Chapter 1

INTRODUCTION OF NATIONAL RURAL HEALTH MISSION

The research scholar first of all would like to introduce the National Rural Health Mission, its goals and strategies. In addition, a brief mention about prevailing situation prior to launch of National Rural Health Mission would be also presented.

1.1 Introduction of National Rural Health Mission

_National Rural Health Mission or NRHM_ as it could be established on the basis of its mission documents was a Government of India intervention to correct the public health sector of the country. It was launched in April 2005 and had continued until March 2012. In fact Government of India had adopted a time bound and mission oriented approach to correct the public health situation in the country (MOHFW 2005). However it was all the probability that it would further continue during the 12th plan period starting from April 1, 2012.

It was found that _National Rural Health Mission_ was a combination of several programs including population stabilization, disease control, nutrition, water & sanitation, improvement of workforce, infrastructure, and logistics. Therefore it could say that _National Rural Health Mission_ was like a sunshade or a podium under which several health and development programs were implemented however the main focus was towards providing financial and know how assistance to states to eliminate the gaps existing in terms of work force, infrastructure, and logistics. In addition it further took in hand health determinants especially nutrition to an extent. For all such diversified approaches _National Rural Health Mission_ had to establish wide spread sectoral and intersectoral convergences, public private partnerships, forging alliances with developmental partners and outsourcing of some key supportive and medical services. It could be further evident from the _NRHM framework of implementation_ (MOHFW 2005) that _National Rural Health Mission_ had recognized the need to make optimal use of the non-governmental sector to strengthen public health systems to increase access to medical care for the poor. _National Rural Health Mission_ attempted a major shift in the governance of public health by giving leadership to _Punchayati Raj Institutions_ and other local bodies in matters related to health at district and sub-district levels.
Although the programs of the National Rural Health Mission was implemented in all the 35 states and union territories of the country however NRHM mission documents had stated that eight Empowered Action Group (EAG) states like Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Orissa, Uttar Pradesh and Uttarakhand, 8 North Eastern states and the hilly states of Himachal Pradesh and Jammu & Kashmir were highly focused.

According to the NRHM Mission document the center objective of National Rural Health Mission was to create fully functional health facilities within the public health system. It was therefore expected to provide a certain service guarantee at each level of the health care delivery system starting from a Health Sub Centre to a District Hospital.

Under NRHM all existing societies relevant to Reproductive and Child Health, National Program for TB, Malaria, Blindness, and Integrated Disease Surveillance were integrated into a unified health mission or society. Therefore National Rural Health Mission was evidently an ambitious program expected to consolidate all existing disease control programs under a common umbrella while simultaneously improving the infrastructure and capacity of the health care system in the country.

As per NRHM mission documents and Framework of implementation the outcome from National Rural Health Mission was expected in form of reduction of Infant Mortality Rate (IMR) from a level of 62 to 30. Further it was targeted that the Maternal Mortality Rate (MMR) would be cut to 100 from a level of 330 in the year 2004-05. On the similar pattern the total fertility rate (TFR), malarial mortality rate, Kala Azar mortality rate were expected to down to 2.1, 70 percent, 100 percent respectively in the year 2012. Likewise, it was expected to bring down filarial /microfilaria rate, dengue mortality rate and leprosy prevalence rate to 100 percent, 50 percent, and below 1 percent respectively in the year 2012. Further National Rural Health Mission aimed at maintaining the tuberculosis cure rate at 85 percent through the entire mission period.

Up gradation of all community health centers to the tune of Indian Public Health Standards, increase in the bed occupancy rate of first referral units from less than 20 percent of referring cases to over 75 percent and cataract operations to 46 lacks until 2012 were also targeted. National Rural Health Mission further aimed to engage 400,000 female Accredited Social Health Activists and double the number of Auxiliary Nurse Midwife in Health Sub Centres (MOHFW 2005).

Absolutely it could say that National Rural Health Mission was expected to improve the overall access of rural people to a reasonable and inexpensive, primary healthcare.
1.2 Situations prevailing preceding to National Rural Health Mission

Prior to the launch of NRHM the public health sector of India was required putting in a perspective and situation had appeared exceedingly substandard which could no way suitable. The Indian public health sector was found inundated due to a merge of long ignore, lacked outlay, infrastructure, logistics, workforce, and skill. The management of public health sector was also not professional and suffered from deficiencies, which often reflected in terms of total collapse of the delivery mechanisms. In fact, the public health delivery system had already collapsed or never started in some states and there was little scope of revival.

The socio-economic progress of the country was also never uniform, as some states had developed tremendously whereas some states had lagged far behind. In the year 2001 the then National Democratic Alliance or NDA government led by the Honorable Prime Minister Sri Atal Bihari Bajpayee in order to bring backward states at par with developed states had constituted Empowered Action Group (EAG) to specifically recognize and address the problems of those backward states (MOHFW 2003).

The state of public health facilities was not adequate as it was rightly described by the District level household survey and facility survey coordinated by Indian Institute of Population Sciences in the year 2003 (DLHS 2003). The reports had stated that only 76 percent of first referral units and 63 percent of Community health centres had adequate infrastructure, 61 percent of the first referral units and 46 percent of Community health centres had adequate equipments, 32 percent of first referral units and 24 percent Community health centres had adequate supply, and 37 percent of first referral units and 14 percent of Community health centres had adequate staff. During the three months preceding the survey only 58 percent of the Primary health centres conducted deliveries, 6 percent conducted medical termination of pregnancy, 22 percent provided Neo natal care and 65 percent did Intra uterus device insertion and 41 percent conducted sterilizations. If the percentage of Primary health centres having adequate staff was more than 90 percent in Tamil Nadu, Maharashtra, and Kerala, it was less than 20 percent in Orissa, West Bengal, and Bihar.

Anaemia among children and women as per National Family Health Survey-III (MOHFW 2006) was measured and 79.1 percent children between age group 6-35 month were found anaemic. 56.1 percent every married women aged 15-49 were found anaemic. According to National Family Health Survey 2005-06 only 43.5 percent children were fully immunized. Similarly Institutional births, 3 Ante natal care visits, post natal care were said to be 40.7
percent institutional births, 50.7 percent 3 Ante natal care visits, 36.4 percent post natal care visits.

Child morbidity according to FOCUS survey 2004 in Tamil Nadu, HP, Maharashtra, Rajasthan, Chhattisgarh, and Uttar Pradesh were 32 percent children had fever, 21 percent had diarrhoea, 17 percent had persistent cough, 11 percent had extreme weakness, 5 percent had skin rashes, and 2 percent had eye infections during the two weeks preceding the survey. Fifty percent children had one of the above problems.

The Infant Mortality Rate according to Sample Registration System, Registrar General of India Office for the year 2004 was 62 for the country with a low of 12 for Kerala and a high of 79 for Madhya Pradesh. Similarly the Maternal Mortality Rate according to sample registration system bulletin 2006 was 332 for the country with a low of 110 for Kerala and a high of 517 for UP and Uttarakhand in the 2001-03 period (SRS 2006).

The non hospitalized treatment from government sources according to the National Sample Survey 60th Round during the year 2004 was 22 percent for the Country, from a low of 5 percent in Bihar to a high of 68 percent in Himachal Pradesh. The Inpatient treated in public hospitals was 41.7 percent for the country, from a low of 14.4 percent in Bihar to a high of 91.3 percent in Jammu and Kashmir. The Average medical expenditure per hospitalization was Rs. 3238 in government hospitals compared to Rs. 7408 in private hospitals in rural areas.

The poor performance of the Indian public health system was not just easily perceivable but widely acknowledged through different agencies; World health organization or WHO statistics for the year 2005 could be another indicative (WHO 2005).

After independence in the year 1947, India had prioritized its public health needs and framed policies and programs. Despite the progress on public health was not adequate. The rapid industrialization of the country had resulted in corporatization of the health sector and five star hospitals and nursing homes came up in numbers. While the private health sector could say being at par or even better in comparison to any developed country yet the public health sector never took off in this country (Tyagi 2011).

Due to aforesaid deliberations as the country was having a history of bad health indicator and therefore concern for the public health were getting more often reflected in form of judicial activisms, committee recommendations, international commitments and agreements.
Several population and health policies of India had recommended a very strong role of government as public health provider. India was also a welfare state and for this sake union government was serious over all those concern. The population control program in the country had already died in the 1970s. The experience with RCH-I in the 1990s was also not chorus and need of a comprehensive package to energize and put confidence into conception of people was highly felt (Kaushik 2011). A stimulus was definitely needed to fortify the rural health sector and all those situations collectively created ground for unleash of the National Rural Health Mission.

Therefore after investigating the challenges for long the then United Progressive Alliance or UPA government led by honorable Prime Minister Dr. Man Mohan Singh in April 2005 had come up with a comprehensive mission-oriented approach to overhaul the rural health care delivery system, which was appropriately named National Rural Health Mission or NRHM.

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