IFMR Research | CENTRE FOR DEVELOPMENT FINANCE

THE NATIONAL RURAL HEALTH MISSION

2009-10 SCHEME BRIEF

The National Rural Health Mission, launched in 2005, is the largest primary healthcare programme run in the world and reflects the Government of India's commitment to increase public spending on health to 2-3 percent of GDP.

It aims provide effective healthcare in rural areas, especially to poor and disadvantaged sections of the population, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralisation. It will do so through an architectural correction in the existing delivery mechanism and use of traditional Indian medicine systems. This brief examines the Mission's salient features and summarises progress to date.

BACKGROUND

The National Rural Health Mission (NRHM) is a flagship scheme of them central government to improve the access and provision of basic healthcare facilities in rural India by undertaking an architectural correction in the existing healthcare delivery system and by promoting good health through improvements in nutrition, sanitation, hygiene and safe drinking water. It also seeks to revitalise Indian health traditions of ayurveda, yoga, unani, siddha and homeopathy (AYUSH), and mainstream them in to the healthcare system. NRHM is an umbrella programme subsuming existing health and family welfare programmes, such as the second phase of the Reproductive and Child Health programme (RCH II), National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness, Iodine Deficiency (NDCP), and the Integrated Disease Surveillance Programme (IDSP). By integrating these vertical health programmes, NRHM seeks to optimise utilisation of funds and infrastructure, thereby strengthening delivery of public healthcare. A task force has been constituted to recommend strategies for expanding the programme to include the urban poor.

NRHM comes in response to a growing healthcare crisis in the country, wherein households' private expenditure on health is more than three times the public expenditure on health. It aims to increase public expenditure on preventive health services while simultaneously making healthcare affordable and accessible for the ru-

Ministry	Ministry of Health and Family Welfare
Sector	Healthcare
Goal	Provide accessible, affordable, accountable, effective and reliable healthcare facilities in rural areas, especially to the poor and vulnerable sections of the population Promote population, gender and demographic balance. Revitalise local health traditions and mainstream AYUSH Promote healthy life styles
Output/ Scheme Indicator	Reduce Infant Mortality Rate to 100 per 100,000 live births by 2012 Reduce Maternal Mortality Ratio to 30 per 1000 live births by 2012 Reduce Total Fertility Rate to 2.1 by 2012 Achieve Malaria Mortality Reduction Rate of 50% by 2010, additional 10% by 2012 Reduce Leprosy Prevalence Rate to 1 per 10,000 Achieve Filaria Reduction Rate of 70% by 2010, 80% by 2012 and elimination by 2015
Funding	Shared by centre and states in the ratio 85:15
Year of Inception	2005
Expiration date	2012
2009-2010 Budget outlay	₹15,722 crore

ral poor. It is operational in the entire country, but has a special focus on eighteen states that have weak public health indicators and/or weak infrastructure. These include eight Empowered Action Group (EAG)[1] states of (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttarakhand, Jharkhand, Chhattisgarh), eight North Eastern states (Assam, Sikkim, Arunachal Pradesh, Manipur, Mizoram, Nagaland, Meghalaya, Tripura), Himachal Pradesh and Jammu and Kashmir.

Funding: The scheme's guidelines state that the budget outlay would increase 30% every year to bring the outlays on public health from 0.9 percent in 2004-05 to three percent of GDP by 2012. States are to increase budget allocations by ten% annually to support NRHM activities. Of the outlay on NRHM, ten % is committed to the eight North-eastern states. All central assistance is provided to sub-centres (SCs) in the form of salaries for female nurses, rent and untied contingency funds of ₹10,000 per annum, in addition to essential drugs (both allopathic and AYUSH) and equipment kits. The salary for male nurses is borne by state governments.

How does it work?: Health is listed as a state subject in the Indian Constitution while family welfare is in the concurrent list. Primary healthcare is a subject of local self governments. Therefore, public expenditure is restricted by resources available at the state and sub-state levels. NRHM envisages a significant role for communities in the delivery and monitoring of primary healthcare. One of the scheme's core strategies is to build the capacity of Panchayati Raj Institutions (PRIs) to control and manage public health services. NRHM has a provision for professional bodies and non-governmental organisations (NGOs) to conduct monitoring and evaluation. It also relies on communities to monitor the delivery system and the provision of health services. Preparation of annual district health report involves government line departments and NGOs, and state and national reports are tabled in State Legislative Assemblies and the Parliament. At the national level, NRHM is jointly led by a Mission Steering Group, headed by the Union Minister of Health and Family Welfare, and an Empowered Programme Committee, headed by the Union Secretary for Health and Family Welfare. A Mission Directorate has been created for planning, implementation and monitoring day-to-day administration. At the state level, the State Health Mission, headed by the Chief Minister, carries out the activities through State Health Societies, which integrate the societies of various disease control programmes. At the sub-state level, The District Health Mission shall be led by the Chairman of the Zilla Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant Departments, NGOs and private professionals. District Health Societies are responsible for preparing perspective plans for the entire period (2005-12), annual plans of all NRHM components and for integrating public health plans with those for water, sanitation, hygiene and nutrition. Block level health plans form the basis for district plans and are formulated by integrating village plans.

NRHM Approaches

Decentralisation and Community Participation
- Hospital management committees
- Untied grants to community bodies
- Funds & functions to local community organisations
- Decentralised planning
- Inter-sectoral convergence

Improved Management through Capacity Building
- Block And District Health Office With Management Skills
- NGOs in capacity building
- Continuous skill development support

Flexible Financing
- Unties grants to institutions
- NGOs as implementers
- More resources for reforms

Innovations in Human Resource Management
- More nurses and local resident criteria
- 24x7 emergencies by nurses at CHC, PHC

Monitor Progress against Standards
- Setting IPHS standards
- Facility surveys
- Independent monitoring at block, district and state levels

CENTER	POPULATION NORMS	
	PLAIN AREAS	HILLY/TRIBAL/ DIFFICULT AREAS
Sub-centre (SC)	5,000	3,000
Primary healthcare centre (PHC)	30,000	20,000
Community health centres (CHCs)	1,20,000	80,000

The rural healthcare system comprises of SCs at the gram panchayat level, primary healthcare centres (PHC) for a cluster of panchayats, and community health centres (CHC) at the block level (Table 2).[2] Rogi Kalyan Samitis[3] (RKS) at the block level are responsible for the day-to-day management of hospitals. The SC, staffed by an Auxiliary Nurse Midwife (ANM)[4] and a male nurse, is the first point of contact with the primary health system and provides immunisations, diarrhoea control, and maternal and child healthcare. In each village, a Village Health and Sanitation Samiti is accountable to the panchayat and is comprised of a female Accredited Social Health Activist (ASHA)[5] who is the bridge for the village, an ANM, a teacher, a panchayat representative, and community health volunteers. PHCs are staffed by a medical officer and fourteen paramedical staff, and provide integrated curative and preventive care. PHCs are the first point of contact with a medical officer and act as referral units for six SCs. At the block level, CHCs, serving as referral units for four PHCs, are manned by four medical specialists (surgeon, physician, gynaecologist and paediatrician) and provide obstetric care and specialist consultations. NRHM seeks to bring CHCs and PHCs on par with Indian Public Health Standards (IPHS)[6] and makes the provision of adequate funds and powers to enable these committees to reach desired levels.

PROGRESS

How has the scheme performed?: While it is too soon to make a clear linkage between NRHM's performance and health outcomes, it can be broadly concluded that the scheme has made poor progress in national health indicators, such as life expectancy, infant mortality, and maternal mortality, and that this can be attributed to inadequate expenditure and interventions.

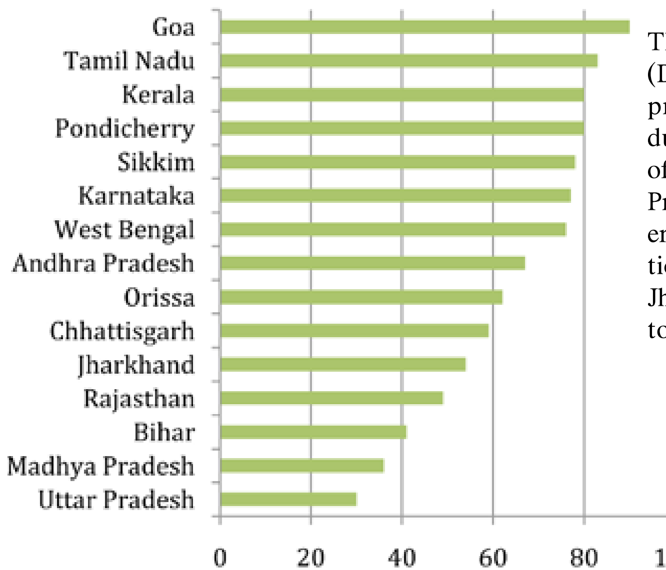

Figure 1: Percentage of children that received full immunisation
Source: DLHS 3 (Phase 1)

The first phase of District Level Household and facility Survey (DLHS-3)[7] registered an improvement in maternal and child health programmes. Infant Mortality Rate was 55% in 2008, having reduced by 2 percentage points over the previous year.[8] Percentage of children receiving full immunisation[9] varies from 30% in Uttar Pradesh to 90% in Goa, with Kerala, Tamil Nadu and Pondicherry achieving more than 80% coverage (Figure 1). Full immunisation increased from 20.7% to 41.4% in Bihar, 25.7% to 54.1% in Jharkhand, from 30.1% to 36.1% in Madhya Pradesh, from 53.5% to 62.4% in Orissa, and from 23.9% to 48.8% in Rajasthan.

In eight of the fifteen states surveyed in Phase 1 of DLHS-3, more than 90% of women who had given birth in the preceding three years reported receiving antenatal care[10] during their last pregnancy (Figure 2). Between DLHS-2 and DLHS-3, institutionalised delivery has increased by 66.4% in Madhya Pradesh, 47.3% in Bihar, 43.8% in Orissa, 20.9% in Andhra Pradesh and 12.4% in Uttar Pradesh. However, only in the states of Kerala, Goa, Pondicherry and Tamil Nadu had more than 90% women accessed institutional facilities for deliveries. In Jharkhand and Chhattisgarh this figure was less than 20%, with most women not having access to proper hygienic conditions and supervision of trained health personnel.

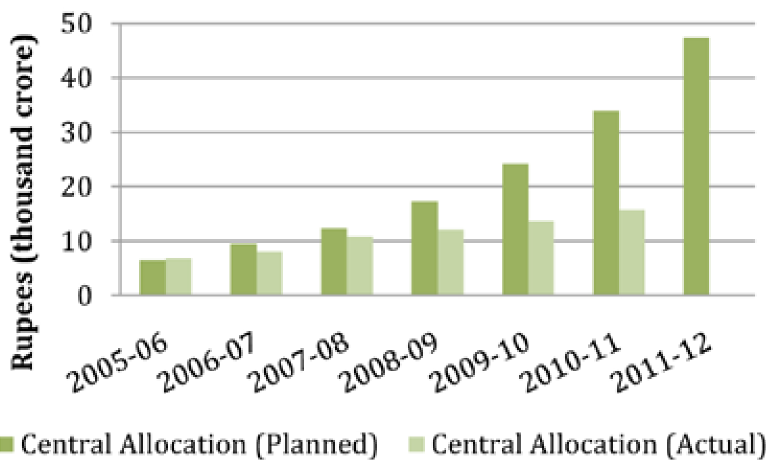

Figure 2: Maternal Health Care
Source: DLHS 3 (Phase 1)

Infrastructure: The performance of NRHM can be seen in the improved health infrastructure and organisational set-up and the transparency and timeliness of data on the Ministry of Health and Family Welfare (MoHFW) website as of November 2009.[11] Rogi Kalyan Samitis with untied funds have been created in 566 district hospitals (DH) and 4.59 lakh ASHAs have been trained, provided with drug kits and placed in their respective villages.

How much funding is being spent? The scheme was initiated in 2005-6 with an initial budget

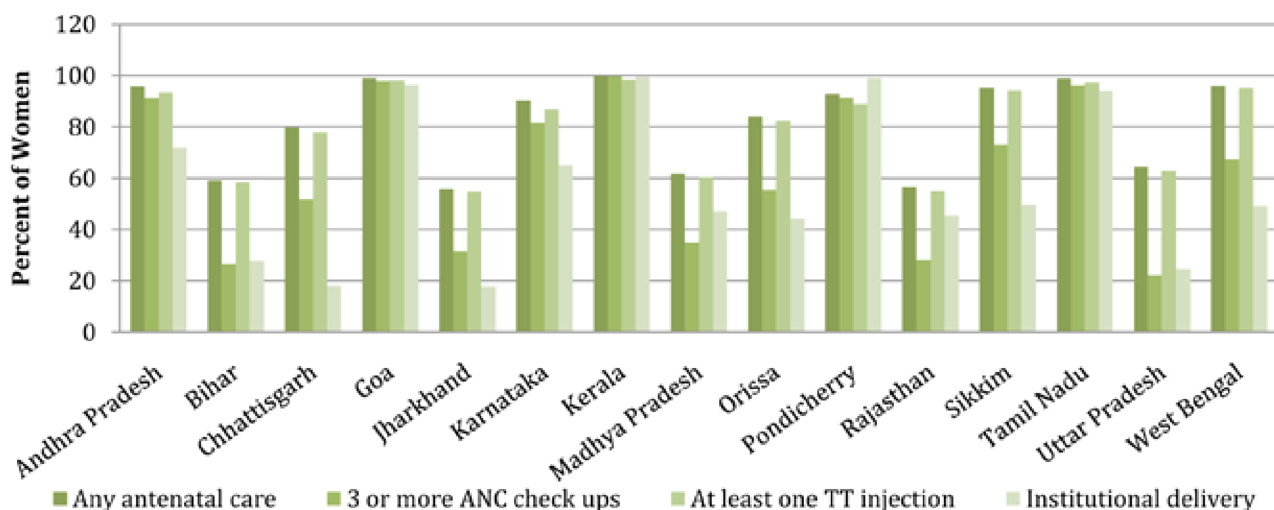

Figure 3: Planned and Actual central government allocations
Source: Union Budgets and NRHM Framework for Implementation 2005-12

outlay of approximately ₹6,700 crore. Planned central government allocations have steadily increased over the past five years to more than ₹67,000 crore (Figure 3). However, actual allocations (revised estimates from the union budgets) fall short. As against an envisaged annual increase of 30 to 40%, actual allocations have increased by less than half. The only exception was in the year 2005-6 when the actual allocation marginally exceeded the planned allocation.

CHALLENGES

Poor coordination and integration with other health interventions The objectives of NRHM to increase expenditure on public health, provide access to healthcare to the rural poor, reduce IMR/MMR/TFR, and revitalise Indian health traditions are not different from previous programmes. It recognises that diseases are caused by several factors and stresses on the convergence of inter-sectoral services, such as nutrition, water, sanitation and hygiene. It integrates previously vertical disease-specific programmes at the national, state and district levels, ensuring that these different aspects are represented in the district health plan.

NRHM is designed to coordinate efforts between related schemes such as Total Sanitation Campaign, Integrated Child Development Services, Mid Day Meal, and National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme. However, coordination between different ministries and integration between various intersectoral programmes remains the biggest challenge for NRHM.

Lack of data The NRHM framework states targets for public health outcomes, but lacks mechanisms to judge state performance against targets. MoHFW maintains annual state-wise data, but without state targets in the framework, it is not possible to arrive at meaningful regional and inter-state comparisons. Baseline surveys, that are important to estimate current status and to measure all future progress, were completed in only eight states and Union Territories (UTs), were incomplete in eight, and were not initiated in twenty states and UTs. The lack of baseline data prevents any meaningful evaluation of progress of the scheme in the states and in the country. In the absence of complete, timely and accessible household and facility data it is not possible to adequately plan future interventions based on relative need analysis.[12]

[1] In order to provide thrust to the primary healthcare infrastructure, so that the delivery of family welfare services could be made more efficient, the Government of India constituted the Empowered Action Group (EAG) in March 2001 as an administrative mechanism for the purpose of closely monitoring the implementation of existing family welfare programmes.

[2] Rural Healthcare System in India, Ministry of Health and Family Welfare http://mohfw.nic.in/Bulletin%20on%20RHS%20-%20March,%202008%20-%20PDF%20Version/Rural%20Health%20Care%20System%20in%20India.pdf
Website accessed on March 1, 2010..

[3] Rogi Kalyan Samiti (Patient welfare society) is a committee for the management of public hospitals through community participation. Rogi Kalyan samitis are registered societies and have been set up in all medical colleges, district hospitals, civil hospitals, community health centres (CHC), primary health centres (PHC), have people's representatives, health functionaries, local district officials, leading members of the community, representatives of the Indian Medical Association, members of the urban local bodies and Panchayat Raj institutions (PRIs) as well as leading donors as their members..

[4] Auxiliary Nurse Midwives (ANMs) are multipurpose extension health workers who work at the interface between the community and public health system. While a team of physicians and paramedical workers staff the primary and community health centers, a single ANM manages the sub-center, mandated at a population of 3,000-5,000 for rural areas. She is expected to perform a large number of diverse preventive and curative functions such as motivation for family planning, immunisation, conducting deliveries, and treatment for childhood illnesses. She is expected to reside in the subcenter village and remain available round the clock.

[5] ASHA is a health activist in the community who creates awareness on health and its social determinants and mobilises the community towards local health planning and increased utilisation and accountability of the existing health services..

[6] The Government introduced the Indian Public Health Standards, which specify personnel, management and equipment norms for public health services.

[7] The Ministry of Health and Family Welfare (MoHFW) has designated the International Institute for Population Sciences (IIPS), Mumbai as the nodal agency for conducting the District Level Household and facility Survey (DLHS). DLHS 1 was conducted in 1998-99 and DLHS in 2002-04. The focus of DLHS-3 (2007-9) is to provide health care and utilisation indicators at the district level for the enhancement of the activities under National Rural Health Mission (NRHM).

[8] National Family Health Survey www.nfhsindia.org

[9] The Universal Immunisation Programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant women with immunisation against identified vaccine preventable diseases.

[10] Antenatal care (ANC) refers to pregnancy-related health care provided by a doctor, an ANM or any health professional to women. In India, the Reproductive and Child Health Programme aims at providing at least three antenatal check-up, immunization against tetanus, and iron and folic acid for anaemia management.

[11] http://www.mohfw.nic.in/NRHM/Documents/NRHM_The_Progress_so_far.pdf Website accessed on March 1, 2010.

[12] Gill, Kaveri A Primary Evaluation of Service Delivery under NRHM: Findings from a study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan; Working Paper 1/2009 – PEO, Planning Commission of India

FOR ADDITIONAL INFORMATION	
www.mohfw.nic.in	The Ministry of Health and Family Welfare is the nodal authority on health and family welfare and is responsible for the execution of all government schemes
www.chiips.org	Website for the District Level Household and family Surveys conducted by the International Institute for Population Sciences (IIPS), Mumbai
www.cag.gov.in	The Comptroller and Auditor General of India audits schemes and undertakings at the behest of the principal authority. The CAG Audit Report 8 for the year 2009-10

This scheme brief was prepared by Satyarupa Shekhar with support from Bree Bacon as part of CDF's Centrally Sponsored Schemes initiative, which is supported by the IFMR Foundation.

IFMR Research
CENTRE FOR DEVELOPMENT FINANCE