NRHM – THE PROGRESS SO FAR

Introduction

1. The National Rural Health Mission was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions. The difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. 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 simultaneous action on a wide range of determinants of health like 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. From narrowly defined schemes, the NRHM was shifting the focus to a functional health system at all levels, from the village to the district.

The State of Public Health in India

2. In order to assess the progress under NRHM, it is important to take note of the state of public health in India, as reflected in a large number of independent surveys and studies. Some of the key findings regarding important health indicators are as follows:

	Indicator	The Gain under NRHM
1.	Infant Mortality Rate	IMR down to 53. Down by 4 points in 2008 as compared to a point a year in earlier years (2003-2006). Possible to achieve the required reduction of 4-5 points a year to reach 30 by 2012, if neonatal mortality is effectively addressed through 48 hour stay after institutional delivery.
2.	Institutional Delivery	Increased by 66.4% in MP, 50.2% in Rajasthan, 47.3% in Bihar, 43.8% in Orissa, 20.9% in Andhra Pradesh and 12.4% in Uttar Pradesh between DLHS – II (2004) and DLHS – III (2007). Significant gains in hitherto low performing States with high maternal mortality.

3.	Immunization	Full immunization increased from 20.7% to 41.4% in Bihar, 25.7% to 54.1% in Jharkhand, 30.1% to 36.1% in MP, 53.5% to 62.4% in Orissa, 23.9% to 48.8% in Rajasthan25.8% to 30.3% in UP between DLHS – II and DLHS-III.	
4.	Average medical expenditure per Hospitalization	National Sample Survey 60th Round 2004	Rs. 3238 in Government Hospitals compared to Rs. 7408 in private Hospitals in rural areas.
5.	State of Health Facilities	DLHS and Facility Survey coordinated by IIPS 2003	If adequacy is defined as having at least 60 percent of the required inputs, only 76% of FRUs, and 63 percent of CHCs have adequate infrastructure, 61 percent of the FRUs and 46 percent of CHCs have adequate equipments, 32 percent of FRUs and 24 percent CHCs have adequate supply and 37 percent of FRUs and 14 percent of CHCs have adequate staff. During the three months preceding the survey only 58 percent of the PHCs conducted deliveries, 6 percent conducted MTP, 22 percent provided Neo natal care, 65 percent did IUD insertion and 41 percent conducted sterilizations. If the percentage of PHCs having adequate staff is more than 90 percent in Tamil Nadu, Maharashtra and Kerala, it is less than 20 percent in Orissa, West Bengal and Bihar.
6.	Anaemia among children and women	National Family Health Survey 2005-06	79.1% 6-35 month children are anaemic. 56.1% Ever married women aged 15-49 are anemic.

7.	Child Morbidity	FOCUS Survey 2004 (Jean Dreze et al) in Tamil Nadu, HP, Maharashtra, Rajasthan, Chhattisgarh and Uttar Pradesh	32% children had fever, 21% had diarrhea, 17% had persistent cough, 11% had extreme weakness, 5% had skin rashes, 2% had eye infections during the two weeks preceding the survey. 50% children had one of the above problems.

The Challenges before NRHM and its key approaches

3. The data above clearly brings out the unsatisfactory state of public health in India. It is clearly a gigantic task to bring about major changes in outcomes by simultaneous action on a wide range of determinants of health. The NRHM has based its interventions on the evidence from the studies and surveys listed above. It has identified communitization, flexible financing, innovations in human resource management, monitoring against IPH Standards, and building capacities at all levels as the principal approaches to ensure quality service delivery, efficient utilization of scarce resources, and most of all, to ensure service guarantees to local households. Health is a state subject and the NRHM is an effort at building a partnership with the States to ensure meaningful reforms with more resources. Ultimately, the success of NRHM will depend on the ability of the Mission interventions to galvanize State Governments into action, pursuing innovations and flexibility in all spheres of public health action. Ensuring availability of fully trained and equipped resident health functionaries at all levels and large scale demand side financing under initiatives like the Janani Suraksha Yojana for institutional deliveries are a few priorities for action. Partnerships with non governmental providers to strengthen pubic health delivery are also an important need given the distribution of Specialist doctors in India. While we have 30,000 MBBS graduates coming out of our Colleges every year, the entire rural health system for more than 750 million people never has more than 26000 doctors.

The Progress so far

4. In its very short journey of 4-5 years, there are some very significant gains in the health sector, in partnership with States. The Table below tries to capture some of

the gains made during this period in key areas and the evidence from the States in this regard. Illustrative evidence from States is indicated to convey the impact of the programme so far.

1.	**Rogi Kalyan Samitis**	570 DHs, 4210 CHCs, 1125 other than CHC Hospitals above CHC level but below DH level, 16920 PHCs, 6795 other Health facilities above SC but below block level have then own Rogi Kalyan Samitis with untied funds for improving quality of health services.
2.	**ASHAs**	8.09 lakhs ASHAs selected, 2.55 lakh trained upto 5th Module and 5.53 lakh with Drug kits in their respective villages.
3.	**Village Health & Sanitation Committees**	4.95 lakh villages (nearly 77%) have their own Village Health & Sanitation Committees. All have received the Rs.10,000/- untied grant for local action.
4.	**Village health & Nutrition Days**	35.06 lakh in 2006-07, 49.62 lakh in 2007-08, 58.19 lakh in 2008-09, 56.20 lakh in 2009-10 and 8.45 lakh in 2010-11 Village Health & Nutrition Days organized at ICDS centre to reach basic health services.
5.	**24 x 7 Health Facilities in Rural Areas**	A total of 15,873 APHCs, PHCs, CHCs and other Sub District facilities are functional 24 x 7
6.	**Addition of Human Resources**	1,589 Specialists, 8,648 MBBS Doctors, 25,790 Staff Nurses, 46,351 ANMs, 17,575 Para Medics added on contract under NRHM
7.	**Programme Management units**	584 District Programme Managers, 568 District Accounts Managers, 533 District Data Managers, 633 DPMUs, 34 SPMUs, 3434 Block Managers, 3150 Accountants, 3434 Block PMUs added on contract under NRHM.
8.	**Janani Suraksha Yojana Beneficiaries**	Over 3.19 crore women covered under JSY so far.

9.	**Mobile Medical Units**	1031 MMUs under NRHM functional to provide diagnostic & out patient case closer to hamlets and villages in remote areas.
10.	**AYUSH**	12134 health facilities have co-located AYUSH services. 7993 AYUSH Doctors and 3232 AYUSH paramedics added to the system on contract.

The Way Ahead

5. As is evident from the Table on progress, a lot has been achieved in the last five years in partnership with States. This is a sector that requires simultaneous action on many fronts. The institutional platform of Village Health and Sanitation Committees, the Rogi Kalyan Samitis and the Panchayati Raj Institution committees at various levels is providing a rare opportunity for convergent action on all determinants of health. An army of locally resident Accredited Social health Activists with strong referral links with the strengthened health system will put even greater pressure on the public sector health system to delivery quality services. Along with need based and transparent partnerships with non governmental providers for public health goals, the strengthened system will have positive consequences for all interventions, whether they are for family welfare, disease surveillance, National Health Programmes, etc. The innovative engagement of human resource as per need and the arrangements for incentives at each level will help craft a new and innovative system of public health delivery. The experience of the last four years gives us the confidence that we are on the right track and that we need to deepen institutional reforms and effective decentralization through a concerted effort at capacity building. The setting up of a National Health System Resource Centre is a step in that direction. Several states have already setup state resource centres & others are also in the process of setting up their resource Centres. The North Eastern Regional Resource Centre is already playing a critical role in developing need based programmes in the eight North Eastern States.