

Impact of National Rural Health Mission: A Public Welfare Programme of the Government on Indian Health Sector

Wakeel Ahmad Rather

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Abstract

The study reveals circumstances under which the National Rural Health Mission (NRHM) program was launched by the Government of India to fulfill the target set out by the United Nation's Millennium Development Goals (MDG's). It examines the role and functioning of NRHM in delivering basic health care services to rural India. It further delineates the role of NRHM in reducing Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), Total Fertility Rate (TFR), Dengue Mortality Reduction Rate, etc. The study also highlights the character of NRHM in providing equitable, affordable, and quality health care services to the rural population, particularly the vulnerable groups. It was instrumental in creating new institutions, decentralizing of services, and providing new ideas and resources for health system. The study mainly focused on the approaches, major planks, achievements and evaluation of the NRHM program.

Index terms— national rural health mission, infant mortality rate, maternal mortality rate, common review mission, empowered action group, india.

1 Introduction

he United Nations 'Alma Ata Declaration' in 1978 called on "all governments to formulate national policies, strategies and plans of action to launch and sustain primary health system." However, the health system in India received low priority in the central and state budgets. Even less than 1% of the GDP on health expenditure was found in 1999, one of the lowest in the world. ??Zakir, 2008).

In 2002, India's National Health Policy acknowledged the sorry health situation and suggested a basket of reforms from co-opting rural doctors to medical tourism ??Shyam, 2008). Subsequently, the Congress-led United Progressive Alliance (UPA) government of India integrated public health as a critical component into its common minimum program after it formed government at the center in 2004.

A Need for robust and concerted policy in targeting rural India forced the UPA government to introduce National Rural Health Mission (NRHM) as its flagship health program in 2005 (Scheme 1) (Hussain, 2011). Accordingly, NRHM was launched on 12 th April 2005 throughout India with a commitment of the government to carry out the necessary architectural corrections in the basic health care delivery system. It covers the entire country but focuses on eighteen states, identified to have weak public health indicators and weak health infrastructure ??Nandan, 2011). Scheme 1: Illustrative Structure of NRHM NRHM launched to provide equitable, affordable, and quality health care to the rural population, particularly the vulnerable groups. NRHM program's special focus had been on the Empowered Action Group (EAG) states, as well as the North Eastern States, including Jammu and Kashmir, and Himachal Pradesh. The main purpose of the mission is on establishing a fully functional, community-owned, decentralized health delivery system with intersectoral convergence at all levels to ensure simulation actions on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality.

The targeted objectives of NRHM (Scheme 2) were to reduce infant mortality, and maternal mortality rates following the Millennium Development Goals (MDGs). These objectives were expected to be achieved through promoting institutional births and thereby protecting both the mother and the newborn. The NRHM has woven

45 everything around this core programme. The programme facilitates expectant mothers to be escorted by Accredited
46 Social Health Activist (ASHA) to a public or private hospital. She is paid Rs 700 per case (as incentives plus
47 costs). Even the mother also gets cash maternity benefits.

48 2 Major Planks of NRHM

49 ? Appointment of ASHA in each village (one each for 1000 population),
50 ? Health insurance for the poor, and the involvement of the non-profit sector, especially in undeserved regions.
51 ? Fostering PPP (Public-Private Partnerships);
52 ? Improving equity and reducing out of pocket expenses;
53 ? Introducing effective risk-pooling mechanisms and social health insurance ??Sharma, 2014). The major
54 achievements of NRHM are illustrated in Table 1. Thus, NRHM led a tremendous transformation in the
55 Indian health sector on several counts. Firstly, around 7.5 lakh ASHAs worked at the grassroots level and have
56 successfully mobilized women from the valuable communities to come to institutions (the number of beneficiaries
57 under Janani Suraksha Yojana had increased from seven lakhs in 2005 -2006 to over 86 lakhs in 2008 -2009)
58 (Express Healthcare, 2019). Secondly, NRHM played a crucial role in addressing basic healthcare issues of the
59 rural population as rural people primarily rely on the public. healthcare that comprises of Sub-Centers (SCs) and
60 primary health centers (PHCs) for immediate health needs, and Community Health Centers (CHC) and district
61 hospitals are opted for in case of complicated procedures and specialist care. The Sub-Centre is the first spot
62 of contact for seeking public health care that provides preventive care; a Primary Health Centre works as the
63 first point of contact with a qualified doctor; and CHC provides specialist care, including (Ayurveda, Yoga and
64 Naturopathy, Unani Siddha and Homeopathy (AYUSH) care. Thirdly, NRHM had several achievements to its
65 credit like; it has increased health finance, improved infrastructure for health delivery, established institutional
66 standards, trained healthcare staff and provided technical support; facilitated financial management, assisted in
67 computerization of health data, suggested central procurement of drugs, equipment, and supplies, mandated the
68 formation of village health and hospital committees and community monitoring of services (Jacob, 2017) Fourthly,
69 to target mortality, morbidity, and inclusive social development, NRHM since its inception led a comprehensive
70 war on undernutrition, ill health and ignorance. To address these issues, the Government of India launched
71 NRHM in April 2005 with a clear objective of providing quality health care in the remotest areas by making it
72 accessible, affordable and accountable (Ministry of Health and Family Welfare, Government of ??ndia, 2009).
73 Therefore, NRHM has made a remarkable impact on the public system of health care in the country (Figure ??
74 and Figure ??).

75 3 Evaluation of NRHM

76 To monitor, review, and evaluation of NRHM, the government of India established annually Common Review
77 Mission (CRM) to examine and document progress on key process parameters of the NRHM strategies, to identify
78 key constraints limiting the pace of architectural correction in the health system envisaged under the NRHM,
79 and to recommend policy and implementation level adaptations that could accelerate achievements of the goals
80 of the NRHM. Subsequently, these reports highlighted the track record of progress made by NRHM from time
81 to time (Table 2). ? Setting up of integrated State and District Societies.
82 ? Sub-Centres, PHCs, CHCs, district hospitals are fully functional.
83 ? Planning and Monitoring with Community Ownership.
84 ? Convergence of programmes for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing
85 safe drinking water, etc., with community support.
86 ? Need for the Reformation of health sector governance; decentralization of Panchayat Raj Institution;
87 ? Strengthening the ASHA Programme; monitoring against Norms and Fully Functional Facilities; Improved
88 maternal and Child Survival.
89 ? Need for preventive and promotive health.

90 4 Second CRM (November, 2008)

91 ? General increase in utilization of public health services like, increase in number of outpatients, in-patients,
92 increase in the institutional deliveries; Increasing services in PHCs and CHCs; expansion of paramedical, nursing
93 and medical education in all states.
94 ? Significant improvements also found in infrastructure, drugs, diagnostics, sanitation and dietary arrange-
95 ments.
96 ? Improvement in Reproductive and child health development was found.
97 ? Need to revitalize PHCs and CHCs. According to the report of 'NRHM: The Progress So Far' (Ministry of
98 Health and Family Welfare, 2012) states that NRHM has reduced IMR at a higher rate than earlier, increased
99 institutional deliveries, raised the figures of full immunization, constituted Rogi Kalyan Samitis, appointed and
100 trained ASHAs, constituted Village Health Committees, created village health and nutrition days, provided
101 mobile medical units, and co-located Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH) and another
102 number of health facilities. Moreover, to assess the working of NRHM, it is very difficult to evaluate the cost-
103 effectiveness of a national project NRHM as it has multiple goals, all of which have not been achieved to the

104 same extent. Further, health depends on a several numbers of factors, such as living and working conditions of
105 people, education, degree of social integration, awareness, belief systems, quality of the environment, and access
106 to health facilities, etc. However, based on certain studies and reports, the evaluation of NRHM has been done.

107 The International Institute for Population Sciences (IIPS, 2010) Mumbai has produced a voluminous fact sheet
108 of concurrent evaluation of NRHM 2009. The report establishes that there are pronounced inequalities between
109 states and the achievements are far from satisfactory.

110 According to Special Bulletin on Maternal Mortality in India 2007 -09 of Sample Registration Scheme (SRS,
111 June 2011), which showed that Maternal mortality ratio varies from 8.1 in Kerala to 390 in Assam, and the
112 maternal mortality rate varies from 4.1 in Kerala to 40.0 in Uttar Pradesh/Uttarakhand.

113 According to SRS Bulletin 2012 (SRS, 2012), while for the whole country, IMR has declined to 44, ?? the
114 differences between urban and rural localities and across different states have persisted. While the urban IMR
115 has declined to 29, the rural IMR was still 48.

116 According to the Report of World Bank (2012), "the out-of-pocket expenditure on health in India reduced by
117 9 percent points; 68 percent in 2005 to 59.4% in 2011.

118 Though NRHM focused on the expansion of infrastructure, human resources, and service coverage. However,
119 quality aspects had received inadequate attention, only 15 percent of Primary Health Centres (PHCs) and
120 Community Health Centres (CHCs) had been able to meet Indian Public Health Standards (IPHS), quality
121 gaps are repeatedly articulated in government audits and in all four Common Review Mission (First CRM
122 2007; Second CRM 2008; Third CRM 2009; Fourth CRM 2010) reports. The 6 th CRM quoted, 'quality
123 of care is compromised, and infection control was a problem in all states. The quality of care is poorer in
124 the Empowered Action Group states with huge variation across districts and health facilities. High human
125 resource vacancies, inappropriate postings of the staff, and skill gap due to constant high attrition, clubbed
126 with unavailability of adequate infrastructure such as Intensive Care Units (ICUs) at several district hospitals
127 or Functional Operation Theatres at First Referral Units (FRUs), and inadequate biomedical waste disposal
128 mechanisms severely undermine the quality of care. Large network of private health care sector also remains
129 unregulated, despite the Clinical Establishments (Registration and Regulation) Act, 2010 (Ministry of Health
130 and Family Welfare, 2010) which only eight states and seven UTs have adopted but implementation remains
131 arduous and slow.

132 According to WHO 2011, 53 percent of all deaths in India although were attributed to non -communicable
133 diseases, the focus of the NRHM was largely been on Reproductive and Child Health (RCH) which got nearly
134 two thirds of all financial resources. The non high focused states did expend non communicable disease services,
135 but the scope was limited in range of services. Several studies and government reports suggest that inefficient use
136 of already scarce financial and other resources, lack of performance management and accountability mechanisms
137 continue to mar the public health system. According to WHO estimates, 20 -40 percent of resources spent on
138 health are wasted because of diversion to least priority areas, de-motivated health workers, and inappropriate
139 use or overuse of medicines and technologies.

140 Eleventh

141 5 Conclusion

142 On the one side, NRHM proved to be a landmark flagship programe of the government of the India, as it
143 successfully reduced IMR, MMR, and TFR and has made Indian health care delivery system accessible, affordable
144 and quality health care services to the rural population of India, particularly the vulnerable groups. Moreover,
145 the NRHM became instrumental in the developing of new and up-gradation of the existing infrastructure in
146 the health sector. On the other side, NRHM, no doubt, focused on the expansion of Infrastructure, human
147 resources, and service coverage. However, quality aspects had received inadequate attention. Insufficient funds,
148 poor performance management and less accountability mechanisms continue to mar the Indian public health
149 system. Though, NRHM could not fulfill its 100 percent predetermined targets to raise Indian public health
150 standards at par with the health system of developed countries, still, it proved to be a beneficial health programe
151 as it reduced IMR, MMR, Malaria, and other noncommunicable disease's victimized people of India for several
152 decades, etc. The efficacy of the programe largely depends upon its continuance to date though clubbed with
153 NHM (National Health Mission).

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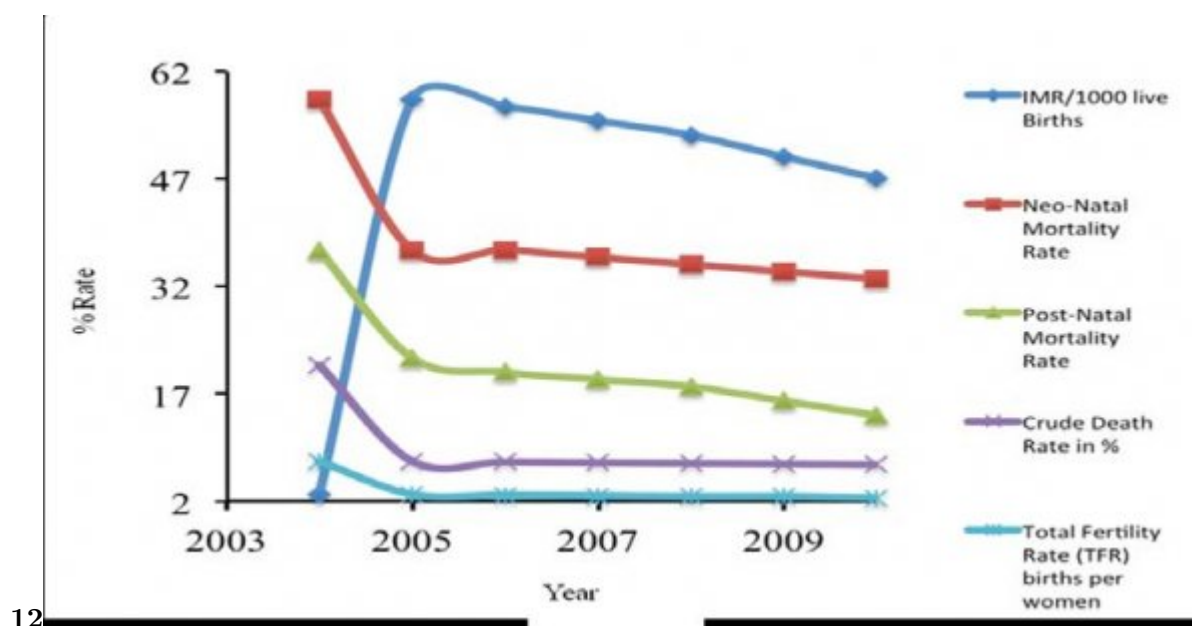


Figure 1: Figure 1 :Figure 2 :

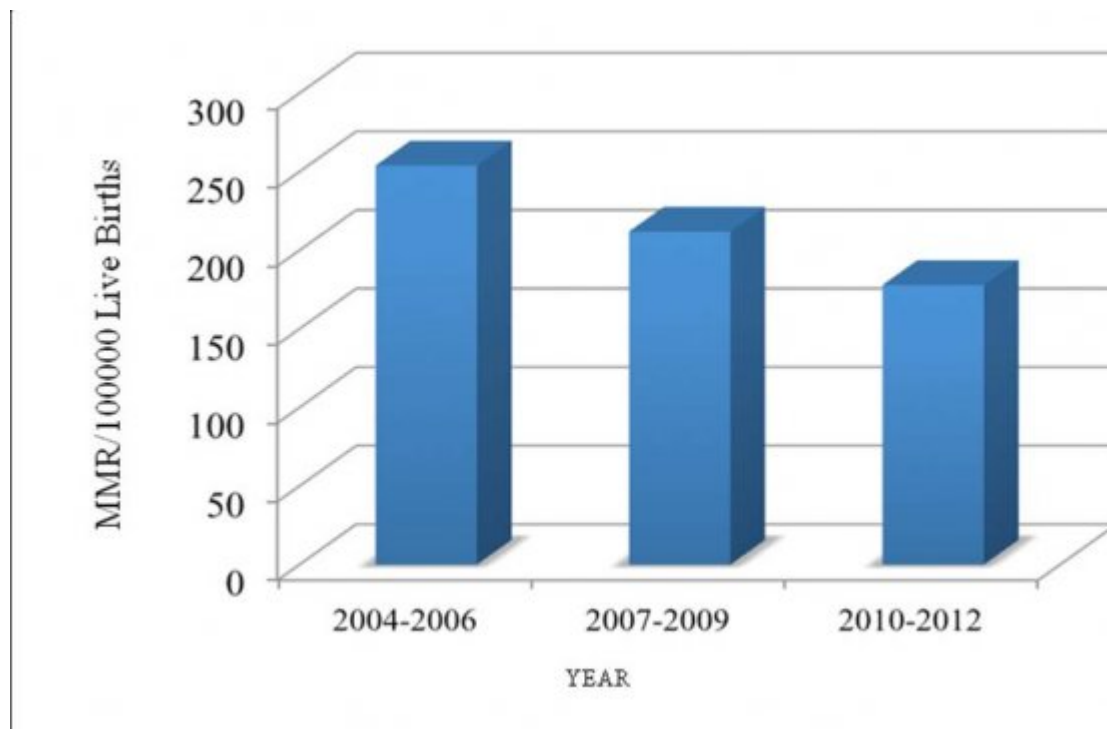


Figure 2:)

Year 2022
28

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Family Welfare (MOHFW)

Block Level Hospital / CHC ? CHC serve as first referral units and for four to five PHCs ? Provide facilities for obstetric care and specialist consultations. ? Total CHCs were 4045 (MOHFW , 2010).

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[Note: Abbreviations: Community Health Centre (CHC), Primary Health Centre (PHC), Sub Health Centre (SHC), Ministry of Health]

Figure 3: Primary Health Centre (PHC) Level

Figure 4: Third Level 1 Lakh population 100 villages Second Level 30-40 villages Scheme 2: Five Major Approaches of NRHM II.

1

of National Rural Health Mission

[Note: Improved Management Through Capacity1. Block and District Health Office with management Skills.2.NGOs in capacity building..3. Continuous skill developmentSupport.]

Figure 5: Table 1 :

2

Reports	Achievements under NRHM	Recommendations
? Selection and Training of ASHAs Unveiling of Development Societies, VHSCs.	JSY;	Constitution Hospital
First CRM (November 2007)		

Figure 6: Table 2 :

155 Year 2022 A

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