Editorial

# National Rural Health Mission: Turning into Reality

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On 12 April 2005, the Government of India took a major welfare initiative by launching National Rural Health Mission (NRHM) in 18 states with weak public health indicators and infrastructure and extended it across the entire country. What constituted the conceptual build-up to this mission was a spectrum of systemic deficiencies in the health system. These included lack of holistic approach, absence of linkages with collateral health determinants, gross shortage of infrastructure and human resources, lack of community ownership and accountability, non-integration of vertical disease control programs, non-responsiveness and lack of financial resources.

The NRHM employed five main approaches while addressing these issues – communitization, flexible financing, improved management through capacity building, monitoring progress against standards, and innovations in human resource management, which became the mainstay. What helped immensely in communitizing the health care was the ongoing process of decentralization with concomitant convergence. Development of village health plan through Village Health and Sanitation Committee (VHSC) and its integration into the district plan, which in turn has been made the main instrument for planning, inter-sectoral convergence, implementation and monitoring, was instituted as the fulcrum of decentralization (till date more than 451,000 VHSCs are functional).[1] Convergence of all programs is being ensured at village and facility level. Effective integration of health concerns with other health determinants like sanitation and hygiene, nutrition and safe drinking water through district health plan is being made. *Panchayat Raj* Institutions (PRIs), self-help groups, and health, nutrition and sanitation committees have been activated to seek local accountability in the delivery of programs.

On the other hand, untied funds are making things somewhat easier for the peripheral health facilities, while overcoming small day-to-day problems. Each sub-center is provided with Rs. 10,000 to facilitate urgent activities needing relatively small sums of money. Funds are kept in the joint bank account of ANM and *Village Pradhan* and are used only for common good, e.g. purchase of consumables such as bandages in sub-center or purchase of bleaching powder and disinfectants for use in common areas of the village. Barring the case of referral and transport in emergency situations, the untied fund is not utilized for individual clients. Sub-centers are encouraged to use the untied funds for minor modifications and repairs of sub-center; *ad-hoc* payments for cleaning up sub-center; transport of samples during epidemics; labor and supplies for environmental sanitation, such as clearing or larvicidal measures for stagnant water. This can also be used to reward volunteers for certain identified activities, but not to meet the expenses of the *Gram Panchayat*. An annual maintenance grant is also available to Primary and Community Health Centres (PHCs and CHCs). There are certain special financial provisions too which may be underscored as NRHM innovation for upgrading CHCs, district hospitals, etc. to Indian Public Health Standards; corpus grant for *Rogi Kalyan Samitis (RKS)*; and grant for Mobile Medical Unit (MMU) per district (there are currently 29,223 RKS operational and 1031 MMUs in different states).[1] Needless to say, NRHM has succeeded in making resources available at the level of facilities, which were earlier starved of the needed resources.

In the process of communitization, the role of Non-governmental Organizations (NGOs) is critical for the success of NRHM. Their partnership is being utilized under the disease control programs, reproductive and child health, routine immunization and special immunization activities (SIAs). To this effect, a highly imaginative *Janani Suraksha Yojana* (JSY) is already making use of partnerships of various NGOs. Efforts are being made to involve NGOs at all levels of the health delivery system and more infrastructures in training of Accredited Social Health Activists (ASHAs) (300 mother NGOs are involved in ASHA training).[1] This involves entering into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services. Some of the other innovative actions in this domain are about developing/leasing out vacant land in the

premises of the hospital for commercial purposes, with a view to improve financial position of the health societies, encouraging community participation in the maintenance and upkeep of the hospital, promoting measures for resource conservation through adoption of wards by institutions or individuals, and adopting sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water recharging systems.

Half a decade back, when the NRHM was launched, certain concerns were placed on record and debated. It was said, and rightly so, that the success of this mission would heavily depend on PRIs for effective utilization of resources and providing micro-level leadership – while the state governments were yet to empower PRIs in most parts, with real devolution of power.[2] NRHM gains are being registered at an accelerated pace in states where the PRIs are in full command. States will have to invest in capacity building of PRIs, so that locally designed initiatives are responsive to needs of local community and equity related issues are addressed. Social audit is gradually being accepted as one of the important mechanisms to ensure that intended benefits reach target groups. There are immense political commitments to promote social audit in schemes like Mahatma Gandhi National Rual Employment Guarantee Act (MNREGA). A similar target has to be given to evolving a framework of social audit of NRHM, engaging different stakeholders additionally. Unlike all other programmes in the past, NRHM has clearly laid down the guidelines of operationalization of decentralization and implementation of the strategy which undoubtedly ensures the greater participation of the community.[3]

One of the success stories being attributed to NRHM is a huge increase in institutional deliveries. ASHAs (around 7.5 lakh in number)[1] at grassroot level have done a phenomenal job in mobilizing women from valuable community to come to institutions (the number of beneficiaries under JSY had increased from 7 lakhs in 2005–2006 to over 86 lakhs in 2008–2009).[1] It is critical to ensure that there is corresponding increase in inputs available at the facilities, so that health outcomes for mother and baby are ensured. There definitely have been gains as shown by statistics – infant mortality rate has come down to 53/1000 live births, maternal mortality rate has come down to 254/1000 live births and total fertility rate is now 2.7.[1]

What the future holds for NRHM should be seen through the lens of similar challenges ahead. Complexities in attaining inter-sectoral convergence; multidimensional strategy at district, block and village levels; cross-linkages with the issues of poverty, illiteracy, and social inertia; governance issues, including ongoing empowerment of PRIs; vibrant VHSC including safe water management; impediments in release of funds; and assured availability of incremental outlays for mission period are going to test the endurance of NRHM. The inherent riddles in public–private partnership will continue to examine the pro-people character of NRHM for a very long period. There is also a need to explore linkages with the ongoing programs like MNREGA, added with the deployment of rich repository of human resource of elderly men and women, who could be used for community mobilization. Social audit for community action is the call of the day to ensure that dreams of Mahatma Gandhi for *Swaraj* come true.

Let communitization be our path finder during such testing times.

## References


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