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India's National Rural Health Mission: A Critical Review of the Mission Implementation and Achievements

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Abstract:
People's health is the State's wealth. A majority of the population in India lives in the rural areas. Though there are many health policies in India, they could not reach the rural masses due to poor implementation. In the wake of this, the Government of India launched the National Rural Health Mission (NRHM) in April 2005 as a sub-mission of the National Health Mission.
The strategy in NRHM contains 'Programme Implementation Plans' for each state and it is more focused on special status states that are weak in public health indicators. The mission's vision is to be more community-owned and decentralized in providing health care to the larger populations.
This paper attempts to review the mission's objectives, implementation, and achievements. It also tries to examine the role of the new national health program of India 'Ayushman Bharat' through its objectives. In addition, the study evaluated the functioning of the mission in tribal areas of the country. It analyses the convergence and divergence of the new policy with the National Health Mission, but not merely a repetition of the same. Secondary analysis using the government reports, and published works on the mission was used in this study.

Keywords: Health, National Health Mission, National Rural Health Mission, Ayushman Bharat, National Health Policy.

INTRODUCTION:

A Telugu saying about health goes, *"Aarogyame Mahabaagyam"* which means that health is the greatest wealth. The people with good health create more wealth through high and quality production; thereby increasing the economic growth and social development. When we look at health, it is not only about individual health but also about the wider community health that one must look at. Community health strengthens the State's policies through better implementation as people's participation helps in achieving the goals of the policy.
"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1948). Physical well-being causes high production capacity, mental well-being can cause more productive innovations, and finally, social well-being causes better social indicators and a better life for sustainable growth and development.

OBJECTIVE OF THE STUDY:

The study focused on the objectives of the National Rural Health Mission (NRHM) and how it is working on the ground by reviewing its implementation process and strategic approach. It reviews the objectives of the Indian new health program "Aayushman Bharat" which can be used to fill the lacunas of the NRHM. The study also aimed to look at how the NRHM has impacted the tribal population in India.

MATERIAL AND METHODS OF THE STUDY:

The study reviewed the reports of the government, in the process of evaluation of the mission. The study reviewed secondary data, such as reports by the Sample Survey of India and published articles to understand the critical nature of the mission. The newspaper articles also have been used to evaluate the mission. The study has used the critical review method to evaluate the success of the NRHM and Ayushman Bharat.

INDIA'S HEALTH CARE POLICIES:

Indian healthcare policies date back to British colonial rule, where they developed infrastructure, framed a few policies on healthcare, and focused on some specific diseases that took more lives, like the plague, tuberculosis, malaria, etc. For the first time, a committee called Bhore committee was formed in 1946, which talked about community health care (both preventive and curative) at the three-tier level. On the foundations of Bhore Committee recommendations, India's health policies evolved. National Health Policy 1983 is the first among in this timeline. It focused mainly on achieving primary health care by the year 2000. National Health Policy 2002 aimed at decentralization of the health care system in India. However, no health policy in India achieved the goals up to their mark due to a lack of a holistic approach in framing the policies. The Government of India launched the NRHM with the aim of achieving the objectives of the National Health Policy 2002 and the United Nations Millennium Development Goals. All the Millennium Development Goals, directly or indirectly talk about the health of the individual or the State and all these are interconnected to each other.

"The National Rural Health Mission (NRHM) was launched by the Honourable Prime Minister of India on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups" (National Health Mission, 2018). It was the part of Planning Commission's tenth and eleventh five-year plans. The Mission has given the hope that it will entirely change the health care system through its holistic approach. The mission was focused more on the Empowered Action Group (EAG) states, North East states, Jammu & Kashmir, and Himachal Pradesh, which were weak in public health indices. It has several components such as Accredited Social Health Activist (ASHA), Rogi Kalyana Samiti, Village Health Sanitation and Nutrition Committee, Janani Suraksha Yojana, mainstreaming of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy) through which the mission will be taken to the rural mass and completes it thereby.

WORKING OF NATIONAL RURAL HEALTH MISSION:

Objectives: NRHM is designed in such a way that it helps in decentralizing the health care system through its strategies such as a community-based approach and empowering Accredited Social Health Activists (ASHA). It is targeted at a fully functional healthcare system by focusing on several infrastructural and innovative aspects such as National Mobile Medical Units, Facility Based New Born

Care, free diagnostic service, free drug service, etc.

> *"The mission includes various determinants such as clean and drinking water, sanitation, and nutrition which are aimed at bringing preventive actions for better health. The other determinants, education, and social and gender equality bring more social development to the State. By special focus on the states like Empowered Action Group (EAG) states, North Eastern states, Jammu and Kashmir, Himachal Pradesh, etc. bring these states at par with the other states in better health which also helps in bringing the true federal nature to the Indian State. Inter-sectoral governance as an objective of the mission needs overall cooperation among all the policies, be it economic, societal, or environmental which affects health. This is the only aspect that can bring overall meaning to the well-being of an individual or a community."* (Wismar Matthias, 2012)

The Government of India's other schemes like Pradhan Mantri Mathru Vandana Yojana (PMMVY), Integrated Child Development Service (ICDS), and maternity benefits can be studied to understand the mission's holistic objectives and it gives the picture of the inter-sectoral governance aspect. Various schemes have been institutionalized under the NRHM such as Rashtriya Bal Swasthya Karyakram (RBSK) for child health screening and better management through early intervention to decrease disease burden, Rashtriya Kishor Swasthya Karyakram (RKSK) for adolescent health management, and Mother and Child Health Wings (MCH Wings) for etc.

> *"The National Rural Health Mission (NRHM) was launched with several key goals aimed at improving public health outcomes in India. The primary objectives included the reduction of Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). The mission sought to ensure universal access to public health services, encompassing areas such as women's health, child health, water, sanitation, hygiene, immunization, and nutrition. Another critical goal was the prevention and control of both communicable and non-communicable diseases, including diseases endemic to specific regions. The NRHM aimed to provide access to integrated and comprehensive primary health care, work towards population stabilization, and promote gender and demographic balance. Additionally, the mission aimed to revitalize local health traditions and mainstream AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy) systems of medicine, along with promoting healthy lifestyles."* (Four Years of NRHM 2005-2009, 2013)

The Mission has set to reach its goals as World Health Organization determined goals, by 2012 (eleventh five-year plan ending year). But it has been extending through the years and now it is targeted to 2020. The goals are also modified according to the time-to-time review of the mission. When the NRHM subsumed into the National Health Mission (NHM) in 2013 the goals were revised and targeted to reach them by 2017. For example, "the reduction in Infant Mortality Rate has been revised to 27/1000 live births and Maternal Mortality Rate has been revised to 100/10000 live births." (National Health Mission, 2013)

Management of Funds: States have to implement the NRHM through the state's own designed Progra-

mme Implementation Plans (PIPs) and funds will be dispensed by the Ministry of Health and Family Welfare.

NHM its website explains how the management of financing of the program is done which goes as, *"Ministry of Health and Family Welfare is involved in planning, budgeting, accounting, financial reporting, internal controls including internal audit, external audit, procurement, disbursement of funds and monitoring the physical and financial performance of the program, with the main aim of managing resources efficiently and achieving pre-determined objectives."* (National Health Mission, 2018).

Review of the Mission: NRHM has subsumed into the NHM and it was regarded as a sub-mission of the NHM along with the National Urban Health Mission (NHUM). Up to 2013 i.e., before the launching of the NHUM, NRHM had been reviewed through Common Review Mission(CRM). After the introduction of the NHM, both the NRHM and NUHM are being reviewed together. The Ministry of Health and Family Welfare started reviewing the mission implementation in 2006 through its CRMs. As of now, it completed 11 CRMs. These review missions give the achievements and the areas to be strengthened of the NRHM, state-wise and goal-wise.

NRHM has been reviewed several other times in 2009 (for the years 2005-2009), and 2014 (for the years 2013-2014), by the Ministry of Health and Family Welfare. The Comptroller and Auditor General of India reviews the mission at the Central and state level to analyze the financing aspects of the mission. Planning Commission in its five-year performance reports analyzed the working of NRHM and its achievements and lacunas. Sample Registration System of the Census of India under the Ministry of Home Affairs also publishes data on birth and death rates of the country. Annual Health Survey Report also publishes by Ministry of Home Affairs on core and vital indicators of health. National Family and Health Survey data are being used several times by the various departments to analyze the performance of the mission.

Achievements: NRHM in its 13 years of journey achieved some of its desired goals partially and some goals have been far from the desired targets. It also has state-level and regional-level disparities in achieving these goals.

If we analyze the mission's goals objectively, it has achieved more when compared to the earlier policies. ASHA being the greatest achievement tool of the mission made it most successful in raising awareness about health to most of the rural masses and also helped in making the mission more decentralized. It also helped in the participation of rural masses in framing the health system according to their health settings. By subsuming the NRHM into the NHM, the State has set to achieve the goal of 'Health for All' and it is been in the process through various schemes.

As per the Sample Registration System of the Census of India (Sample Registration System, 2018), India could reduce its Maternal Mortality Rate to 130/10000 live births by 2014-16, whereas it was 254/10000 live births in 2004-06. It is almost close to the target of 109/10000 live births set in 2009 according to Millennium Development Goals. The infant mortality rate in 2005 was 58/1000 live births at the national level and the rural level, it was 64/1000 live births. The infant Mortality Rate was targeted at 28/1000 in 2009, and it achieved 34/1000 of the national average, 38/1000 at the rural level. Infant Mortality Rate also almost decreased to its targeted levels. By 2018 India reduced its Total Fertility Rate to 2.2 where the global average set by the World Health Organization is 2.1 which is very close.

EAG states are in pace with other states in reduction rate but the disparity remains high. For example, the Maternal Mortality Rate of Empowered Action Group states and Assam stood at 188/10000 live births (from 375/10000 live births in 2004-06), 58 points away from the national average, where

Southern states stood at 77/10000 live births (from 149/10000 live births in 2004-06) which is 57 points below the national average. This data gives the picture that though the special focus on the Empowered Action Group states and other states could not fetch them to reach the other non-focused states.

Janani Suraksha Yojana which is targeted for institutional deliveries has shown an enormous increase since its inception. As per the Ministry of Health and Family Welfare Annual Report of 2013-14 (National Health Mission, 2018), institutional deliveries increased to more than 1 crore where as it was around 7.3 lakhs in 2005, and by 2014 around 8.5 crore women benefited from this. According to the National Family Health Survey (NFHS), 89 percent of rural women go for deliveries under a skilled provider (NFHS-4 Report, 2015-16).

Combating communicable and non-communicable diseases is the greatest burden on the community without having good sanitation, hygiene practices, and nutritional intake. Though the NRHM contributed very much to tackling this issue, India is still struggling to achieve the desired goals due to low sanitation levels, unhygienic practices, and improper nutrition.

The determinants of the mission such as hygiene, drinking water, and sanitation have achieved the goals partially and there are targets to achieve 100 percent achievement. According to the NFHS, 89 percent of Indian rural households have access to drinking water of which 51 percent of drinking water is from bore wells. And out of 89 percent, only 71 percent clean their water. When it comes to sanitation around 69 percent of rural masses have toilet facilities.

Nutrition determines the children's health indicators and the future of non-communicable disease burdens such as diabetes, blood pressure, heart attacks, etc. According to the National Family Health Survey 2015-16, Anganwadi centers are better used in rural areas when compared to urban areas. Integrated Child Development Programme as a great innovation for better child nutrition is being used better in rural areas than in urban areas. Unfortunately, stunting is more common in rural areas than in urban areas (41% in rural areas and 31 % in urban areas). The variety of diets also is higher in urban areas when compared to rural areas.

NFHS reported in its 4th report of 2015-2016, that 76 percent of rural masses use the public health sector for contraceptive methods. It is high when compared to urban people which is at 58 per cent. (NFHS-4 Report, 2015-16)

Basic vaccinations also increased in rural levels at a higher percentage than in urban areas. In rural areas, the increase is from 39 percent to 61 percent whereas in urban areas it is 58 percent to 64 percent.

The Eleventh Common Review Mission (CRM), has observed few progresses in some components like Janani Shishu Suraksha Karyakram (JSSK), newborn services, antenatal care (ANC) services (National Health Mission, 2017). Annual Report of 2013-14 mentioned that the Government's initiatives such as Rogi Kalyan Samiti, the Village Health Sanitation and Nutrition Committee, National Ambulance Services, etc., are working well in achieving community-owned approach and functional objectives.

Working of the Mission in Tribal Areas: In India, the NRHM has greatly lowered newborn and neonatal mortality, contributing to achieving the Sustainable Development Goals and universal health coverage.

Development of infrastructure There were 26,351 Sub Centers (SCs), 3,966 Primary Health Centers (PHCs), and 975 Community Health Centers (CHCs) in tribal territories as of March 31, 2022. Despite this, 8,503 SCs, 1,464 PHCs, and 347 CHCs are still notably short of what is required to meet demand in these regions.

The Janani Suraksha Yojana (JSY) program of the NRHM has demonstrated gains in maternal health for

tribal women; however, there is still a need for immediate attention due to the shortage of medical personnel and equipment. With a focus on a comprehensive strategy, connections with ancillary health determinants, infrastructure and human resources, community ownership, accountability, and disease control integration, the Mission (NRHM) has effectively addressed systemic flaws in India's health system.

By adding more healthcare facilities and hiring medical specialists like Accredited Social Health Activists (ASHAs), the NRHM sought to increase access to healthcare in isolated tribal communities. Due to the mission, the tribal areas now have better healthcare access and improved access to vital medical services. Maternal health was a major focus, and the initiatives were added to the mission in which Janani Suraksha Yojana (JSY) with a great focus on institutional deliveries.

Building and renovating facilities was part of the NRHM's investment in healthcare infrastructure, guaranteeing better-equipped centers for emergency treatment, diagnostics, and basic services. Through the Village Health Sanitation and Nutrition Committees (VHSNCs), which strengthen local governance and decision-making in health-related areas, the NRHM also encourages community engagement.

AYUSHMAN BHARAT:

"Nearly 65% of health-care expenditure in India is "Out-of-Pocket"". (World Health Organization, 1948). "A report by the World Health Organisation has shown that around 3.2% of Indians fall below the poverty line because of high out-of-pocket health expenditures."(Narayan & Narayan, 2018). India as a developing country tackling the issue of poverty focused on Out-of-pocket expenditure by launching a huge health scheme called "Ayushman Bharat" which is said to be the National Health Protection Mission. It aims to make part around 50 Crores of India's poor and vulnerable section and this scheme facilitates secondary and tertiary health services only. Each state needs to create a State Health Agency (SHA) to implement this policy where they have to spend their part of the expenditure (National Portal of India, 2018). As of now most of the states adopted this policy and a few other states did not, due to various causes. It is implemented through Public Private Participation (PPP), where the premium will be paid by the government to insurance companies and the services will be provided by both government and private hospitals, these are empanelled hospitals.

Objective: High amounts of Out-of-Pocket Expenditure in India compelled the State to launch a prestigious and mammoth program like Ayushman Bharat. It is the initiative of the National Think Tank 'NITI Aayog' which came into effect on 23rd September 2018 under the new National Health Policy, 2017. The new concept of NITI Aayog "Co-operative Federalism" is the salient feature of the program.

Goals: Ayushman Bharat has the target of reaching its facilities to 10.74 crore families (approximately 50 crore people). It facilitates an amount of 5 lakhs per family in a year. It covers secondary and tertiary healthcare services for the poor. Universal Health Coverage is a goal of the World Health Organization and Sustainable Development Goal (SDG 3), Ayushman Bharat can achieve this goal if it is implemented in the right way.

CHALLENGES OF THE MISSION:

Poor Infrastructure*:* In some states with poor infrastructure such as government buildings for Community Health Centres (CHC), Primary Health Centres (PHC), Sub-centres (SC), and equipment in the hospitals, emergency drugs are lagging behind the other states in rendering services. According to

the C & AG report in 2017, five states Bihar, Jharkhand, Uttarakhand, Sikkim, and West Bengal are with 50% of shortfall in physical infrastructure.

Lack of data*:* When a person goes for treatment in one hospital and is not cured, he/she goes to another hospital and again he/she has to go for all the diagnoses to pretend the cause and come to clarity about the disease. This is due to a lack of coordination between the hospitals and sometimes, though the data is available, a lack of belief in the previous hospital makes the patient go for a second diagnosis.

Though the mission is decentralized in its objective, the data about health is not even available at the district level which led to relying on state-level data to assess the mission up to 2010. It necessitated the Government to start the Annual Health Survey only in Empowered Action Group States during the financial year 2010-11, and later it was updated during 2011-12 and 2012-13 which lacks data from other states. We have a lack of centralized data which should imbibe decentralized data.

The data from the Sample Registration Survey, Annual Health Survey Report, and other review committees may give factual figures but most of the time they fail to give actual figures. For example, every Common Review Mission (CMR), by the Ministry of Health and Family Welfare, misses one or other state in its review.

State-level disparities: Health as a state subject has to have its policy for the betterment of its health care system. NRHM which gives a way for states to approach in their setting has been not used by some states properly. Though Several states have given special focus, they could not reach the desired goals of the mission which could be attributed to a lack of community involvement, poor implementation practices, and quality workforce. Some states are striving with better state-owned policies to combat the challenges while some are not even putting their efforts into the implementation process.

Sample Registration System in its Special Report on Maternal Mortality reported that Kerala has stood at first place with MMR 46/10000 live births, where Assam stood at last with MMR 237/10000 live births (Sample Registration System, 2018). This severely alters the average of India's Maternal Mortality Rate.

Less and Irrational use of the workforce: In India, the doctor-patient ratio is not at the standards of the World Health Organization. Even there are no sufficient auxiliary nurse mid-wife facilities under the scheme. Then lessening the capacity and capability of doctors makes the health system poor. In India, it is most unfortunate that doctors are being used as administrative workers, who cease to do the treatment for patients and research on public health, which should be their main duty. ASHA as a better tool for achieving social well beingness has not been used up to its efficiency to achieve the desired goals. It is merely working for an increase of awareness among people which also can educate the people, with better training and capacity building.

Inefficient Usage of Funds: As per the Comptroller and Auditor General of India Report on the performance of the NRHM, most of the states are not utilizing their funds up to the level and the funds remain unspent. In its report C &AG has observed that the unspent amounts with 27 states rose from Rs. 7,375 crores in 2011-12 to Rs. 9,509 crores in 2015-16 (Comptroller and Auditor General of Indian, 2017)

Rural-Urban Variations in Indicators: Teenage pregnancy in rural areas is high which can be attributed to early child marriages. Anaemia has prevailed in rural areas at high levels though overall at the national level, it has observed a decline. Diet practices are more diverse in urban areas when compared to rural areas. Obesity is more observable in urban mass whereas stunting prevails more in rural mass. Gender variations have also been observed in nutrition, women are less nutritious compared

to men. “Medically treated TB prevalence is somewhat higher in rural areas (332 persons per 100,000) than in urban areas (251 persons per 100,000).” (NFHS-4 Report, 2015-16) Both sex and age differentials are more pronounced in rural areas than they are in urban areas. All these variations made rural masses vulnerable to both communicable diseases and non-communicable diseases because of low sanitation levels, hygiene, and poor nutrition which are led by less awareness among rural masses.

The NRHM in India's rural areas has shown varied outcomes, highlighting the need for future implementation of community-based accountability strategies.

Awareness levels among healthcare workers and the general population in tribal areas are crucial for the successful implementation of the scheme. A study among healthcare workers in a tertiary care hospital in Eastern India found that the mean awareness score was 5.52 out of a possible higher score, indicating moderate awareness. The readiness to implement the scheme improved with increased awareness.

WAY FORWARD:

India is perhaps not the only developing country but it is one among many, that designed its health policies targeting the physical and mental well-being for many years of its independence and it ignored the social well-being of individuals or communities till the NRHM’s implementation. All those policies introduced by the Government of India were focused more on health care infrastructure such as buildings and capacity building of health care providers etc. But NRHM focused on every aspect of health, be it physical health, mental health, and also social health. Though social well-being is an objective of the mission, in implementation it has not given good results in achieving the goal of social well-being.

Innovations in any sector make the infrastructure simple and efficient, thereby making the implementation simple too. However due to a lack of innovation, the implementation of policies of the Indian healthcare system has been affected too; therefore, India is lagging in its healthcare system when compared to other countries. Innovations have to come from better research and development where India should keep its eye focused on this and these innovations are the need of the hour at the primary level of healthcare services.

Awareness and education at the community level in the process of decentralization of any system should be one of the components of any program or policy. NRHM included such a better awareness component like ASHA to achieve the problem of sanitation, and hygiene. However, the mission’s strategy has missed the component of educating the people which causes the poor results of the mission.

Though AYUSH has been streamlined, it has been given a separate ministry for its implementation and put as a separate mission (National AYUSH Mission (NAM)) to reach the common mass. But it has seen disengaged in several states and is struggling for its survival and accessibility to all.

Environment plays a bigger role in determining the health of a community. Successive governments and their health policies focused less on environmental issues. This lessens the objective of inter-sectoral governance when it comes to health policies, where our focus should be on this aspect too.

Patient health information at all levels (primary, secondary, and tertiary) has to be integrated which will help in saving diagnostic expenditure and time. This information is also helpful in predictive health care systems for lowering the disease burden both on common people and the Government.

Not only communicable and non-communicable mortality but also accident-related mortality such as electric shock, snake bite, and road accidents have to be focused on in rural areas. Though accidental injuries cause one-fourth of deaths among the 15-30 age group, it has been focused on less. Recently,

increasing snake bite-related mortality has shifted the focus of the World Health Organization to put it as its goal to reduce snake bite deaths. At least quality first aid has to be provided at Primary Health Centres and Community Health Centres to reduce accidental mortality.

The new National Health Policy of 2017 has the potential to fulfill the gap of affordability to access the health services at secondary and tertiary levels. The launch of Ayushman Bharat is a welcome step by the Government, a huge program that can solve the issues in secondary and tertiary health care systems, but the majority of the rural expenditure is on primary health care where the focus should be more and has to be strengthened.

The Ayushman Bharat Program, when fully implemented and supplemented with additional interventions, can potentially reform India's healthcare system and accelerate its journey towards universal health coverage.

CONCLUSION:

Indian rural health care system in the light of, a lack of holistic approach to Government policies, lack of inter-sectoral governance to formulation and administration of policies, poor implementation of the Government policies, ill-maintained infrastructure, people's participation, and lack of interest in medical persons to work in rural areas, struggled for the decades and led to a huge mission, NRHM which helped in partially reaching the Millennium Development Goals by United Nations and better health of rural mass. NRHM as subsumed into the NHM, the approach became larger to include the urban poor. This step by the Government of India will help in achieving the goals of Sustainable Development goals holistically. To reach the global standards of health, the objectives of the NRHM should be more functional, better utilization of ASHA, and proper implementation of all other components of the mission make Indian rural masses healthier; thus, helping in the sustainable development of the country. Further, the goal of Universal Health Coverage can be achieved through a recent scheme, "Ayushman Bharat", which emerged in the process of reforming the healthcare process. It can decrease the burden of Out-of-Pocket Expenditure and thus increase the growth and development of India if implemented in good faith. Though there are a few lacunas in the implementation the NRHM and Ayushman Bharat are two mammoth programs that entirely shifted the Indian health history at the respective times. The NRHM significantly improved healthcare access and outcomes for India's tribal populations. However, challenges remain, including further infrastructure development, cultural sensitivity in healthcare delivery, and ensuring consistent and high-quality care across all tribal areas. Continued focus and adaptation of healthcare strategies are necessary to address these challenges effectively. Though the two missions NRHM and National Health Protection Mission (Ayushman Bharat) are different in their objectives and strategies, the need of working both together is necessary to achieve the affordability objective of the NRHM at any level of health care system (primary, secondary, tertiary).

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