National Rural Health Mission
A promising approach towards better Rural Health

Summary:

The National Rural Health Mission (NRHM) was launched in 2005 to provide equitable, affordable and quality health care to the poor residing in rural and remote areas of the country. NRHM has paved the way for a holistic approach in concentrating on the services provided by the primary healthcare institutions. It has allowed 18 states to innovate themselves in how to provide better health standards and services to its vast majority. This has resulted in an unbelievable 150 innovative schemes that have been implemented in different states. The focus has now changed from inputs like providing drugs, equipment and doctors to hospitals to outputs that have to be produced. The local community has not just become active in monitoring but has become empowered through this rights based approach.

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Introduction

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister Mr. Manmohan Singh on 12th April 2005, to provide accessible, affordable, equitable and quality health services to the poorest households in the remotest and rural regions of the country. The NRHM covers the entire country, with special focus on 18 States where the challenge of strengthening poor public health systems and thereby
improving key health indicators is the greatest. The States of Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura are covered under NRHM.

Situation Description
The NRHM was launched as a framework of partnership among Government of India, related Departments of the Government, especially Departments of Women & Child Development, Drinking Water Supply, Panchayati Raj and Development of North Eastern Region State Governments, Panchayati Raj Institutions, NGOs and private health providers. The Mission Steering Group under the Chairmanship of the Union Minister for Health & Family Welfare provides policy guidance and operational oversight at the National level. The State Governments have been part of the Stakeholder Consultations for finalization of the strategy of the Mission. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels, to ensure action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and with gender equality.

The Mission was started to achieve the following goals set under the National Health Policy (2002) and the Millennium Development Goals.

- To facilitate the access and utilisation of quality health services by all
- To forge a partnership between the three tiers of government
- To set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- To provide an opportunity for promoting equity and social justice.
- To establish a mechanism to provide flexibility to the states and the community to promote local initiatives

To develop a framework for promoting inter-sectoral convergence for promotive and preventive health care
Situation Analysis

The Indian public health system suffers from serious regional and social inequities. The Curative services favour the non-poor i.e. for every Rs.1 spent on the poorest 20% population, Rs.3 is spent on the richest quintile. There is a lack of community ownership of public health programmes which impacts the levels of efficiency, accountability and effectiveness. There is no integration of sanitation, hygiene, nutrition and drinking water issues which have a great impact on primary health. Only 10% Indians have some form of health insurance, which is mostly inadequate. Over 25% of hospitalized Indians fall below poverty line because of hospital expenses.

To overcome the lapses in public health system and recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission. The Mission will make the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.

The National Rural health Mission is different from its preceding schemes as the focus was on holistic health system at all levels, from the village to the district with active Panchayati Raj Institution and community ownership and participation. NRHM also subsumes the key national programmes, namely, the Reproductive and Child health II project (RCH II), the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP) thus making it an umbrella initiative of the government.

Solution

The core strategies of NRHM include, decentralized village and district level health planning and management, appointment of Accredited Social Health Activist (ASHA) to
facilitate access to health services, strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels, mainstreaming AYUSH, improved management capacity to organize health systems and services in public health, emphasizing evidence based planning and implementation through improved capacity and infrastructure, promoting the non-profit sector to increase social participation and community empowerment, promoting healthy behaviors and improving intersectoral convergence.

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – ‘ASHA’ or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.

Community-based Monitoring of health services is another key strategy of National Rural Health Mission (NRHM) to ensure that the services reach those for whom they are meant, especially for those residing in rural areas, the poor, women and children. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health.

Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society are to be formed which are a registered society will act as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre.

The supplementary strategies of NRHM include regulation of the private sector to improve equity and reduce out of pocket expenses, foster public-private partnerships to meet national public health goals, reorienting medical education, introduction of effective risk pooling mechanisms, involvement of NGOs and social insurance to raise the health security of the poor and taking full advantage of local health traditions.
Ease in Service Delivery

There is significant increase in institutional delivery, outpatient care, availability of medicine, better access through mobile Medical unit.

Chiranjeevi Yojna (CY) was initiated as a scheme to increase institutional deliveries and to encourage private practitioner to provide maternity services in remote areas that record the highest infant mortality and maternal mortality rates in Gujarat.

PANCHAMRIT was launched in Rajasthan in to reach the left out and hard to reach area i.e. to promote over all health of the mother and child living in far- flung and vulnerable areas by concentrating efforts and resources; in reaching inaccessible and un-approached areas and improving coverage of health services . Vaccine for Preventable Diseases, Elimination of Micronutrient Deficiency:, Family Welfare , Safe Motherhood and Ensuring Healthy New Born were the 5 main focus areas.

In Orissa, few local NGOs with partnership with Interact Worldwide have been managing Public Health Centers. This is being done using various participatory techniques to understand community needs, developing local resources and meeting the health needs of unmet. As a result health centers lying defunct have become vibrant dispensing basic health needs to the poor and marginalized.

Capacity Building

There are more than 1200 Programme Management, Finance Management and Data Management professionals who have joined the system at State and District levels. The introduction of these skills has improved programme management, monitoring and
evaluation, financial reporting and record keeping. IMNCI training for management of neonatal and childhood illnesses has been in more than 25 States. Skilled Birth Attendant Training of MOs and ANMs, Training of MOs for Anaesthesia for emergency Obstetric Care, Training of MOs for Obstetric care, professional development programmes for MOs, District Planning and Appraisal programmes for NRHM State level teams, have been taken up on a large scale.

Assam Government has initiated a radio programme for ASHAs with All India Radio (AIR), Assam to develop their knowledge and skills

Evaluation

NRHM has set up effective systems of monitoring and evaluation. A detailed MIS that provides disaggregated information about performance with respect to vulnerable groups like SCs and STs, has been operationalized. An effective Financial Management Reporting System has become functional with quarterly, activity wise reports from States. A pilot initiative on community monitoring is being initiated in partnership with NGOs. The Institute of Public Auditors of India are working in five States (Bihar, Assam, UP, Tamil Nadu and Kerala). The assessment of ASHA programme in MP, Rajasthan, Orissa, UP, Bihar is under way with the support of UNFPA/Unicef. A system of independent assessment of performance of States by institutions of excellence is in the process of finalization. An intensive field based joint review mechanism is in place for the RCH – II that covers core areas of NRHM as well. Three such reviews have already been conducted.

Sustainability

The time period of NRHM is seven years. But it has already made commendable achievements. Lots of local initiatives are enjoying good success both in terms of popularity and effectiveness thus making NRHM a sustainable practice of the government.
Moreover, not all schemes have budgetary implications tied to them thus making health centers relatively free of financial constraints.

*Is it a best practice?*

It is a best practice because plan provided for making the community and the peripheral health staff partners in the path to achieving positive changes in the health system. This attempt to make the community partners in monitoring the health posts was the real innovation in the NRHM.

As better public health system is the priority concern for policy makers as well as implementers, to devise a mechanism that reaches to the socio economically weaker section, especially in rural area has become a challenge for the nation. In such scenario, NRHM can be adopted with regional specification to make it more successful and effective.

*Replicability*

The scheme has high replicability value. It is already being implemented in 18 states. The National Urban Health Mission on the lines of National rural Health Mission is already underway. Lots of local initiatives like Chiranjeevi scheme in Gujarat, Delivery huts in Haryana etc have got lot of success and recognition are being implemented in other states and districts of the country. The mission is a viable option for other States and districts where health indicators are very poor.

*Lessons learnt*

The NRHM is implemented through decentralized administrative system in which local bodies have full say in designing and implementation of health schemes according to the
local needs. Thus making it locally popular and effective as community has huge say in both planning and implementation.

It has also been observed that linking health services to community participation and to some extent defining roles for community participants facilitates accountability of key providers. This not only improves accessibility of services to ordinary people but at the same time strengthens entrepreneurial energy of people in creative outcomes. It, in the ultimate strengthens democracy and people’s consciousness for a healthy community.