

National Rural Health Mission

(2005-2012)

Mission Document

PREAMBLE

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

1. STATE OF PUBLIC HEALTH

- Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's Budgetary allocation is 5.5%.
- Union Government contribution to public health expenditure is 15% while States contribution about 85%
- Vertical Health and Family Welfare Programmes have limited synergisation at operational levels.
- Lack of community ownership of public health programmes impacts levels of efficiency, accountability and effectiveness.
- Lack of integration of sanitation, hygiene, nutrition and drinking water issues.
- There are striking regional inequalities.
- Population Stabilization is still a challenge, especially in States with weak demographic indicators.
- Curative services favour the non-poor: for every Re.1 spent on the poorest 20% population, Rs.3 is spent on the richest quintile.
- Only 10% Indians have some form of health insurance, mostly inadequate
- Hospitalized Indians spend on an average 58% of their total annual expenditure
- Over 40% of hospitalized Indians borrow heavily or sell assets to cover expenses
- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses

2. NATIONAL RURAL HEALTH MISSION – THE VISION

- The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

- It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.
- It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.
- It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.
- It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.
- It seeks decentralization of programmes for district management of health.
- It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.
- It shall define time-bound goals and report publicly on their progress.
- It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

3. GOALS

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

4. STRATEGIES

(a) Core Strategies:

- **Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.**
- **Promote access to improved healthcare at household level through the female health activist (ASHA).**
- **Health Plan for each village through Village Health Committee of the Panchayat.**
- **Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).**
- **Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).**
- **Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.**
- **Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.**
- **Technical Support to National, State and District Health Missions, for Public Health Management.**
- **Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.**
- **Formulation of transparent policies for deployment and career development of Human Resources for health.**
- **Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.**
- **Promoting non-profit sector particularly in under served areas.**

(b) Supplementary Strategies:

- **Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.**
- **Promotion of Public Private Partnerships for achieving public health goals.**
- **Mainstreaming AYUSH – revitalizing local health traditions.**
- **Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.**

- **Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.**

5. PLAN OF ACTION

COMPONENT (A): ACCREDITED SOCIAL HEALTH ACTIVISTS

- **Every village/large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.**
- **ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.**
- **She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.**
- **She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.**
- **She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.**
- **She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.**
- **She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.**
- **Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year.**
- **Prototype training material to be developed at National level subject to State level modifications.**
- **Cascade model of training proposed through Training of Trainers including contract plus distance learning model**

- Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

COMPONENT (B): STRENGTHENING SUB-CENTRES

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.
- In case of additional Outlays, Multipurpose Workers (Male)/Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered.

COMPONENT (C): STRENGTHENING PRIMARY HEALTH CENTRES

Mission aims at Strengthening PHC for quality preventive, promotive, curative, supervisory and Outreach services, through:

- Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunization) to PHCs
- Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.
- Observance of Standard treatment guidelines & protocols.
- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need.

COMPONENT (D): STRENGTHENING CHCs FOR FIRST REFERRAL CARE

A key strategy of the Mission is:

- Operationalizing 3222 existing Community Health Centres (30-50 beds) as 24 Hour First Referral Units, including posting of anaesthetists.
- Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc. for CHCs.
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.

- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.
- In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

COMPONENT (E): DISTRICT HEALTH PLAN

- District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.
- Health Plans would form the core unit of action proposed in areas like water supply, sanitation, hygiene and nutrition. Implementing Departments would integrate into District Health Mission for monitoring.
- District becomes core unit of planning, budgeting and implementation.
- Centrally Sponsored Schemes could be rationalized/modified accordingly in consultation with States.
- Concept of "funneling" funds to district for effective integration of programmes
- All vertical Health and Family Welfare Programmes at District and state level merge into one common "District Health Mission" at the District level and the "State Health Mission" at the state level
- Provision of Project Management Unit for all districts, through contractual engagement of MBA, Inter Charter/Inter Cost and Data Entry Operator, for improved programme management

COMPONENT (F): CONVERGING SANITATION AND HYGIENE UNDER NRHM

- Total Sanitation Campaign (TSC) is presently implemented in 350 districts, and is proposed to cover all districts in 10th Plan.
- Components of TSC include IEC activities, rural sanitary marts, individual household toilets, women sanitary complex, and School Sanitation Programme.
- Similar to the DHM, the TSC is also implemented through Panchayati Raj Institutions (PRIs).
- The District Health Mission would therefore guide activities of sanitation at district level, and promote joint IEC for public health, sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Programme. ASHA would be incentivized for promoting household toilets by the Mission.

COMPONENT (G): STRENGTHENING DISEASE CONTROL PROGRAMMES

- **National Disease Control Programmes for Malaria, TB, Kala Azar, Filariasis, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme shall be integrated under the Mission, for improved programme delivery.**
- **New Initiatives would be launched for control of Non Communicable Diseases.**
- **Disease surveillance system at village level would be strengthened.**
- **Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.**
- **Provision of a mobile medical unit at District level for improved Outreach services.**

COMPONENT (H): PUBLIC-PRIVATE PARTNERSHIP FOR PUBLIC HEALTH GOALS, INCLUDING REGULATION OF PRIVATE SECTOR

- **Since almost 75% of health services are being currently provided by the private sector, there is a need to refine regulation**
- **Regulation to be transparent and accountable**
- **Reform of regulatory bodies/creation where necessary**
- **District Institutional Mechanism for Mission must have representation of private sector**
- **Need to develop guidelines for Public-Private Partnership (PPP) in health sector. Identifying areas of partnership, which are need based, thematic and geographic.**
- **Public sector to play the lead role in defining the framework and sustaining the partnership**
- **Management plan for PPP initiatives: at District/State and National levels**

COMPONENT (I): NEW HEALTH FINANCING MECHANISMS

A Task Group to examine new health financing mechanisms, including Risk Pooling for Hospital Care as follows:

- **Progressively the District Health Missions to move towards paying hospitals for services by way of reimbursement, on the principle of “money follows the patient.”**
- **Standardization of services – outpatient, in-patient, laboratory, surgical interventions- and costs will be done periodically by a committee of experts in each state.**
- **A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.**

- All existing CHCs to have wage component paid on monthly basis. Other recurrent costs may be reimbursed for services rendered from District Health Fund. Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.
- A district health accounting system, and an ombudsman to be created to monitor the District Health Fund Management, and take corrective action.
- Adequate technical managerial and accounting support to be provided to DHM in managing risk-pooling and health security.
- Where credible Community Based Health Insurance Schemes (CBHI) exist/are launched, they will be encouraged as part of the Mission.
- The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.
- The IRDA will be approached to promote such CBHIs, which will be periodically evaluated for effective delivery.

COMPONENT (J): REORIENTING HEALTH/MEDICAL EDUCATION TO SUPPORT RURAL HEALTH ISSUES

- While district and tertiary hospitals are necessarily located in urban centres, they form an integral part of the referral care chain serving the needs of the rural people.
- Medical and para-medical education facilities need to be created in states, based on need assessment.
- Suggestion for Commission for Excellence in Health Care (Medical Grants Commission), National Institution for Public Health Management etc.
- Task Group to improve guidelines/details.

6. INSTITUTIONAL MECHANISMS

- Village Health & Sanitation Samiti (at village level consisting of Panchayat Representative/s, ANM/MPW, Anganwadi worker, teacher, ASHA, community health volunteers)
- Rogi Kalyan Samiti (or equivalent) for community management of public hospitals
- District Health Mission, under the leadership of Zila Parishad with District Health Head as Convener and all relevant departments, NGOs, private professionals etc represented on it
- State Health Mission, Chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convener- representation of related departments, NGOs, private professionals etc

- **Integration of Departments of Health and Family Welfare, at National and State level**
- **National Mission Steering Group chaired by Union Minister for Health & Family Welfare with Deputy Chairman Planning Commission, Ministers of Panchayat Raj, Rural Development and Human Resource Development and public health professionals as members, to provide policy support and guidance to the Mission**
- **Empowered Programme Committee chaired by Secretary HFW, to be the Executive Body of the Mission**
- **Standing Mentoring Group shall guide and oversee the implementation of ASHA initiative**
- **Task Groups for Selected Tasks (time-bound)**

7. TECHNICAL SUPPORT

- **To be effective the Mission needs a strong component of Technical Support**
- **This would include reorientation into public health management**
- **Reposition existing health resource institutions, like Population Research Centre (PRC), Regional Resource Centre (RRC), State Institute of Health & Family Welfare (SIHFW)**
- **Involve NGOs as resource organisations**
- **Improved Health Information System**
- **Support required at all levels: National, State, District and sub-district.**
- **Mission would require two distinct support mechanisms – Program Management Support Centre and Health Trust of India.**

(A) PROGRAM MANAGEMENT SUPPORT CENTRE

- **For Strengthening Management Systems-basic program management, financial systems, infrastructure maintenance, procurement & logistics systems, Monitoring & Information System (MIS), non-lapsable health pool etc.**
- **For Developing Manpower Systems – recruitment (induction of MBAs/CAs /MCAs), training & curriculum development (revitalization of existing institutions & partnerships with NGO & private sector. Sector institutions), motivation & performance appraisal etc.**
- **For Improved Governance – decentralization & empowerment of communities, induction of IT based systems like e-banking, social audit and right to information.**

(B) HEALTH TRUST OF INDIA

- **Proposed as a knowledge institution, to be the repository of innovation – research & documentation, health information system, planning, monitoring & evaluation etc.**
- **For establishing Public Accountability Systems – external evaluations, community based feedback mechanisms, participation of PRIs /NGOs etc.**
- **For developing a Framework for pro-poor Innovations**
- **For reviewing Health Legislations.**
- **A base for encouraging experimentation and action research.**
- **For inter & intra Sector Networking with National and International Organizations.**
- **Think Tank for developing a long-term vision of the Sector & for building planning capacities of PRIs, Districts etc.**

8. ROLE OF STATE GOVERNMENTS UNDER NRHM

- **The Mission covers the entire country. The 18 high focus States are Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir. GoI would provide funding for key components in these 18 high focus States. Other States would fund interventions like ASHA, Programme Management Unit (PMU), and upgradation of SC/PHC/CHC through Integrated Financial Envelope.**
- **NRHM provides broad conceptual framework. States would project operational modalities in their State Action Plans, to be decided in consultation with the Mission Steering Group.**
- **NRHM would prioritize funding for addressing inter-state and intra-district disparities in terms of health infrastructure and indicators.**
- **States would sign Memorandum of Understanding with Government of India, indicating their commitment to increase contribution to Public Health Budget (preferably by 10% each year), increased devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act, and performance benchmarks for release of funds.**

9. FOCUS ON THE NORTH EASTERN STATES

- All 8 North East States, including Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura, are among the States selected under the Mission, for special focus.
- Empowerment to the Mission would mean greater flexibilities for the 10% committed Outlay of the Ministry of Health & Family Welfare, for North East States.
- States shall be supported for creation/upgradation of health infrastructure, increased mobility, contractual engagement, and technical support under the Mission.
- Regional Resource Centre is being supported under NRHM for the North Eastern States.
- Funding would be available to address local health issues in a comprehensive manner, through State specific schemes and initiatives.

10. ROLE OF PANCHAYATI RAJ INSTITUTIONS

The Mission envisages the following roles for PRIs:

- States to indicate in their MoUs the commitment for devolution of funds, functionaries and programmes for health, to PRIs.
- The District Health Mission to be led by the Zila Parishad. The DHM will control, guide and manage all public health institutions in the district, Sub-centres, PHCs and CHCs.
- ASHAs would be selected by and be accountable to the Village Panchayat.
- The Village Health Committee of the Panchayat would prepare the Village Health Plan, and promote intersectoral integration
- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.
- PRI involvement in Rogi Kalyan Samitis for good hospital management.
- Provision of training to members of PRIs.

- Making available health related databases to all stakeholders, including Panchayats at all levels.

11. ROLE OF NGOs IN THE MISSION

- Included in institutional arrangement at National, State and District levels, including Standing Mentoring Group for ASHA
- Member of Task Groups
- Provision of Training, BCC and Technical Support for ASHAs/DHM
- Health Resource Organizations
- Service delivery for identified population groups on select themes
- For monitoring, evaluation and social audit

12. MAINSTREAMING AYUSH

- The Mission seeks to revitalize local health traditions and mainstream AYUSH infrastructure, including manpower, and drugs, to strengthen the public health system at all levels.
- AYUSH medications shall be included in the Drug Kit provided at village levels to ASHA.
- The additional supply of generic drugs for common ailments at Sub-centre/PHC/CHC levels under the Mission shall also include AYUSH formulations.
- At the CHC level, two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health System (IPHS) model.
- Single doctor PHCs shall be upgraded to two doctor PHCs by mainstreaming AYUSH practitioner at that level.

13. FUNDING ARRANGEMENTS

- The Mission is conceived as an umbrella programme subsuming the existing programmes of health and family welfare, including the RCH-II, National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme.
- The Budget Head For NRHM shall be created in B.E. 2006-07 at National and State levels. Initially, the vertical health and family welfare programmes shall retain their Sub-Budget Head under the NRHM.

- The Outlay of the NRHM for 2005-06 is in the range of Rs.6700 crores.
- The Mission envisages an additionality of 30% over existing Annual Budgetary Outlays, every year, to fulfill the mandate of the National Common Minimum Programme to raise the Outlays for Public Health from 0.9% of GDP to 2-3% of GDP
- The Outlay for NRHM shall accordingly be determined in the Annual Budgetary exercise.
- The States are expected to raise their contributions to Public Health Budget by minimum 10% p.a. to support the Mission activities.
- Funds shall be released to States through SCOVA, largely in the form of Financial Envelopes, with weightage to 18 high focus States.

14. TIMELINES (FOR MAJOR COMPONENTS)

Merger of Multiple Societies Constitution of District/State Mission	June 2005
Provision of additional generic drugs at SC/PHC/CHC level	December 2005
Operational Programme Management Units	2005-2006
Preparation of Village Health Plans	2006
ASHA at village level (with Drug Kit)	2005-2008
Upgrading of Rural Hospitals	2005-2007
Operationalizing District Planning	2005-2007
Mobile Medical Unit at district level	2005-08

15. OUTCOMES

(a) National Level:

- **Infant Mortality Rate reduced to 30/1000 live births**
- **Maternal Mortality Ratio reduced to 100/100,000**
- **Total Fertility Rate reduced to 2.1**
- **Malaria mortality reduction rate –50% upto 2010, additional 10% by 2012**
- **Kala Azar mortality reduction rate: 100% by 2010 and sustaining elimination until 2012**
- **Filaria/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015**
- **Dengue mortality reduction rate: 50% by 2010 and sustaining at that level until 2012**
- **Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012**
- **Cataract Operation: increasing to 46 lakhs per year until 2012.**
- **Leprosy prevalence rate: reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter**
- **Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.**
- **Upgrading Community Health Centers to Indian Public Health Standards**
- **Increase utilization of First Referral Units from less than 20% to 75%**
- **Engaging 250,000 female Accredited Social Health Activists (ASHAs) in 10 States.**

(b) Community Level:

- **Availability of trained community level worker at village level, with a drug kit for generic ailments**
- **Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition.**
- **Availability of generic drugs for common ailments at Sub-centre and hospital level**
- **Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level**
- **Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme**

- Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families
- Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission
- Provision of household toilets
- Improved Outreach services through mobile medical unit at district-level

16. MONITORING AND EVALUATION

- Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny
- Sub-centres to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad
- The District Health Mission to monitor compliance to Citizen's Charter at CHC level
- Annual District Reports on People's Health (to be prepared by Govt/NGO collaboration)
- State and National Reports on People's Health to be tabled in Assemblies, Parliament
- External evaluation/social audit through professional bodies/NGOs
- Mid Course reviews and appropriate correction