Chapter 8

ACHIEVEMENTS OF NATIONAL RURAL HEALTH MISSION

Since this was made clear that this research would present its findings in two segments firstly execution and secondly achievements. Further the achievements would be parted into performance and attainments. Execution being already described in previous Chapter 7 therefore in these chapter achievements of NRHM in terms of performance and attainment would be described. In addition targets versus achievements and inconsistencies in terms of health indicators at the national and international levels would be also presented. Further the deficiencies in terms of number of health facilities and work force would be also presented.

8.1 Performance of National Rural Health Mission

The performance, as stated has been largely described on the basis of MIS or Executive Summary of NRHM which was a periodical data published by the Ministry of Health & FW, Government of India. The data was a summary of functioning and progress of different gamut of National Rural Health Mission in terms of both national and state levels. The said data was so far available for the period up to 31/12/2011 since 2005-06 onwards. Therefore data related to substantial period of NRHM 2005-12 was available.

8.1.1 Categorization of states

The coverage of National Rural Health Mission was extended to almost 743 million-population spread over 642 districts, 2502 sub divisions, 6348 blocks, and 638588 villages. All the 35 states and union territories of India were categorized in four groups as per amount of focus to be put on those states. All four categories were mentioned in tabular form in Table 11; therefore you may please see in Table 11. It would appear from Table 11 that states like Bihar, Chhattisgarh, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and Uttaranchal were placed among high focus non-North Eastern states. North-Eastern states of Arunachal Pradesh, Assam, Meghalaya, Mizoram, Manipur, Nagaland, Tripura, and Sikkim were also included in high focus states under National Rural Health Mission.
With those findings it could be established that *National Rural Health Mission* was not uniformly implemented across the country and poor performing states were identified and categorized in high focus category.

### 8.1.2 Institutional arrangements

The performance of the *National Rural Health Mission* in terms of institutional arrangements was presented in form of a table; therefore you may please see in *Table 12*. It could be evident from the *Table 12* that the State Program Management Units or SPMUs were constituted in all 35 states of the country at state level. Whereas in 635-districts program management units were set up, further in 580 districts District Program Managers were deployed and in 555 districts District Accounts Manager were deployed. In addition, in 539 districts, Data Assistants were deployed in the country. It would be further become evident from the *Table 12* that respectively in 3529, 4524 primary health centres of the country, Block Program Managers, Accounts Managers were positioned. In addition in almost 615 districts and 34 states merger of societies were accomplished.

A total number of 29904 *Rogi Kalyan Samities* were constituted in the country out of which 599 were at District Hospitals (DH), 4210 at CHCs, 1136 at Other than CHC at or above block level but below district level, 17097 at PHCs and 6862 at other health facilities above SC but below block level included APHC. The number of *Rogi Kalyan Samities (RKSs)* registered for DHs, CHCs, FRUs and PHCs were 694, 4835, 1136 and 17097 respectively in the country. Likewise, almost 6862 RKS were registered for other health facilities, which included *Additional Primary Health Centres (APHSc)*.

The number of cases prosecuted under PNDT Act till June 2011 was 921 in the country. In 82 cases action were taken under PNDT till that period. In 323 districts of the country IMNCI was implemented and total number of people trained on IMNCI was 478741. A total number of 301 districts of the country were covered by the mother NGO scheme whereas total number of MNGOs in states was 321 s on 31.03.2011.

The total number of *Aanganwadi Centres* as per Ministry of Women & Child Development sources as of 31.12.2010 sanctioned was 1366776 while number of operationalised AWWs was 1241749. Total number of AWW in the country was above 2.4 million. Number of VHSNC, Joint account operational at Sub Centre, and Joint account operational at VHSNCs were respectively 496338, 145098, and 428287.
As per RHS 2010 total number of HSCs functional in government building, number of HSCs functional with one ANM, number of HSCs functional without ANM, number of HSCs functional with Second ANMs were 84957, 140942, 6127, 62536 respectively. A total APHCs, PHCs, CHCs & other Sub District facilities functional as 24X7 bases were 14373. Total number of primary health centre had gone to 23663 in the country. Total number of PHCs functioning as 24x7 bases at start of NRHM on 31/3/2005 was 1263 and after NRHM they were at 8330. Number of PHC where three staff nurses posted was 6718.

Total number of Community Health Centre was 4535 in the country. Total number of CHCs functioning as 24x7 bases at start of NRHM on 31/3/2005 was 980 which rose to 3975.

Total number of facilities other than CHC at or above block level but below district level which were functioning on 24X7 bases were 1002 and three staff nurses were available at 858 CHCs.

The number of district hospitals in the country was 673, number of district level health facilities other than district hospital was 224 and number of district level health facilities which were FRU was 696.

A total number of district hospitals functional as FRUs which was at 237 on 31/03/2005 rose to 596. Like wise sub divisional hospitals functional as FRUs which was at 375 on 31/03/2005 rose to 658. CHCs which were functional as FRUs on 31/03/2005 were 343 which were now at 1099.

With those findings it could be established that institutional arrangements were made in the country fully on the pattern of the mission documents and frame work of implementation of NRHM. The same could prove by the research scholar during case studies that institutions were existed and functional in all health facilities visited. However as per table 12 it could not say about a satisfactory account of implementation of PNDT act in the country. The PNDT act was considered an instrument against the adverse sex ration in the country.

8.1.3 AYUSH:

A massive promotion of AYUSH had happened under National Rural Health Mission. It was found that number of AYUSH persons which included in the health societies, state health missions, Rogi Kalyan Samities and ASHA training were 29, 26, 25 and 20 respectively. Like wise AYUSH facilities were made available at 424 district hospitals, 2495 community health centres, and 372 other than a CHC, 8366 primary health centres, and 3303 at other health facilities. A
total number of AYUSH persons deployed in the country were 14960 out of which 10851 were doctors and 3855 were paramedic staff appointed on contractual basis.

8.1.4 Functioning of the institutions:

The proper functioning of any institution could be identified with the number of meetings organized having the full quorum and decisions - deliberation took place in any particular meeting according to set byelaws. The number of different institutions at state levels and district levels were illustrated in the MIS or Executive Summary of NRHM which was available to the scholar for the period up to September 30, 2011. Therefore the number of meetings of health societies and Rogi Kalyan Samities organized could be an indicative of the proper functioning of that particular institution. Research scholar during case studies had visited several health facilities and was able to see the proceeding registers at several places. However it could be said that though meetings held regularly however deliberations at the meetings was not very clear and it required noting the deliberations of each members in very clear terms.

On the basis of MIS on NRHM or executive summary up to September 2011 the number of meetings held by different health societies in the country at different levels over the periods was tabulated in Table 13. Therefore you may please see in Table 13. Number of meetings of State Health Mission held in the year 06-07 was 54 and in years 07-08, 08-09, 09-10, 10-11, 11-12 up to September 11 were respectively 67, 50, 61, 58, and 24. Likewise, number of meetings of District Health Missions held during years 06-07, 07-08, 08-09, 09-10, 10-11 and 11-12 were 911, 892, 1308, 1092, 1116, and 1042.

In addition, Table 13 would also make it clear those almost 380 meetings of all the state health societies held in the country over the period of last six years, which averaged almost 63 meetings each year. It indicated that almost 2-3 meetings of each state health societies held in the country in every year which almost according to the suggested pattern. It would also become clear that almost 6361 meetings of the district health societies held in the country over the period of last six years, which almost averaged about 1000 meetings per year. Almost every state had submitted their year wise program implementation plans (PIPs). Similarly almost all the districts had submitted their annual district health action plans (DHAPs).
In table 13 you may also find the year wise number of village health and nutrition days organized at Aanganwadi Centers. You could find that almost 27125147 village health and nutritional days (VHNDs) were organized in the country during 2005-06 to 2011-12, which was tremendous performance and it indicated the capacity of public health system to organize such events. Almost 9140 health melas were organized over the last five years up to year 2010-11 which means almost 1800 health melas organized in the country each year on the average.

8. 1.5 Accredited Social Health Activists Program:

It would become clear from Table-13 that almost 8855168 ASHAs selected in the country under NRHM during the last seven years and since inception of NRHM. Number of ASHAs who have received training for the 1st module, 2nd module, 3rd module, 4th module, 5th module, 6th module and 7th modules were respectively 807897, 736956, 713096, 690423, 573127, 93147 and 92747. Total number of ASHAs in position with drug kits was 741502. Figure 7 would demonstrate the training of ASHA which appeared dismal as only 92747 ASHAs were able to take all the 7 module training prescribed.

Figure 7: ASHA training

8. 1.6 Male and female sterilizations:

Further, in Table-13 several other performance of the NRHM had been also mentioned. It could further provide information about the male and female sterilizations in the country. It could become apparent that female sterilization was many folds higher than male sterilization in the country. Figure 8 would demonstrate the male versus female sterilizations in the country.
8. 1.7 Number of Health Facilities:

As per MIS on NRHM or Executive Summary on NRHM a total number of APHCs, PHCs, CHCs, & other Sub District facilities functional as 24X7 bases in the country were recorded as 16338 and at the same time almost 145920 HSCs were functional in the country out of which 79216 were in the govt. building and 50728 were with second ANM.

Total number of PHC functional on 24X7 bases had increased from a level of 1263 in the year 2005 to a level of 8717 in the year 2011-12. Similarly, CHC functional on the 24X7 basis had increased to a level of 3942 from a level of 980 in the year 2005.

Number of CHCs selected for up gradation to the tune of IPHS were 2921 where as number of CHCs for which facility survey was completed were recorded as 2864, the number of CHC for which physical up gradation started were 2051 and number of CHCs for which physical up gradation completed were 1141. Total Number of specialists at CHCs required as per RHS 2009 was 18040. Total numbers of posts sanctioned as per RHS 2009 were 9028 and total number of specialists in position were 5789 whereas a total number specialists appointed on contract basis under NRHM were 1572. However those figures would further become little enhanced the moment the RHS data for the period 2011-12 would be published.
The total number of District Hospitals, District level Health Facilities other than District Hospitals, District level Health Facilities which were FRU and DHs which have been taken up for upgradation under NRHM in the country were 601, 457, 549 and 443 respectively.

8. 1.8 Performance of Vector borne disease control programs:

Performance of borne disease control programs had been summarized in Table 15; therefore you may please see in table 15. The performance of almost all vector borne diseases control program appeared somehow satisfactory. Most of the targets were either achieved or would be achieved the moment all the data from different and respective divisions would emerge. It was not so that the set target was achieved up to 2011-12 then also it was expected that they might be tackled up to year 2015 as decline in number of cases and mortality was clearly indicated. Deaths due to Malaria, Cases of Kala Azar, Deaths due to Kala Azar, Suspected cases of Japanese Encephalitis, Deaths due to suspected Japanese Encephalitis, Suspected cases of Dengue, Deaths due to dengue, and No of confirmed cases of Chikungunya were measured respectively at 6443, 199641, 623, 27643, 4849, 88286, 632, and 290910 during the last seven years. The Kala Azar, Japanese encephalitis and dengue mortality rates were measured as 0.40, 17.39 and 0.71 percent respectively.

Figure 9, Figure 10 and Figure 11 would demonstrate the respective positions of Kala Azar, Japanese encephalitis and Dengue in the country.

Figure 9: Kala Azar situation in the country
Figure 10: Japanese encephalitis situation in the country

Figure 11: Dengue situation in the country

8. 1.9 Institutional delivery and Janani Suraksha Yojna

State wise number of institutional deliveries (IDs) and beneficiaries of Janani Suraksha Yojna had been summarized in table 16. Almost 46332507 women were benefitted under the Janani Suraksha Yojna. The total number of institutional deliveries in the country since inception of NRHM had surpassed 93303046 although this number could increase little bit as final report for the last six months was not posted.

Further in table 16 per capita institutional delivery and beneficiaries under JSY was analyzed by the research scholar based upon the statistical formula already mentioned in methods section. This action was initiated to see how different
states had performed. On the basis of this exercise it became evident that states like Madhya Pradesh, Mizoram, Rajasthan, Orissa, Assam, Chhattisgarh, Bihar, Jharkhand, Andhra, U.P, West Bengal and Uttaranchal were some best performing states in terms of implementing Janani Suraksha Yojna.

Like wise Pondicherry, Chandigarh, Andhra, M.P, Kerala, Tamil Nadu, Gujarat, Mizoram, Rajasthan, A &N Islands, Delhi, D & Diu, Maharashtra, Haryana, and UP were some best performing states in terms of institutional delivery.

It required mentioned here that Janani Suraksha Yojna and Institutional Delivery were expected to correspond with each other as Janani Suraksha Yojna was a safe motherhood intervention which expected to promote institutional delivery and performance of different states was little contradictory however at national level there was some uniformity. Therefore this issue raised by this study definitely required future study specially using some statistical analysis. Also it was found that performance of non high focus states was relatively much better in comparison of high focus states. It could indicate that health facilities might still not improved adequately in those states.

8. 1.10 Funds release and utilization

How much funds were released and utilized by each state in India was summarized in table 17; therefore you may please see in table 17. Also the per capita funds released and utilized by each state were also analyzed by the research scholar based upon the formula mentioned in methods section of this treatise however result could also see in table 17. It would appear from table 17 that per capita release of funds was highest in case of Sikkim at Rs. 2798.64 and lowest for Gujarat and Bihar respectively at Rs. 384.11 during the last seven years. It was a clear indication that despite being high focused state Bihar was not released funds accordingly to its population. The almost same was the situation with the other EAG states whereas more funds released to smaller states. Also non high focus states were provided funds not any less than high focused states. This was not according to the principles of EAG mandates as high focus states were required to be provided more funds in comparison of non high focused states. Allocation was required to be done on the basis of population of the states however release of funds was an issue which could be based on funds utilization by the respective states. However it also became clear to research scholar that even funds allocation to states was definitely not based upon the respective population of the states.
Per capita funds utilization was measured highest in states like Karnataka, Gujarat, Chandigarh, Daman & Diu, Andhra, Uttarakhand, Meghalaya, Jharkhand, Lakshadweep, Maharashtra, J & K, Himachal, and Bihar which was measured respectively at Rs. 2781, 2781, 2652, 2316, 2316, 1665, 1120, 1120, 1097, 1097, 1014, 1004, and 1004. However D & N Haveli and Haryana were at lowest in terms of per capita utilization of funds which was measured at Rs. 390.

8.1.11 Performance of National Blindness Control program

In table 18 you may please see the total number of cataract surgeries, Intra Ocular Lens (IOL) implanted and Eye / Cornea Donations performed during the last seven years up to September 2011, which was respectively at 305.73 lakh, 1950897, and 245682. Considering the data shown this was not any mean achievements.

8.2 Attainments of National Rural Health Mission

In previous paragraphs of this chapter it was described that how different components under NRHM had performed. That performance was required being resulted in certain positive changes in macro health indicators what defined at attainment under this research and that would be described hereafter.

8.2.1 Changes in demographic indicators

The State wise changes in Sex Ratio, Decadal Growth Rate, and Population 7 & above was compared and recorded by the research scholar based upon comparative census reports for the year 2001 and 2011 and that had been mentioned in table-19 which would describe how changes occurred between 2001 and 2011. It would definitely cover those seven years also during which NRHM was implemented; therefore you may please see in table-19 for this purpose. Table 19 would demonstrate the comparative change of nation, states and union territories in terms of Sex ratio, Decadal growth rate, and Child population in the age group 0-6 years per 1000 males, and Population aged 7 and above which respectively changed by 7, 3.7, -13, and 10 points respectively. The change in sex ratio and decadal growth rate was most significant and positive and it confirmed the assumptions that country’s population was in transition state. However why some states especially Daman & Diu, Dadar & Nagar Haveli and Jammu & Kashmir showed negative change in terms of sex ration was a matter of further research. Decadal growth rate of population had improved by almost 3.7 percent at the national level which was at 17.63. Although most of the high focused states and north eastern states were having
higher decadal growth rate in comparison of national average. All those data for different states were mostly positive and hence it could present a satisfactory yet a slow rate of achievements.

Further in table 20 it had been mentioned that how the decadal growth rate of population had changed since 1901. The steep rise in decadal growth rate which started almost simultaneously with India being independent in the forties and since then 2001-11 was the only period during which the population growth rate had declined more than earlier. The decadal growth rate of population in India was also illustrated vide figure 12.

Figure 12: Changes in decadal growth rate of population since 1901

8.2.2 Changes in Macro Health Indicators

The comparative changes in some macro health indicators such as Crude birth rate (CBR), Crude death rate (CDR), Natural Growth rate, and Infant mortality rate (IMR) which was based upon comparison of SRS data of two point of time April 2006 and December 2011 were mentioned in Table-21. Therefore you may please see in table-21.

It would appear from table 21that almost all states of India had exhibited positive growth in terms of Crude birth rate excepting states like Manipur and Nagaland which had shown negative growth. At national level CBR improved by almost 2 points from a level of 24.1 measured in the year April 2006 to a level of 22.1 in the year December 2011. Further crude death rates had also improved in several states excepting states like Andhra Pradesh, Chhattisgarh, J
Natural growth rate had improved for all states excepting Jharkhand, Manipur, Nagaland and Manipur. At national level the improvement was recorded as 1.7 points. Further at national level IMR improved by 11 points from a level of 58 in the year 2005-06 to a level of 47 in the year 2011-12. However some states such as Mizoram and Nagaland had some negative growth in terms of IMR. How such changes occurred at national level could be displayed vide figure-13.

**Figure 13: Change in macro health indicators**

8. 2.3 Increases in immunization coverage

As per **NRHM MIS or Executive Summary** up to September 30, 2011 the immunization coverage reported to be 43.50 percent as per NFHS-III data. While in this regard the data of forthcoming NFHS could be more useful however that was not published yet and expected to be published during 2012-13. It was believed that immunization coverage in the country had gone above fifty percent which could be a massive attainment.

However number of BCG delivered in the year 2009 was measured at 25879000 at public health facilities and the figure of number of expected children in the same year could be 26662242 as per **table 27**. Table 27 was presented after considering the population in the year 2009 and crude birth rate of the country. Further when infant mortality rate would be almost 50 in the year 2009 the total number of BCG likely to be delivered in the whole country could not be more
than 25329130. Total BCG delivered in the year 2009 versus likely BCG in the same year was found to be low which could be an indicative of that the BCG administered to almost 97 percent new born babies in the country. Therefore it could be said that the BCG coverage was as high as 97 percent. The same could say for DPT although this finding was not found appropriate by the research scholar and definitely would require future research. The immunization coverage in the country could see in figure 14.

**Figure 14: Immunization coverage**

8. 2.4 Polio elimination

The major battle country had won was in form of polio elimination as no polio cases were reported from any part of the country since January 2011 onwards therefore country was expected to be declared polio free. It would appear from table 14; the number of polio cases had gradually declined in the country and so much so that in the year 2010-11, only 55 cases were reported. The most of cases of polio had been reported from U.P and Bihar. However no polio cases was reported from any part of the country during the period 2011-12 and country was on the verge of declaring polio free which could be a most welcome relief for the functionaries towards end of the current tenure of NRHM. However good work would be required being continued as it was reported that though polio was eliminated from several countries yet in almost 26 countries it reemerged in the year 2010. The decline in polio cases could be demonstrated as figure 15. It would appear from figure 15 that number of polio cases had increased during 2006-07 which came down during 2007-08 and
further increased during 2008-09. After 2008-09 there was steep decline in number of cases and ultimately that touched zero mark for the first time in knowing history.

**Figure 15: Polio cases**

![Polio cases graph](image)

8.3 Tasks remained

Despite all round gains in the country on the front of macro health indicators it was not so that every targets were achieved during 2005-12 of the NRHM and perhaps it would take much long provided good planning and implementation of health programs continued. Also it was required to sustain those achievements and make further improvements.

8.3.1 Target versus achievement

As it would easily appear from **table 22** that most of targets set at the onset of NRHM in the year 2005 were either achieved or they were on the path of being achieved very soon. Despite such achievements country was having the task to improve further on that macro health indicator as it could be also evident from **Figure 16**.

8.3.2 Inconsistencies in health indicators at national and international levels

One of the major weaknesses in the public health situation was already outlined as inconsistent health indicators at the national and international levels. Though it was required to bring those health indicators close to each other both at national level and international level yet it found not happening despite first tenure of NRHM being over in the year 2012. **Table-23** and **table 24** would indicate the certain health indicators at international level and national level
respectively. It would establish from table 23 that India was having highly depressing health indicators in comparison of developed countries and so much so that it’s relative health indicators were even low in the comparison of China and Sri Lanka. Also table 24 would demonstrate that how health indicators of Indian states were also not uniform as some states and union territories was found having health indicators equivalent to developed countries, some states were on a course to achieve them in near future and some states were still lagging far behind. Until and unless those health indicators at the national and level levels could make almost uniform the task could not deem over.

Figure 16: Targets versus achievements of National Rural Health Mission

8.3.2 Deficiencies of health facilities

There were huge deficiency in the number of required and existing health facilities in the country and though NRHM had increased the number of health facilities yet it was required to further increase the number as per norms of Indian Public Health Standards. A gap analysis was conducted by the research scholar to see that how much health facilities country would require based on the population of the country in the year 2011. The gap analysis was conducted on the bases of population norms of Indian Public Health Standards and mentioned state wise in the table-25. It would appear from the table 25 that country was still deficient of almost 100914, 17399, 5728, and 1476 health sub centers, primary health centers, community health centers and first referral units respectively.
8.3.3 Deficiencies of workforce

The deficiency in the number of public health work force was also identified by the research scholar in terms of norms prescribed by the Indian Public Health Standards. The summary of findings was summarized in table 26. Thus it could say on the basis of table 26 that there was huge gap persisted in number and kind of work force required by the country for making its public health coverage adequate. Filling this gap was most required in the country as infrastructure and logistics without work force would be a precious waste.

8.4 Ranking of Indian States and Union territories

The ranking of all the 35 states and union territories of India for their respective performances against different parameters such as Infant Mortality rate, Crude death rate, Crude birth rate, Per capita Institutional deliveries, and Per capita funds utilization was dome. For this sake you may please see in table 28. Further points were allocated in tune of 1 point for best and gradually more points in ascending order to low performers. This could be seen in table 29. Further points scored by the states were summed and averaged by 35 to give final points. The state having lowest final points were declared highest overall performing states against the already mentioned parameters combined.

It would appear from table 28 that states like MP, Bihar, Lakshadweep, Pondicherry, and Lakshadweep were best performers in terms of Infant Mortality rate, Crude death rate, Crude birth rate, Per capita Institutional deliveries, and Per capita funds utilization.

Finally it could found as per table 30 that Madhya Pradesh had emerged best overall performing state in the country under National Rural Health Mission 2005-12. Rajasthan, D & Diu, U.P, Bihar, and Haryana had followed Madhya Pradesh respectively in this ranking. This was definitely indicative that high focus states had performed better.

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