W)

Health infrastructure indicators of Uttar Pradesh

Table- 02

Particular	In position	Required
Sub-Centre	20521	31037
Primary Health Centre (PHC)	3692	5172
Community Health Centre (CHC)	515	1293
Health Worker (female)/ANM at Sub centers and PHC	22464	24213
Health Worker (male) at sub centers	1729	20521
Health assistant (female)/LHV at PHCs	2040	3692
Doctor at PHCs	2861	3692
Obstetricians and Gynecologists at CHCs	475	515
Total specialist at CHCs	1740	2060
Laboratory Technicians at PHCs and CHCs	1836	4207
Nursing staff at PHCs and CHCs	2627	7297

(Source: RHS Bulletin, March 2012, M/o Health and f.w., Gol)

According to the national family health servey-3 (2005-06) the prevalence of stunting in children younger's that 5 years of age is 57%, 42% children are malnourished and 50% of the total female populations are anemic in Uttar Pradesh.

Acknowledging this, the planning commission of India set up the high level expert Group (HLEG) to address, inter alia, issues of rising costs of private care and Insurance payment the few can afford. The HLEG has suggest comprehensive framework and developed investment plan to attain "Universal Health Coverage (UHC)" by 2020 and to help every citizen access to a national health package of essential Primary, Secondary and tertiary care, both inpatient and outpatient.

Accepting HLEG's suggestions and to meet to commitment to United Nation's Millennium Development Goals (UNMDGs) by 2015, the Government of India launched the National rural health mission (NHRM) on 12th April 2005. NHRM is a 7 years programme ending in year 2012. The vision of the mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children. The NHRM focused especially on 18 states with poor infrastructure and low public health indicator, namely the eight empowered action groups like-Bihar, Uttar Pradesh, Uttaranchal, Jharkhand, Rajasthan, Orissa, Madhya Pradesh, Chhattisgarh, North East states- Manipur, Mizoram, Meghalaya, Arunachal Pradesh, Sikkim, Assam, Nagaland, Tripura, and other states Jammu and Kashmir, and Himachal Pradesh.

AIMS OF NHRM

The main aim of NHRM is to strengthen state health system with special focus on reproductive and child health services and disease control programmes. Its other objectives are to establish an access to integrated comprehensive primary health care services and universal immunization.

GOALS OF NRHM

Goals of NRHM by 2012 are:-

- Reducing MMR to 100 per 1, 00,00 live birth,
- Reducing IMR to 30 per 1000 live birth,
- Reducing TFR to 2.1,
- Elimination ofFaleria-in all 250 districts, Kala-azar in all 514 Blocks and leprosy in all districts,

- Reduction in T.B. Prevalence and mortality by 50%
- Providing clean drinking water for all by 2009,
- Reducing anemia among women and girls by 50%

STRATEGIES TO ACHIEVE THE NRHM GOALS-

The strategies to achieve the goals include-

- Health plan for each village through village health committee of the Panchayat.
- Strengthening sub-centre through a united fund of Rs. 10000 for local action and planning. This fund will be deposited in a joint Bank account of the ANM and Sarpanch and operated by the ANM, in consultation with the village health committee, and male Multipurpose workers (MPWS),
- Provision of 24 hour service in 50 percent PHs by addressing shortage of doctors, especially in high focus states, through mainstream AYUSH manpower.
- Preparation and implementation of an intersectional District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition.
- Integrating Vertical Health and family welfare programmes at National, State, Block and District levels.
- Train and enhance capacity of panchayat Raj Institution to own, control and manage public health services.

IMPLEMENTING PROGRAMME UNDER NHRM

With the launch of NHRM on 12th April 2005, the ministry of Health and family welfare has initiated a number of plans. Few of them are:-

1. **Janani Suraksha Yojana-**

   This scheme encourages women to use public health services for safe delivery by providing Rs. 1400 to cover travel cost and other expenses in rural areas of low performance state. It also provides cash incentives to female community health worker for promoting safe care in pregnancy and facilitating access to institutional care. ASHAs have contributed signification in promoting this JSY scheme and Institutional delivery in rural areas.

2. **Janani-ShishuSurkshaKaryakaram-**

   This scheme's aim to provide better health services to the mother and child. Under this all women delivering in public health institutions will have absolutely free of cost services including medicines, food, diagnostic, free transport from home and back even blood if required.

3. **Operationalisation of 24*7 facility at PHCs-**

   Under the NRHM scheme to provide round the clock service to the mother and child all the primary health centers have been operationalised on 24 hrs basis with all the facilities like new born corners, delivery and nursing assistants so that immediate care can be provides to the pregnant women in need.

Under NRHM, Uttar Pradesh government has launched **"108" SAMAJWADI SWASTHYA SEWA (EMTS), and"102" NATIONAL AMBULANCE SERVICE (NAS).**

ACHIEVEMENT OF NRHM IN INDIA WITH SPECIAL REFERENCE TO UTTAR PRADESH:

After implementation of NRHM health indicator of India and Uttar Pradesh has been improved. It is clear from following point given below:

- As on September 2011, the NRHM added over 1,40,000 staff, which include 11,712 doctors and specialists, 10,851 AYUSH doctors, 66,784 auxiliary nurse midwives, 32,860 staff nurses and 14,434 paramedics and AYUSH Paramedics:
- As on September 2011, under NRHM 8, 55,000 ASHAS (Accredited social Health Activist) have been selected out of 8,07,000, which were trained, and has been provided each village one ASHA per 1000 population.
- As on march 2010 under NRHM 1,47,069 sub-Centre's(SCs),30,431. PHCs (Primary Health Centers) and 4535 Community Health Centers) are functioning. During 2005-12, 14,676 (48.23%) PHCs are converted into viable 24*7 facilities at least for reproductive and child care against target of all existing PHCs. 442 districts are equipped with mobile medical units.
- NRHM improved health indicators modesty, via-

  (i) MMR declined from 301 to 212 per 1, 00,000 live births between 2003 and 2009. Seven high focus states accounting for almost 75% of all maternal death still have 39% shortfall of the minimum international norms for access to emergency obstetric care.

  (ii) Institutions deliveries increased from 39% to 78% between 2006 and 2009.

  (iii) IMR declined from 58 infant deaths per 1000 live births to 47 in five years against targeted five per year.

According to report institutional delivery has increased in Uttar Pradesh, which has been shown by given below tables:

"102" NATIONAL AMBULANCE SERVICE (NAS) Achievement up to 31-07-2014

Table no.03

Serial no	Types	Count(Beneficiaries)	Percentage
1.	Home to Hospital	151784	45.0%
2.	Hospital to Home (Drop Back Request)	167485	49.6%
3.	Inter Facility Transfer (IFT)	16051	4.8%
4.	Neonatal	2258	0.7%
Total Beneficiaries		337578	
Delivery in Ambulance		286	
Delivery at Scene (Assisted by EMT)		552	

(Source: upnrhm.gov.in, Accessed Date-08/03/2015)

"108" SAMAJWADI SWASTHYA SEWA (EMTS) Achievement up to 31-07-2014

Tab.04

Serial no.	Types	Count (Beneficiaries)	Percentage
1	Pregnancy related	1650108	61.38%
2	Trauma (Vehicular)	240518	8.95%
3	Acute Abdomen	131234	4.88%
4	Unconscious	90967	3.38%
5	Respiratory	70340	2.62%
6	Cardiac/Cardio Vascular	52561	1.96%
7	Fevers (Infections)	70465	2.62%
8	Other Emergencies	382107	14.21%
Total Beneficiaries		**2688300**	
Delivery in Ambulance		13115	
Delivery at Scene (Assisted by EMT)		50454	

(Source: upnrhm.gov.in, Accessed Date-08/03/2015)

PROBLEMS IN IMPLEMENTATION OF NRHM

The main objective of NRHM is to provide access to health care to the rural poor. But implementation of NRHM in Uttar Pradesh is poor. There are many challenges and problems are emerged. There are-

- Lack of trained personal and infrastructure is a major concern for proper implementation of NRHM. Many PHCs and sub-centres have no specialist doctors, laboratory technicians and male health workers for example, according to RHS Bulletin, March 2012, AT CHCs in Uttar Pradesh, 1740 specials were posted against a requirement of 2060.
- Participation of local self-governing bodies like PRIs are limited. This programme could not achieve the desired result due to petty politics at grass root level and lack of political will.

- Lack of health infrastructure is a also problems in implementation of NRHM for example In Uttar Pradesh, 20521 sub-centres were established against a requirement of 31037.
- Corruption is a big challenge and problem during implementation of NRHM. Recent example of Uttar Pradesh state indicates the possibility of corruption at higher level. Total amount of financial irregularities are to the tune of Rs. 10,000 crore in NRHM scheme.
- Lack of better monitoring system for supervising and control for better implementation of NRHM.
- Utilization of united funds is a also problem. Sometimes united funds are not being released at proper time and most of the medical officers and ANMs were unaware about the proper utilization of these united funds.
- Lack of co-ordination between different departments at district levels has been also seen.Not proper health services delivery in U.P to protect health security due to bad governance and corruption.
- Nexus between political leaders, medical officers, administrative officers, multinational drugs companies and criminals in health sector specially in NRHM in U.P.
- No access to government's health related programme to people in Uttar Pradesh.
- Lack of adequate advance health technologies in hospitals in U.P.
- Lack of awareness in people to their health facilities related to NRHM.

SUGGESTIONS FOR BETTER IMPLEMENTATION OF NRHM-

NRHM is an ambitious Programme to meet human security especially health security but it is found that many challenges and problems are emerged clubbing implementation. Hence, some measured should be taken for better implementation of NRHM. There are-

- Health care training should be provided to ANM, ASHA and laboratory technicians and male health workers.
- To promote participation of PRIs in better implementation of NRHM, some legal and administrative power should be given to PRIs.
- To strengthening the health Infrastructure, it is necessary to provide funds in regular and proper time.
- To reducing and check corruption in NRHM. Auditing should be regularly on time to time. At the Panchayat level social auditing should be done.
- Public health achievements are required presenting in specific terms and clearly mentioning how much contributed by public sector and private health sector respectively.
- The monitoring of programmes are required being made more precise as it was evident that functionaries reported those works also which never accomplished.
- It is most needed to press for proper organization of meeting of the executive committees and governing bodies of respective health societies and Rogi Kalyan Samities.

CONCLUSION

Human security is most important in ere of globalization and health security is also aspect of human security,which impact on environment and economic security. We can achievehuman security through better implementation of NRHM. . Health indicators ofIndia and Uttar Pradesh has been improved but moreattention should be given for better implementation .we should promote the participation of PRIs and use public private participation model for build sub-center and PHCs.

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