MINUTES OF THE FIRST MEETING OF THE MISSION STEERING GROUP ON NATIONAL RURAL HEALTH MISSION HELD UNDER THE CHAIRPERSONSHIP OF HON’BLE UNION MINISTER OF HEALTH & FAMILY WELFARE ON 30.8.2005 AT 5.00 P.M. IN PARLIAMENT HOUSE ANNEXE

The first meeting of the Mission Steering Group was held on 30.8.2005 under the Chairpersonship of Dr. Anbumani Ramadoss, Union Minister for Health and Family Welfare. The list of participants is Annexed.

Smt. Panabaka Lakshmi, Hon’ble Minister of State for Health & Family Welfare welcoming the participants, underlined the commitment of the present government regarding strengthening of Primary Health Care infrastructure through increased funding for the National Rural Health Mission (NRHM), and outlined the strategies being adopted under the Mission.

Dr. Anbumani Ramadoss, Union Minister of Health & Family Welfare, highlighted the importance being given by the present UPA government to provision of accessible, affordable and quality health care services to the rural people, especially to the vulnerable sections of the population. He stated that the first year would be spent on structural planning of NRHM. Joint strategy was being worked out with related Departments, for integrated approach under the Mission. The Mission Steering Group being the highest policy making Body, could suggest modification of strategies under the NRHM. Three new Task Groups on Urban Heath, Financial Guidelines and Medical Education had been constituted recently. Highlighting that the MMR was unacceptably high i.e. 400+per lakh of population, the Mission needed to address the issue of training of Birth Attendants, and raising the levels of institutional delivery. Access to poor would have to be improved through models of health insurance in coming years. Further, a Cabinet Note had been circulated by the Department of Health and Family Welfare recently seeking greater financial empowerment and flexibility for implementing NRHM.
A short multimedia presentation was made on NRHM. Summarizing the institutional framework and strategic coordinates of the Mission, the tasks accomplished so far and key challenges ahead, **Sh. P.K. Hota, Secretary (H&FW), GoI**, informed the Mission Steering Group that AD syringes were being supplied to the states for rural hospitals to strengthen safe immunization. Drug Kits for ASHA and for Sub-centres/PHCs and CHCs would also be provided to the high focus States. He further stated that in the current year emphasis was being laid on programmes related to women and children. Second year would be for inter-sectoral convergence and district Planning and third year would focus on wide range of community health insurance products.

**Dr. Gauri Pada Dutta, member of the Mission Steering Group** expressed the following views on NRHM:

- It was important to inform, educate and confide the rural beneficiaries about the services available to them under the Mission.
- The duty chart of ASHA should be such as not to overburden her. Her role and status vis-à-vis other health functionaries should be clearly defined.
- The morbidly profile of the people in the States needed to be mapped at all levels.
- It was important to optimize primary healthcare through operationalization of PHCs.
- Manpower in CHCs needed to be upscaled, especially more GDMOs could be posted in CHCs to assist specialists.
- Members of the Mission Steering Group should be assigned mentoring role for one or more States.
- The possibility of mainstreaming traditional drugs, other than AYUSH, should also be looked into, while finalizing the ASHA drug kit.
- It was important to explore innovative methods of Medical Education, under NRHM.
- NRHM should articulate a clear-cut policy on utilization of non-qualified rural practitioners.
Dr. N.H. Antia

- Dr. Antia emphasized the relevance of the ICMR-ICSSR Report 1981, on Health. He stated that Health is a social problem with some technology attached to it. 60% preventive care is possible at village level itself, so more interventions were needed at that level.

- Dr. Saeda Hamid, Member, Planning Commission, and Mrs. Pratibha Patil, Governor, Rajasthan had visited the FRCH, Pune, and were suitably impressed. It was therefore advisable that training to ASHA be modeled as per the modules for National Institute of Open Schooling, which was suitable even for a fourth class pass woman.

- Appropriately trained village women could handle the primary responsibility of rural healthcare under the overall guidance of the Panchayati Raj Institutions. The NRHM should promote such models in the States.

- It was important to regulate private sector to fulfill the public health goals. The concerns of urban poor also needed to be addressed under the Mission.

Dr. R.L. Misra

- The rural-urban divide in health was artificial, as also the assumption that urban poor were better placed to avail of health services. Therefore, it was important to include urban health under NRHM.

- Similarly, the differentiation between primary and secondary care at operational level was also artificial, since strengthening CHCs was already accepted as an important strategy under NRHM. Focusing only on primary healthcare would deprive people of appropriate referral and hospital care services at CHCs and District Hospitals.

- The NRHM presented an unprecedented opportunity in the Health Sector. In this context, a 30% increment in Budgetary Outlay was too small, and would need to be sufficiently upscaled.
• Looking into the financial status of the State Governments, dependency on States for enhanced financial Outlay could jeopardize the strategic framework of the Mission.

• A Cabinet Committee on Health could be constituted to meet on quarterly basis to review the NRHM, while the Committee of Secretaries could be constituted to promote intersectoral convergence.

• The Mission mode implied the redundancy of the concept of taking decisions on file. It was important to empower the Mission at GoI and State levels to take informed decisions in a fast track mode.

• It was also important to strengthen the capacities of the Health and Family Welfare Departments at GoI and State levels to implement the Mission.

• Knowing that the present dysfunctional health delivery system would not be in a position to deliver the goals under NRHM, Action Plans should be prepared within 6 months for each State and district to assess the systemic and functional shortcomings.

• A National Policy needed to be articulated to address the severe shortage of manpower in rural areas.

• It was hoped that the ASHA model had been devised, based on the learnings from the past experience of Village Health Guide Scheme and Jan Swasthya Rakshak Model.

Dr. Shiv Kumar

• The Mission deliverables and outcomes along with the risk factors were stated in Annexure-V of the Background Note. It was important to overcome expected obstacles by suitably empowering the Mission, and by setting realistic goals for various demographic indicators.

• Depending on States for financing the NRHM may not be advisable, looking at their financial status.

• From the Documents, it seemed that quality health services were restricted to CHCs under IPHS. Therefore, there was a need to expand IPHS to PHCs and Sub-Centre also.

• Success of ASHA would depend on proper institutional support. This needed to be articulated clearly.
• It was important to provide technical support to Districts, Blocks and villages for preparing Health Plans under the Mission.
• Wider discussion was needed to chart future course for rolling out Health Insurance products under NRHM.
• It was important to engage appropriate financial and qualified personnel for the Mission.

Dr. Dilip Mavalankar

• There was urgent need to revamp the health delivery infrastructure in the country, since within the neighbouring countries India had the dubious distinction of reporting largest number of maternal deaths.
• Lack of availability of anaesthetists needed to be addressed on an urgent basis. Ideally, there should be a provision for two anaesthetists per CHC to provide round-the-clock emergency obstetric care. Till such time as such anaesthetists were trained and available, training could be given to MBBS doctors and nurses.
• Rural Blood Banks should be established to meet emergency needs.
• There was a need to develop transparent transfer/posting policy for health professionals, similar to the one in Sri Lanka, to overcome shortage of health providers in rural area.
• Accountability and governance issues could also be included as performance benchmarks under the Mission.
• It was important to address the need for maintenance of Government buildings to improve optimal utilization of existing public health infrastructure.
• It was important to introduce a cadre of Skilled Birth Attendants. Else ANMs could be appropriately trained to provide services as Skilled Birth Attendants.
• The possibility of making infant and maternal deaths a nationally notified event should be explored, in which case audit would be undertaken by the District Magistrate for each reported incidence.
Sh. Wajahat Habibullah, Secretary, Panchayati Raj

- It was pointed out that the methodology of selection of ASHA detailed in ASHA Guidelines was erroneous. However, the Background Note for the Mission Steering Group had articulated the process correctly. It was important to make ASHAs accountable to the Panchayati Raj Institutions. NGOs could provide technical and mentoring support to the ASHA initiative, however, primary responsibility for selection and monitoring of ASHA should remain with Panchayati Raj Institutions.

Shri Montek Singh Ahluwalia, Deputy Chairman, Planning Commission

- It was important to provide flexibility to the Mission in the first year to enable simultaneous implementation of different models in different States, before finalizing the strategy and institutional framework of the Mission.
- Although 30% increase in the Budgetary Outlay of the Ministry of Health and Family Welfare was indeed not enough, a 30% annual incremental budget outlay could provide the envisaged additionality during the Mission period.
- It was important to think of all practical ways of addressing issues related to intersectoral convergence. More explicitly, how would components of sanitation, drinking water and nutrition be addressed under NRHM in the District and State Action Plans.
- Concurrent evaluation system should be in place right from the beginning, not from the point of view of fault findings but for learning. NGOs can play a major role in this respect.

Dr. Raghuvansh Prasad, Hon’ble Union Minister for Rural Development

- There was a need for focused attention on rural areas and strengthening of primary healthcare services, particularly in States like Bihar, where the access of rural poor to primary healthcare services was indeed very limited. There was a
sociological context to the health problems of rural poor. Limited access to basic sanitation, drinking water and nutrition in those areas resulted in greater morbidity and mortality. People had to incur huge out-of-pocket expenses for availing healthcare services either from the quacks or from private nursing homes, due to inoperational rural public healthcare system.

- There was a strong case for greater intersectoral convergence between related Sectors of Safe Drinking Water and Total Sanitation Campaign. Almost 2,16,000 habitations in the country had access only to contaminated water. There was a huge shortage of household toilets. All these impacted the health status of the people.

- Since implementation of Centrally Sponsored Schemes rested with the States, there was a need for strict monitoring of the programme.

- Training to Trained Birth Attendants should be addressed under the Mission to provide doorstep services to the rural poor. It was also important to strengthen referrals for good hospital care services.

- Greater financial outlay for the Mission was necessary to strengthen the public healthcare in the rural areas, since reliance on private sector meant higher costs.

Mrs. Gauri Chatterji, Secretary, Development of North Eastern Development

- There was a need for a more flexible approach in services for the North Eastern States which had basic infrastructural weaknesses such as non-availability of roads. Thus norms and standards for primary healthcare facilities for North East would require a relook.

Secretary (HFW), Assam, made a brief intervention requesting for 3 Medical Colleges, a Referral Hospital, and 3 CHCs in every district, as also the provision for Mobile Vans under NRHM.

A short presentation was made by Sh. K. Raamamoorthy, Joint Secretary, Department of Health and Family Welfare highlighting the gaps
in health infrastructure and services in the North-East States and strategies to redress the same.

Secretary (HFW) informed the MSG that in the first year of the Mission, more results were expected in the area of Universal Immunization, maternal healthcare and health strategies for the North East. He requested for inputs from the members on dealing with the accountability and governance issues under the Mission. He also said that the Mission Steering Group was basically a Group of Ministers, while the Empowered Programme Committee was to operate like a Committee of Secretaries for the Mission.

Summing up, the Union Minister for Health & Family Welfare requested the members of the Mission Steering Group to send detailed comments to continue the dialogue for undertaking improvements under the Mission. It should be possible for the MSG members to choose States, which they would like to mentor on long-term basis.

The meeting ended with a vote of thanks to the Chair and the Members of the Mission Steering Group.