National Health Mission

With the Millennium Development Goals' (MDGs) deadline approaching and the dialogue on post-2015 Sustainable Development Goals (SDGs) heating up, India—one of the biggest contributors to the global disease burden and high Out-of-Pocket (OOP) expenditure on healthcare, is also at the crossroads of health policy reforms. The challenge for India's policymakers is not only to improve Maternal and Child Health (MCH) but also to effectively tackle communicable and non-communicable diseases, while improving equity and quality in coverage of services and providing social protection against rising healthcare costs. To inform the future policy, it is pertinent to review the success and constraints of the National Rural Health Mission (NRHM) which was launched in 2005, and is hailed as one of the most ambitious public health programmes that the Government of India ever embarked upon—in terms of scale, scope, and objectives. While the NRHM aimed to carry out necessary architectural correction in the health system which improved the availability of, and access to quality healthcare services in an equitable manner, addressing the health needs of the world's largest rural population of 740 million, spread across 600,000 villages, isn't simple. Health being a 'state subject', and all 35 states/Union Territories (UTs) being at different levels of economic, socio-demographic, political, and health system evolution, adds to the complexity. The NRHM could be operationalized only towards the end of the 2006–7 financial year and its strategies too, evolved over the course of implementation. The National Health Mission (NHM) envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

NRHM is being operationalized throughout the country with special focus on 18 states. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care facilities, especially, to the poor and vulnerable sections of the population.

It also aims at bridging the gap in rural health care services through the creation of a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources.

NRHM further aims to provide support to the existing programmes of health and family welfare including RCH-II, malaria, blindness, iodine deficiency,

filaria, kala- azar, tuberculosis, and leprosy and for integrated disease surveillance.

Further, it addresses the issue of health in the context of sector-wide approach towards sanitation and hygiene, nutrition and safe drinking water as basic determinants of good health in order to have greater convergence among the related social sector departments.

History

The National Rural Health Mission (NRHM), now under National Health Mission[1] is an initiative undertaken by the government of India to address the health needs of under-served rural areas. Launched on 12 April 2005 by then Indian Prime Minister Manmohan Singh, the NRHM was initially tasked with addressing the health needs of 18 states that had been identified as having weak public health indicators. The Union Cabinet headed by Manmohan Singh vide its decision dated 1 May 2013, has approved the launch of *National Urban Health Mission (NUHM)* as a Sub-mission of an overarching *National Health Mission (NHM)*, with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. As per the 12th Plan document of the Planning Commission, the flagship programme of NRHM will be strengthened under the umbrella of National Health Mission. The focus on covering rural areas and rural population will continue along with up scaling of NRHM to include non-communicable diseases and expanding health coverage to urban areas. Accordingly, the Union Cabinet, in May 2013, has approved the launch of National Urban Health Mission (NUHM) as a sub-mission of an overarching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of the National Health Mission.

The National Health Mission seeks to ensure the achievement of the following indicators.

1. Reduce Maternal Mortality Rate (MMR) to 1/1000 live births
2. Reduce Infant Mortality Rate (IMR) to 25/1000 live births
3. Reduce Total Fertility Rate (TFR) to 2.1
4. Prevention and reduction of anemia in women aged 15–49 years
5. Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
6. Reduce household out-of-pocket expenditure on total health care expenditure
7. Reduce annual incidence and mortality from Tuberculosis by half
8. Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
9. Annual Malaria Incidence to be <1/1000
10. Less than 1 per cent microfilaria prevalence in all districts
11. Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Initiatives

Some of the major initiatives under National Health Mission (NHM) are as follows:

Accredited Social Health Activists

Community Health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission for establishing a link between the community and the health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme is expanding across States and has particularly been successful in bringing people back to Public Health System and has increased the utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient
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Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society

The Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society is a management structure that acts as a group of trustees for the hospitals to manage the affairs of the hospital. Financial assistance is provided to these Committees through untied fund to undertake activities for patient welfare.

Untied Grants to Sub-Centres

Untied Grants to Sub-Centers have been used to fund grass-root improvements in health care. Some examples include:

- Improved efficacy of Auxiliary Nurse Midwives (ANMs) in the field that can now undertake better antenatal care and other health care services.
- Village Health Sanitation and Nutrition Committees (VHSNC) have used untied grants to increase their involvement in their local communities to address the needs of poor households and children.

Health care contractors

NRHM has provided health care contractors to underserved areas, and has been involved in training to expand the skill set of doctors at strategically located facilities identified by the states. Similarly, due importance is given to capacity building of nursing staff and auxiliary workers such as ANMs. NHM also supports co-location of AYUSH services in Health facilities such as PHCs, CHCs and District Hospitals.

Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention scheme implemented by the Government of India. It was launched on 12 April 2005 by the Prime Minister of India. It aims to promote institutional delivery among poor pregnant women and to reduce neo-natal mortality and maternal mortality. It is operated under the Ministry of Health and Family Welfare as part of the National Rural Health Mission. The Scheme integrates cash assistance with delivery and post-delivery care, particularly in states with low institutional delivery rates.

In 2014 -15, 10,438,000 women obtained benefits under the scheme.[8] As per the World Health Organization, the proportion of institutional deliveries in India almost tripled between 2005 and 2016, from 18% to 52%.

Components of the scheme

The Janani Suraksha Yojana was implemented to ensure that pregnant women who are Below the Poverty Line (BPL) access health facilities for childbirth. It provides cash benefit to eligible pregnant women if they choose to deliver in a health facility, irrespective of their age and the number of children they have.

Special dispensation is provided to states that have low institutional delivery rates. These states are Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha, and Jammu and Kashmir, and are referred to as Low Performing States (LPS) under the Scheme.[10] Other states and Union Territories are called High Performing States (HPS) owing to their higher institutional delivery rates.

Accredited Social Health Activists (ASHA) are also incentivised under the Scheme for promoting institutional deliveries among pregnant women.

Entitlements under the scheme

The Scheme has different eligibility criteria in Low Performing States (LPS) and High Performing States (HPS).[11]

In LPS, all pregnant women delivering in government health facilities are eligible for a cash benefit. Women who choose to deliver in accredited private institutions are eligible only if they are Below the Poverty Line or belong to a Scheduled Caste or Scheduled Tribe.

In HPS, only pregnant women who are Below the Poverty Line or belong to a Scheduled Caste or Scheduled Tribe are eligible for cash benefits, irrespective of whether they choose to deliver in a government health facility or an accredited private institution.

Women who are Below the Poverty Line and choose to deliver at home are entitled to a cash assistance per delivery.

National Mobile Medical Units (NMMUs)

Many un-served areas have been covered through National Mobile Medical Units (NMMUs).

National ambulance services

Free ambulance services are provided in every nook and corner of the country connected with a toll free number and reaches within 30 minutes of the call.

Janani Shishu Suraksha Karyakram (JSSK)

As part of recent initiatives and further moving in the direction of universal healthcare, Janani Shishu Suraksha Karyakarm (JSSK) was introduced to provide free to and fro transport, free drugs, free diagnostic, free blood, free diet to pregnant women who come for delivery in public health institutions and sick infants up to one year.

Rashtriya Bal Swasthya Karyakram (RBSK)

A Child Health Screening and Early Intervention Services has been launched in February 2013 to screen diseases specific to childhood, developmental delays, disabilities, birth defects and deficiencies. The initiative will cover about 27 crore children between 0–18 years of age and also provide free treatment including surgery for health problems diagnosed under this initiative.

Mother and child health wings (MCH Wings)

With a focus to reduce maternal and child mortality, dedicated Mother and Child Health Wings with 100/50/30 bed capacity have been sanctioned in high case load district hospitals and CHCs which would create additional beds for mothers and children.

Free drugs and free diagnostic service

A new initiative is launched under the National Health Mission to provide Free Drugs Service and Free Diagnostic Service with a motive to lower the out of pocket expenditure on health.

District hospital and knowledge center (DHKC)

As a new initiative District Hospitals are being strengthened to provide Multi-specialty health care including dialysis care, intensive cardiac care, cancer treatment, mental illness, emergency medical and trauma care etc. These hospitals would act as the knowledge support for clinical care in facilities below it through a tele-medicine center located in the district headquarters and also developed as centers for training of paramedics and nurses.

National Iron+ Initiative

The National Iron+ Initiative is an attempt to look at Iron Deficiency Anaemia in which beneficiaries will receive iron and folic acid supplementation irrespective of their Iron/Hb status. This initiative will bring together existing programmes (IFA supplementation for: pregnant and lactating women and; children in the age group of 6–60 months) and introduce new age groups.

Tribal TB eradication project

This project is launched by MoS Health Shri Faggan Singh Kulaste at Mandla on 20 January 2017.

Criticism

Dependency of ASHA on Anganwadi workers (AWW) and Auxiliary Nurse Midwife (ANM) is likely and it seems that there is hardly any freedom for her to work independently. It may be detrimental to the system in a way that other functionaries might start delegating their work to ASHA. The work responsibility of ASHA and other workers need to be more clearly defined and mutually exclusive.

Action plan in NRHM discusses the making of health system functional from the sub centers level. An untied fund of Rs 10,000 has been widely publicized as component of strengthening the sub centres. While, it is a well known fact that most sub centers are in operation without any available buildings, the priority should be given to find a building for sub centers and allocation of Rs 10,000 would be useful only when infrastructure is available to carry out activities. The strengthening of sub centers is of paramount importance and allocation of this money is good but it does not solve the most important issue of the building for the sub centers as SC are the point of first contact between the community and the health system and it should be presentable enough.

More focus should be given to the continuous on job training for most functionaries as this would keep the workers motivated. Posting of another doctor from AYUSH at Primary Health Centers (PHCs) would improve the functioning there but we still need some mechanism in place to deal with the absentee doctors at this level.

Rogi Kalyan Samiti (RKS) scheme was started in Madhya Pradesh a low performance state and was very successful. This simply conveys that we need not to be unnecessarily cynical [5] but try to replicate it all over the country. It is a good step which can be extended to the all hospitals in our country in future.

The success of any program requires a system in place where no link is missing. Functioning from the level of ASHA, sub centres, PHC has to be improved to bring people to a referral facility. This period in improving health system at lower level can be utilized for implementation of IPHS standards at CHCs, so the raised expectation are not marred by below par facilities at CHC. As some experts have suggested5 a system of concurrent evaluation should be in place and generated data may be utilized for ongoing corrective measures at all levels

Conclusion

National rural health mission (NRHM) was initiated in the year 2005 in eleventh five year plan, with the objective of providing quality health care services to the rural population. The mission brought out salient strategies by involving various sectors and forging partnerships with various organizations to unify health and family welfare services into a single window. Though the mission strived for a sustainable health care system, it did not envisage certain challenges in implementation. The public health system in India could take off from the foundations laid by the NRHM to overcome these challenges, in order to achieve various goals of health and development and put India on the road map of healthful development. NRHM has been a pioneer in reiterating the need for community participation, coupled with intersectoral convergence, to bring about a paradigm shift in the indicators, which has been reasonably achieved in most of the States. Taking forward the foundations laid by the NRHM, it is essential for the forthcoming policies and plans to focus on capacity building, not only on the infrastructure and technical aspects, but also on streamlining the health workforce, which is crucial to sustaining the public health infrastructure. The public health system in India should take off from the foundations laid by the NRHM. There is an imminent need to focus on forging a sustainable public private partnership, which will deliver quality services, and not compromise on the principles and identity of the public health system of the country, in its pursuit to achieve universal health coverage and sustainable development goals.

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