National Rural Health Mission and Its Achievements

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Abstract

This is a study of the government scheme to see how successful the scheme has been in ensuring good health in the rural area of the India. The article is an attempt to understand the scheme and see the rate of the success of the scheme in the current scenario.

Introduction

The Union Cabinet vide its decision dated 1st May 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

Within the broad national parameters and priorities, states would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.

The State PIPs would be an aggregate of the district/city health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district/city plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state.

The fund flow from the Central Government to the states/UTs would be as per the procedure prescribed by the Government of India.

Findings and Analysis

GOALS of National Rural Health Mission:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality
- Ratio (MMR)
- Universal access to public health services such as Women's health,
- Child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable
- diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

PLAN OF ACTION for NRHM

COMPONENT (A): ACCREDITED SOCIAL HEALTH ACTIVISTS

- Every village/large habitat will have a female Accredited Social

Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.

- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.
- She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.
- She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.
- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other
- Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.
- She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.
- She will be given a Drug Kit containing generic Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH) and allopathic formulations for common ailments. The drug kit would be replenished from time to time.
- Induction training of ASHA to be of 23 days in all, spread over 12 months.
- On the job training would continue throughout the year.
- Prototype training material to be developed at National level subject to State level modifications.
- Cascade model of training proposed through Training of Trainers including contract plus distance learning model
- Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

COMPONENT (B): STRENGTHENING SUB-CENTRES

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM &
- Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.
- In case of additional Outlays, Multipurpose Workers (Male)/Additional
- ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered.

COMPONENT (C): STRENGTHENING PRIMARY HEALTH CENTRES

- Mission aims at Strengthening PHC for quality preventive, promotive, curative, supervisory and Outreach services, through:
- Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunization) to PHCs
- Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.
- Observance of Standard treatment guidelines & protocols.
- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (I male, 1 female) would be undertaken on the basis of felt need.

COMPONENT (D): STRENGTHENING CHCs FOR FIRST REFERRAL CARE

A key strategy of the Mission is:

- Operationalizing 3222 existing Community Health Centres (30-50 beds) as
- 24 Hour First Referral Units, including posting of anesthetists.
- Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc. for CHCs.
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.
- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.
- In case of additional Outlays, creation of new Community Health Centres

(30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

COMPONENT (E): DISTRICT HEALTH PLAN

District Health Plan would be an amalgamation of field responses through

- Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.
- Health Plans would form the core unit of action proposed in areas like water supply, sanitation, hygiene and nutrition. Implementing
- Departments would integrate into District Health Mission for monitoring.
- District becomes core unit of planning, budgeting and implementation.
- Centrally Sponsored Schemes could be rationalized/modified accordingly in consultation with States.
- Concept of "funneling" funds to district for effective integration of programmes
- All vertical Health and Family Welfare Programmes at District and state level merge into one common "District Health Mission" at the District level and the "State Health Mission" at the state level
- Provision of Project Management Unit for all districts, through contractual engagement of MBA, Inter Charter/Inter Cost and Data Entry Operator, for improved programme management

COMPONENT (F): CONVERGING SANITATION AND HYGIENE UNDER NRHM

Total Sanitation Campaign (TSC) is presently implemented in 350 districts and is proposed to cover all districts in 10th Plan.

- Components of TSC include IEC activities, rural sanitary marts, individual household toilets, women sanitary complex, and School Sanitation
- Programme.
- Similar to the DHM, the TSC is also implemented through Panchayati Raj Institutions (PRIs).
- The District Health Mission would therefore guide activities of sanitation at district level, and promote joint IEC for public health, sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Programme. ASHA would be incentivized for promoting household toilets by the Mission.

COMPONENT (G): STRENGTHENING DISEASE CONTROL PROGRAMMES

- National Disease Control Programmes for Malaria, TB, Kala Azar, Filarial,
- Blindness & Iodine Deficiency and Integrated Disease Surveillance

- Programme shall be integrated under the Mission, for improved programme delivery.
- New Initiatives would be launched for control of Non Communicable Diseases.
- Disease surveillance system at village level would be strengthened.
- Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.
- Provision of a mobile medical unit at District level for improved Outreach services.

COMPONENT (H): PUBLIC-PRIVATE PARTNERSHIP FOR PUBLIC

HEALTH GOALS, INCLUDING REGULATION OF PRIVATE SECTOR

- Since almost 75% of health services are being currently provided by the private sector, there is a need to refine regulation
- Regulation to be transparent and accountable
- Reform of regulatory bodies/creation where necessary
- District Institutional Mechanism for Mission must have representation of private sector
- Need to develop guidelines for Public-Private Partnership (PPP) in health sector. Identifying areas of partnership, which are need based, thematic and geographic.
- Public sector to play the lead role in defining the framework and sustaining the partnership
- Management plan for PPP initiatives: at District/State and National levels

COMPONENT (I): NEW HEALTH FINANCING MECHANISMS

A Task Group to examine new health financing mechanisms, including Risk Pooling for Hospital Care as follows:

- Progressively the District Health Missions to move towards paying hospitals for services by way of reimbursement, on the principle of "money follows the patient."
- Standardization of services – outpatient, in-patient, laboratory, surgical interventions- and costs will be done periodically by a committee of experts in each state.
- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.
- All existing CHCs to have wage component paid on monthly basis. Other recurrent costs may be reimbursed for services rendered from District
- Health Fund. Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.
- A district health accounting system, and an ombudsman to be created to

monitor the District Health Fund Management, and take corrective action.

- Adequate technical managerial and accounting support to be provided to
- DHM in managing risk-pooling and health security.
- Where credible Community Based Health Insurance Schemes (CBHI) exist/are launched, they will be encouraged as part of the Mission.
- The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.
- The IRDA will be approached to promote such CBHIs, which will be periodically evaluated for effective delivery.

COMPONENT (J): REORIENTING HEALTH/MEDICAL EDUCATION

TO SUPPORT RURAL HEALTH ISSUES

- While district and tertiary hospitals are necessarily located in urban centres, they form an integral part of the referral care chain serving the needs of the rural people.
- Medical and para-medical education facilities need to be created in states, based on need assessment.
- Suggestion for Commission for Excellence in Health Care (Medical Grants
- Commission), National Institution for Public Health Management etc.
- Task Group to improve guidelines/details.

ROLE OF PANCHAYATI RAJ INSTITUTIONS

The Mission envisages the following roles for PRIs:

- States to indicate in their MoUs the commitment for devolution of funds, functionaries and programmes for health, to PRIs.
- The District Health Mission to be led by the Zila Parishad. The DHM will control, guide and manage all public health institutions in the district, Sub-centres, PHCs and CHCs.
- ASHAs would be selected by and be accountable to the Village Panchayat.
- The Village Health Committee of the Panchayat would prepare the Village Health Plan, and promote intersectoral integration
- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the
- ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- PRI involvement in Rogi Kalyan Samitis for good hospital management.
- Provision of training to members of PRIs.
- Making available health related databases to all stakeholders, including Panchayats at all levels.

ROLE OF NGOs IN THE MISSION

- Included in institutional arrangement at National, State and District levels, including Standing Mentoring Group for ASHA Member of Task Groups
- Provision of Training, BCC and Technical Support for ASHAs/DHM
- Health Resource Organizations
- Service delivery for identified population groups on select themes
- For monitoring, evaluation and social audit

Conclusions

(a) National Level:

- Infant Mortality Rate reduced to 30/1000 live births
- Maternal Mortality Ratio reduced to 100/100,000
- Total Fertility Rate reduced to 2.1
- Malaria mortality reduction rate – 50% upto 2010, additional 10% by 2012
- Kala Azar mortality reduction rate: 100% by 2010 and sustaining elimination until 2012
- Filarial/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015
- Dengue mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- Cataract Operation: increasing to 46 lakhs per year until 2012.
- Leprosy prevalence rate: reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter
- Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.
- Upgrading Community Health Centers to Indian Public Health Standards
- Increase utilization of First Referral Units from less than 20% to 75%
- Engaging 250,000 female Accredited Social Health Activists (ASHAs) in 10 States.

(b) Community Level:

- Availability of trained community level worker at village level, with a drug kit for generic ailments
- Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition.
- Availability of generic drugs for common ailments at Sub-centre and hospital level
- Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level
- Improved access to Universal Immunization through induction of Auto

- Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme
- Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families
- Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission
- Improved Outreach services through mobile medical unit at district level

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