NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM

newsletter

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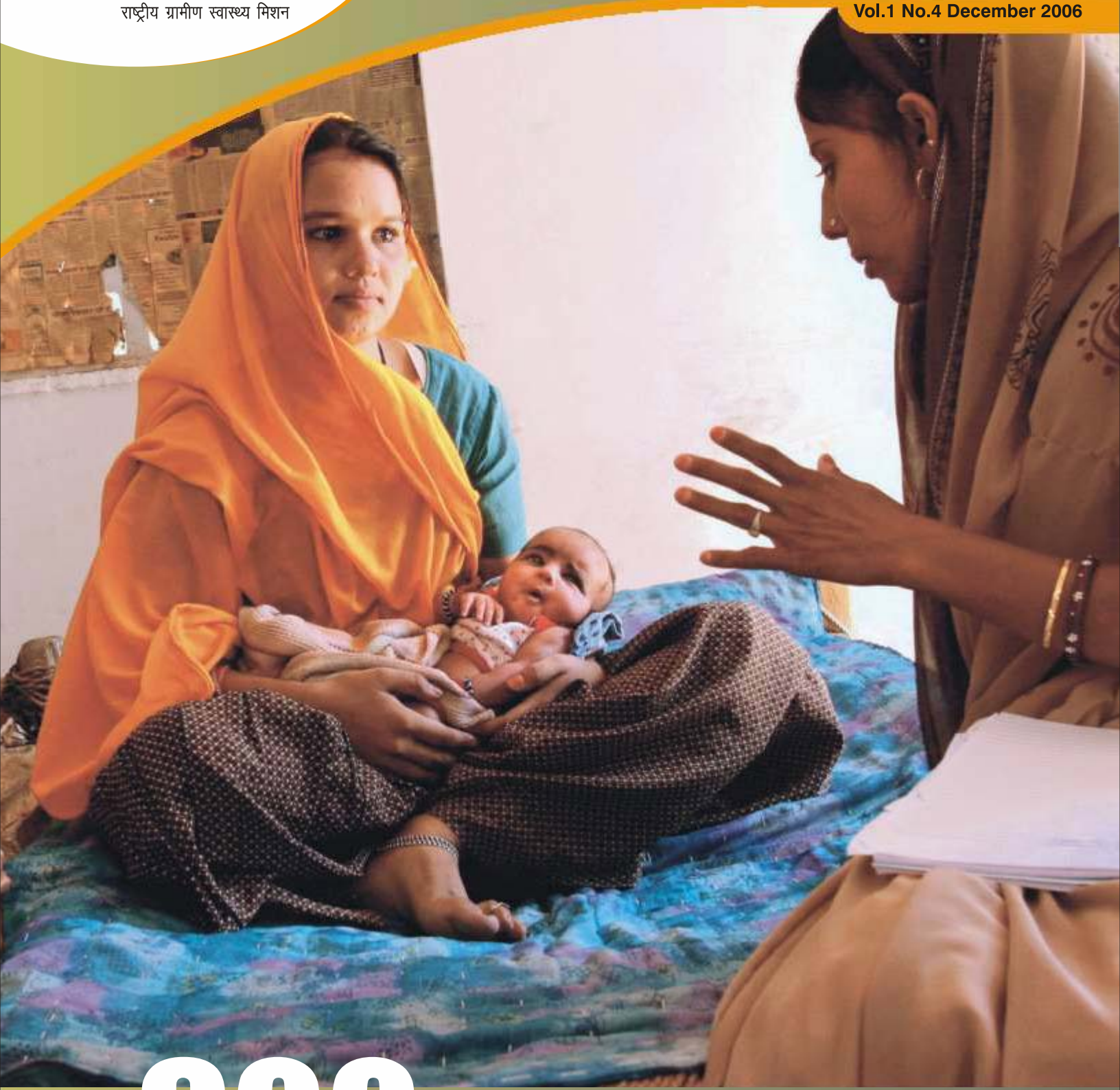

600 days of NRHM

Progress under | NRHM

Institutional setup

- State Health Missions in all States/UTs.
- State launch along with orientation of DMs/CMOs completed in 18 focus states.
- Merger of Departments of Health & Family Welfare completed in all states.
- Merger of State level societies in 28 states. Rest in process.

ASHA

- 2.39 lakh ASHA selected till date. Of these, 1.5 lakh have been trained.
- Mentoring Group for ASHA set up and meetings held.
- Detailed guidelines for the mentoring of ASHAs in the states and the associated generic funding have been disseminated to the states.
- ASHA Training modules finalized and State/District/Block level trainers completed.

Infrastructure

- Facility Survey has been completed in 902 CHCs across the country.
- Untied funds of Rs.10,000/- released to all sub-centres in the country. Total amount released: Rs. 205.87 crore in 2005-06 and Rs. 46.82 crore during 2006-07.
- Indian Public Health Standards (IPHS) finalized for CHCs. Similar standards are in final stages of preparation for Sub Centres, PHCs and District Hospitals.
- 1704 CHCs have been identified for upgradation to IPHS in the first phase. Total amount of Rs. 370 crores released during 2005-06 for this purpose and Rs. 326.40 crores during FY 2006-07 till date for this purpose.
- Over 7000 Rogi Kalyan Samitis set up at various levels.
- Mobility support being given for outreach programmes in the underserved areas. A total of Rs. 153.10 crores has been released for Mobile Medical Units in various states during 2006-07.
- 108 Integrated District Health Action Plans have been prepared in various states. These plans are sector wide in import and address all aspects of health including the collateral health determinants like nutrition, sanitation, drinking water etc.

Human Resource Development

- Accounts personnel are being positioned in the PHCs to strengthen the accounting of funds in view of the substantially larger number of transactions at that level.
- 12738 Doctors, ANMs and other paramedics have been appointed on contract by States to fill in critical gaps.
- Block pooling of doctors has been started in states so as to ensure that there is at least one functional health facility in each of the block. The other health facilities in the territorial are being serviced through outreach visits.
- Over 1000 professionals (CA/MBA) appointed for EAG States in the Program Management Units (PMU) to support NRHM. Similar management support is being planned at the level of the Block also.
- JSY operationalised to promote safe delivery. Incentive for BPL families of Rs. 1300 for safe delivery in EAG states, Assam and J & K and Rs. 1000 in all other states. Assistance also being given for Caesarian section.

Training

- National Health Resource Centre at Central level finalized.
- State level Health System Resource Centre for North East States set up at Guwahati.
- Additional training initiatives undertaken including Upgradation of State Training Institutes/ANMS Colleges Integrated Skill Development Training ANMS/ LHV/MOs. Skilled Birth Attendants Training MO/ANMs Training on Emergency Obstetrics care for Mos. Training on No Scalpel Vasectomy (NSV) for Mos. Professional Development Programme for CMOs. Specialised skill development programme for Mos. Training program for Consultants of Program Management Units

Immunization

- Accelerated Routine Immunization (RI) taken up in all EAG states
- Coverage expected to be around 80 per cent .
- Catch up rounds taken up in Bihar, Jharkhand, Orissa and Assam and other states.
- Organizing sessions in urban slums and under served areas by outsourcing the sessions where ever necessary (Hiring of vaccinator in service deficient areas or where ANM is not available)
- Mobilization of children by ASHA and Anganwadi Workers (AWW) to increase coverage and convergence of Nutrition with Immunization
- JE vaccination initiated in 11 districts in 4 states 93 lakh children immunized.
- Ground work for expansion of Hepatitis vaccine to 11 states finalized.
- AD Syringes introduced.
- Vaccine management addressed. BCG now in 10 dose vial.
- Development and implementation of a Routine Immunization Monitoring System Software.
- Neonatal Tetanus declared eliminated from 7 states.
- Over 5 million children in transit administered polio drops (2005-06).
- During 2006, till date 571cases have been reported.

New Programs & Innovations

- RCH II under implementation with a lot of innovative changes.
- Sterilization compensation scheme launched by GOI.
- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started this year in 16 States namely MP, WB, Jharkhand, UP, Haryana, Maharashtra, Delhi, Mizoram, J&K, Uttaranchal, Bihar, A&N Island, Assam, Andhra Pradesh, Chhattisgarh & Karnataka.
- With the help of Neonatology Forum completed training on Newborn Care in 140 districts in the country.
- Integrated Disease Surveillance Project operationalized.
- Legal changes brought about to allow the ANMs to dispense medication and MBBS doctors to administer anesthesia.
- Short course for anesthesia being proposed.
- Operational Guidelines disseminated on IMNCI, Skilled Birth Attendants, Emergency Obstetric care, 24 hours PHCs, First referral Unit and Blood Storage Units.

Partnership with Non Government Stakeholders

- 287 Mother NGOs appointed.
- Providing services, RCH out reach services, Ambulance Services, Mobile Medical Units, Mentoring of ASHA, Management of Health facilities (as in Gujarat, Tamil Nadu etc), Involvement of Medical colleges, Training programmes, ICCI, Partnership in polio/ immunization programmes etc.

Supply of Drugs

- Empowered Procurement Wing set up in the Ministry
- Single Purchase Committee set up under DGHS
- Involvement of HLL for supply of drugs to EAG/ North East States being finalized.

Inter sectoral Convergence

- Intersectoral convergence Committee under Mission Director set up
- Convergence with ICDS/Drinking Water/Sanitation / AYUSH/NACO ground work completed.
- School health programmes initiated by various states
- Monthly Health day being organized at the

IEC

- Multi-media campaign on health issues including immunization, save the girl child.
- Special issues of NRHM Newsletter.

NRHM has boosted immunization coverage

The National Rural Health Mission (NRHM) has completed 600 days. It was launched by Hon'ble Prime Minister in April 2005 with a view to bring about dramatic improvements in the health system and the health status of the people, especially those who live in the rural areas of the country.

During the last one-year and more, the Mission has strived to achieve progress in providing universal access to equitable, affordable and quality health care which is accountable as well as responsive to the needs of the people. This period also saw putting in place the institutional mechanism necessary for implementation of the Mission. Important initiatives for reducing child and maternal mortality as well as stabilizing population along with gender and demographic balance have been taken. The Reproductive Child Health (RCH-II) programme and Janani Suraksha Yojana have been launched. Immunization has been accelerated. Recruitment and training of doctors, nurses and paramedics have begun in all earnestness. Funds have been released to the States to build up their health infrastructure. Untied funds to the tune of Rs. 205 crores have been allocated to all sub-centres in the country.

The NRHM is in the process of facilitating effective partnerships between the Central and State governments, setting up a platform for involving the Panchayati Raj institutions and the community in the management of primary health facilities. The Mission has developed a framework for promoting inter-sectoral convergence for taking care of the promotive and preventive healthcare. The Mission also provides flexibility to the States and the community to promote local initiatives.

The Mission has thus started the groundwork on all fronts, the foremost of all being the induction of village based female health activists (ASHA) in 10 demographically weaker States. I am sure the NRHM will turn out to be the harbinger of healthy growth of the public health delivery system in the days to come and fulfill the Government's commitment to put in place an efficient and affordable system to meet the needs of all its citizens across the country.

-Dr Anbumani Ramadoss
Union Health & FW Minister
Government of India

The National Rural Health Mission (NRHM is a dream come true for millions of people in the country. It augurs especially well for the country's underprivileged, the women and children.

The singlemost important initiative of NRHM has been the choice of a female voluntary health activist to take care of the health problems in every village. A woman is also a mother, who understands the need of fellow women and their children. By placing ASHAs in every village, basic healthcare has been really brought closer to the vulnerable groups under the NRHM.

Reducing maternal and child mortality is a top priority under the NRHM. The initiatives for upgrading at least one Community Health Centre (CHC) in every block, making the selected Primary Health Centre (PHC) functioning round-the-clock, getting the ANM locally recruited are some of the innovations that will definitely bring down the maternal and child death rate in the days to come.

Nearly 700 million people live in 6 lakh villages of our country. Providing them access to easy, affordable and quality healthcare is not an easy job even under the best of healthcare systems. The corrective step has been taken and the process has been initiated to realize the dream. I am sure the women and children will immensely benefit from the NRHM initiatives. I wish the Mission all support and success in its second year.

Panabaka Lakshmi
Minister of State for Health & Family Welfare
Govt. of India

The NRHM has completed 600 days since its launch by the Hon'ble Prime Minister on 12th April, 2005. The NRHM envisages improving the health system by addressing the key challenges in providing equitable and affordable health care to the rural population.

I am particularly happy to note that all States have set up the institutional mechanisms for the implementation of the Mission in its first year itself. The presence of more than 200,000 ASHAs in the States with poor health indicators has laid the foundation for village level health care, for the first time in the country. Apart from providing the basic health care, the presence of ASHAs in the villages will definitely give a boost to interactive health, education and also the spread of information on health, hygiene and sanitation.

Secretary visiting Health Pavilion at IITF '06

I am sure that ASHAs along with a well functioning public health facilities, will be able to bring about a paradigm shift in the health care delivery system.

Rebuilding the country's primary health care system is a great challenge before us. We have to take it forward for more concrete outcomes.

NARESH DAYAL
Secretary (Health & Family Welfare)
Govt. of India

Shri Dayal has taken over from Shri P.K.Hota who retired on 31st October 2006. An alumni of St. Stephen's college, Delhi, Shri Dayal belongs to the 1972 batch of IAS. Before joining the Health Ministry, Shri Dayal worked as Additional Secretary and Special Secretary in the Ministry of Environment and Forests. He brings with him the considerable knowledge and experience he gained as Principal Secretary, Health & Family Welfare, Uttar Pradesh during the year 2000.

NRHM ISSUES AND CHALLENGES

S. JALAJA
Additional Secretary and
Mission Director (NRHM)

The National Rural Health Mission (NRHM) is a unique program which envisages bringing about dramatic improvements in health care delivery to cater to the needs of millions of people within a short span of seven years. The Mission. has no parallel anywere else in the world. Many people are under this impression that the NRHM "will take care" of all the problems in the health sector. It needs to be appreciated that the Mission which was launched to meet several challenges itself faces many challenges. When the mission completes 600 days, while evaluating its progress, the challenges faced by it also need to be considered. They are briefly discussed below :

1. IMPROVING THE PUBLIC HEALTH DELIVERY SYSTEM

a. INFRASTRUCTURE

NRHM plans to have all health facilities raised to the level of Indian Public Health Standards (IPHS). This involves multifarious tasks including facility survey, providing all facilities with electricity and fresh water, proper designing, taking up huge construction work, providing matching manpower, identifying suitable agencies to carry out works, ensuring quality and timely releases and utilization of funds, involving the PRIs etc. Program Implementation Plans (PIP) prepared by each State detail each such activity. The activities are being monitored closely at all levels.

b. MANPOWER PLANNING

Meeting the huge manpower needs in the health sector in rural areas is one of the major challenges under the NRHM. It is estimated that 5000-7000 doctors in each speciality 2 lakh ANMs and 84,000 staff Nurses are required to fill the vacancies under URHM. Non-availability of specialists could adversely affect provisions of basic emergency obstetric care to save the lives of mothers and newborns. To take care of the problem, a variety of interventions are being tried like compulsory rural postings of doctors, providing incentives, multi-skilling of doctors, pre-service training, contractual/local recruitment of doctors, nurses and paramedics, construction of residential quarters for staff, partnership with NGOs to run facilities, having/strengthening a cadre for nurses and ANMs. Building up necessary infrastructure & providing matching manpower is it self a big challenge under the mission.

c. TRAINING

Training is another area of challenge. We have to train not only the State/District/block level functionaries, doctors, nurses and

paramedics in the health sector but also the vast network of ASHAs, Anganwadi Workers, PRIs, Rogi Kalyan Samitis, NGOs, Professional organizations, management functionaries. This also means upgrading/setting up of new training institutions and also involving all medical colleges in the country. A comprehensive program of training is chalked out under NRHM to meet this challenge.

d. DRUGS / EQUIPMENTS

At present, barring a few, there is no well established procurement system in the States. Setting up procurement and distribution systems, providing logistical support for continuous supply of drugs to various facilities, building capacities of personnel involved etc. are also challenges facing the Mission. The Rogi Kalyan Samitis are to monitor availability of drugs/functioning of equipments in every facility.

e. MANAGEMENT SUPPORT

Many of the states do not have well developed system for handling funds and lack absorption capacity especially the NE States. The NRHM is providing management support at the State/District and block levels (and even PHC levels in NE and EAG States). Setting up of a full fledged National/State Resource Centres would be needed to provide technical and strategic support to the Mission. Their recruitment, training, retention, career progression are issues to be tackled under the Mission. Tracking funds allocated under NRHM would be one of the mandates of this group and is indeed a very important factor for the overall success of the Mission.

ASHA scheme was initially approved only for 10 states. Now it has been extended to 18 States (including NE States) and to the tribal areas of all other States.

II SELECTION AND TRAINING OF ASHA

ASHA scheme was initially approved only for 10 states. Now it has been extended to 18 States (including NE States) and to the tribal areas of all other States. The other States too can opt for health workers for urban slums and other areas under the RCH-II program. Thus, at the end of the Mission about one million ASHAs/health workers are expected to be selected, trained and positioned in communities. This in itself is an enormous task. Setting up of ASHA support mechanism, regular supply of medical kits to ASHA, payment of incentives to her are huge tasks in themselves.

III. DECENTRALISATION

Involvement of Panchayati Raj Institutions all levels, by giving them financial support, building their capacities and providing flexibility are key

strategies under the Mission. Delegation of administrative and financial powers, constitutions of village Health and Sanitation committees, training of all officials/ non-officials involved, dovetailing of PRI schemes with NRHM, providing infrastructure support for the Mission by PRIs (roads/drinking water, sanitation) are to be taken care of to achieve this goal.

The Mission plans to achieve convergence at the village level by organizing monthly health days in all Anganwadis of the country by involving ANMs, Anganwadi Workers and ASHA.

IV CONVERGENCE

Convergence of health nutrition, sanitation, drinking water and involving Panchayati Raj are essential for having a holistic approach to basic health care. How successfully we can integrate the schemes dissolving their boundaries for meeting the health needs of the people is another challenge under the Mission. The Mission plans to achieve this at the village level by organizing monthly health days in all Anganwadis of the country by involving ANMs, Anganwadi Workers and ASHA. Even then, nearly 1,50,000 sub centres/ Anganwadi are to be covered. Building roads connecting facilities with villages, drinking water and sanitation facilities in every village are to be the priority. Malnutrition especially amongst women and children is an area of great concern. Promoting education amongst girls and devising School Health Programs in every state also need convergence of activities. Success of the Mission in achieving all goals is directly related to the outcomes of this activity.

V MAINSTREAMING AYUSH

The rich traditional Indian System of Medicine needs to be fully intergrated with in the Mission. Every PHC/CHC ought to offer choice of ISM to the people.

VI THE BURDEN OF DISEASES/HIV AIDS

NRHM has to take care of not only the existing disease burden but also the burden of existing and emerging diseases. HIV/AIDS and the chronic disease burden also need to be tackled by the same over stretched public health system. Integration of HIV/AIDS programs with the public health system at the sub-district level again needs lot of effort.

VII THE CHALLENGE OF N.E.

North-Eastern States face considerable difficulty on account of lack of infrastructure, manpower shortages, lack of capacity for absorption of funds etc. Decentralizing health administration, Strengthening Nurses' cadre, providing management support, capacity building are being taken up to achieve the goals under the NRHM.

VII THE CHALLENGE OF EQUITY

Although improvements in the system can be brought about, how do we ensure that the poorest of poor especially the SC/CT population, receive adequate and quality health care services? How availability of nutrition, sanitation and drinking water can be assured to them. ASHAs, AWWs, Village Health and Sanitation committees are to play a major role in this regard. The success of NRHM especially improvement of all health indicators of the poorest sections will depend on the focus on equity.

VIII FINANCING NRHM

Meeting the health needs of people also means increasing investments in the Health sector. The NRHM envisages increasing health expenditure from 0.9% to 2.3% of the GDP. The Central and State Governments have to ensure these investments and adequate flow of funds to support all activities under the Mission. Successful risk pooling to contain out of pocket expenditure and rural indebtness is again a priority area.

The ultimate success of NRHM, however, lies in the ownership of the Mission by the people themselves. The vision under NRHM is to make health a movement of people in India which is the real challenge.

IX PARTNERSHIPS

The Mission speaks about successful partnership with a variety of non-govt. stake holders, including voluntary agencies, Trustees, agencies, institutions, international agencies, professional organizations etc. The co-ordination with these agencies is to be done with required sensitivity and understanding. All technical/financial resources need be pooled for optimum usage. Bringing all stakeholders under one umbrella is no easy task.

X MONITORING AND EVALUATION

Absence of health data is a great handicap for the Mission. Setting up a comprehensive Health Management Information System (HMIS) will be one of the useful outcomes of the Mission. Improving collection of primary data, designing the information format, putting the system in place, capacity building, setting up information pathways are essential for building up a foolproof HMIS.

XI GOOD GOVERNANCE

The success of the Mission depends on the political priority accorded to it by the National and State Governments on a sustainable basis. Under good governance, systems are to be put in place by the states, states are to be pro-active partners; they have to commit resources; they are to be responsive to the needs of the people and they need to constantly monitor health outcomes.

XII INVOLVING PEOPLE

The NRHM is meant for improving the health status of the people. Their active participation in planning, implementation, monitoring and evaluation of NRHM activities is very important. Mission plans to do these through periodic village health surveys, community involvement, community monitoring, informing and educating the community on preventive/promotive aspects of health leading to behavioural changes. The Right to Information Act would be a powerful tool to complement the monitoring by the community, which would lead to building up accountability in the system. A human right based health-care system also would ensure much needed accountability. The presence of ASHAs and involvement of Panchayati Raj Institutions will play an important role in changing the face of health care system in India. The challenges facing the Mission make it all the more stronger. The ultimate success of NRHM, however, lies in the ownership of the Mission by the people themselves. The vision under NRHM is to make health a movement of people in India which is the real challenge. ■

Timely vaccination saves life

Sl. No.	Priorities	Constraints	Action to overcome constraints
1.	Functional facilities Establishing fully functional Sub Health Centres / PHCs/ CHCs/Sub Divisional/District Hospitals.	▪ Dilapidated or absent physical infrastructure ▪ Non-availability of doctors / paramedics ▪ Drugs/ vaccines shortages ▪ Dysfunctional equipments ▪ Untimely procurements ▪ Chocked fund flows ▪ Lack of accountability framework ▪ Inflexible financial resources. ▪ No minimum mandatory service provision standards for every facility in place which makes full use of available human and physical resources and no road map to how desirable levels can be achieved	▪ Infrastructure/equipments ▪ Management support ▪ Streamlined fund flows ▪ Contractual appointment and support for capacity development ▪ Pooling of staff/optimal utilization ▪ Improved MIS ▪ Streamlined procurement ▪ Local level flexibility ▪ Community /PRI/RKS for accountability / M&E ▪ Adopt standard treatment guidelines for each facility and different levels of staffing, and develop road maps to reach desirable levels in a five to seven year period.
2.	Increasing and improving human resources in rural areas	▪ Non-availability of doctors ▪ Non-availability of paramedics ▪ Shortage of ANMs/MPWs. ▪ Large jurisdiction and poor monitoring. ▪ No accountability ▪ Lack of any plan for career advancement or for systematic skill upgradation. ▪ No system of appraisal with incentives/disincentives for good/poor performance and governance related problems.	▪ Local preference ▪ Contractual appointment to a facility for filling short term gaps. ▪ Management of facilities including personnel by PRI Committees. ▪ Train and develop local residents of remote areas with appropriate cadre structure and incentives. ▪ Multi-skilling of doctors / paramedics and continuous skill upgradation ▪ Convergence with AYUSH ▪ Involvement of RMPs. ▪ Partnership with non-State Stakeholders.
3.	Accountable health delivery	▪ Panchayati Raj Institutions / user groups have little say in health system ▪ No village / hamlet level unit of delivery ▪ No resources for flexible community action	▪ Referral chain from hamlet to hospital ▪ Control and management of Health facilities by PRIs ▪ Budget to be managed by the PRI/User Group ▪ PRI/User Group mandate for action ▪ Untied funds and Household surveys

Sl. No.	Priorities	Constraints	Action to overcome constraints
4.	Empowerment for effective decentralization and Flexibility for local action	▪ Only tied funds ▪ Local initiatives have no role ▪ Centralized management and schematic inflexibility ▪ Lack of mandated functions of PRIs / User Groups ▪ Lack of financial and human resources for local action ▪ Lack of indicators and local health status assessments that can contribute to local planning. ▪ Poor capability to design and plan programmes.esirable levels can be achieved	▪ Untied funds at all levels including local levels with flexibility for innovation. ▪ Increasing Autonomy to SHC/PHC/CHC/Taluk/ District Hospital along with well monitored quality controls and matched fund flows. ▪ Hospital Management Committees ▪ Evolving diverse appropriate PRI / User framework ▪ PRI/User group action at Village / GP / Block and District level
5.	Reducing maternal and child deaths and population stabilization	▪ Lack of 24X7 facilities for safe deliveries. ▪ Lack of facilities with for emergency obstetric care. ▪ Unsatisfactory access and utilization of skilled assistance at birth ▪ Lack of equity/sensitivity in family welfare services/ counseling. ▪ Non-availability of Specialists for anaesthesia, obstetric care, paediatric care, etc. ▪ No system of new born care with adequate referral support. ▪ Lack of referral transport systems. ▪ Need for universalization of ICDS services and universal access to good quality ante-natal care. ▪ Need for linkage with parallel improvement efforts in social and gender equity dimensions. ▪ Lack of linkages with other dimensions of women's health and women friendliness of public health facilities.	▪ Functional public health system including CHCs as FRUs, PHC-24X7, SHCs, Taluk/District Hospital ▪ Trained ANM locally recruited ▪ Institutional delivery ▪ Quality services at facility ▪ Expanding facilities capable of providing contraception including quality sterilization services on a regular basis so as to meet existing demand and unmet needs. ▪ Thrust on Skilled Birth Attendants/local appointment and training ▪ Training of ASHA ▪ New born care for reducing neo natal mortality; ▪ Active Village Health and Sanitation Committee; ▪ Training of Panchayat members. ▪ Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas. ▪ Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees. ▪ Linkage of all above to the Panchayat committee on health.

Sl. No.	Priorities	Constraints	Action to overcome constraints
6.	Action for preventive and primitive health	▪ Poor emphasis on locally and culturally appropriate health communication efforts. ▪ No community action & household surveys ▪ No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc. ▪ Weak school health programmes ▪ Absence of Health counseling/early detection. ▪ Compartmentalized IEC of every scheme	▪ Untied funds for local action ▪ Convergence with other departments/institutions ▪ IEC Training and capability building ▪ Working together with ICDS/TSC/CRSP/SSA/ MDM ▪ Improved School Health Programmes ▪ Common approach to IEC for health ▪ Involvement of PRIs in health. ▪ Oral hygiene movement.
7.	Disease Surveillance	▪ Vertical programmes for communicable diseases ▪ No integrated / coordinated action for disease surveillance at various levels in place yet. ▪ No periodic data collection and analysis and no district and block specific epidemiological data available	▪ Horizontal integration of programmes through VH&SC,SHC,PHC,CHC. ▪ Initiation and Integration of IDSP at all levels. ▪ Building district / Sub-district level epidemiological capabilities.
8.	Forging hamlet to hospital linkage for curative services	▪ Entitlements of households not defined ▪ No community worker ▪ No well defined functional referral/transport/communication system. ▪ No institutionalized feedback mechanism to referring ASHA/peripheral health facility in place	▪ ASHA/AWW/ANM ▪ Household /facility surveys/survey of non governmental providers for entitlements. ▪ Linkages with SHC / PHC / CHC for referral services
9.	Health Information System.	▪ Absence of a Health Information System facilitating smooth flow of information. ▪ Not possible to make informed choices	▪ A fully functional two way communication system leading to effective decision making. ▪ Publication of State and District Public Reports on Health.

NRHM has boosted immunization coverage

Sl. No.	Priorities	Constraints	Action to overcome constraints
10.	Planning and monitoring with community ownership	No local planning, no household surveys, no Village Health Registers. Lack of involvement of local community, PRI, RKS, NGOs in monitoring of public health institutions like SHC/PHC/CHC/Taluk/District Hospitals.	Habitation/village based household surveys and Facility Surveys as the basis for local action. Untied resources for planning and monitoring. Management of health facilities by the PRIs. Thrust on community monitoring, NGO involvement, PRI action, etc. Ensure Equity & Health. Promote education of women SC/ST & other vulnerable groups.
11.	Work towards women's empowerment and securing entitlements of SCs /STs /OBCs /Minorities	Standard package of interventions under current schemes. Coverage and quality of services to women, SCs/STs/OBCs/ Minorities not tracked health institution wise. No analysis of access to services and its quality	Facility and household services to generate useful data for disaggregated monitoring of services to special categories. NGO and research institution involvement in Facility surveys to ensure focus on quality services for the poor. Visits by ASHAs. Outreach services by Mobile Clinics.
12.	Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water etc. with community support.	▪ Vertical implementation of programme. ▪ Only curative care. ▪ Inadequate service delivery. ▪ Non-involvement of community.	▪ Convergence of programmes. ▪ Preventive care. ▪ Health & Education ▪ Empowering Communities. ▪ Providing functional health facility [SHC], PHC [CHC] for effective intervention.
13.	Chronic disease burden.	▪ Double disease burden. ▪ Lack of stress on preventive health. ▪ Lack of integration of programmes with main health programmes. ▪ No IEC/advocacy. ▪ Inadequate Policy interventions	▪ Village to National level integration . ▪ Stress on preventive Health ▪ IEC/Advocacy ▪ Help of NGOs ▪ Policy measures.
14.	Social security to poor to cover for ill health linked impoverishment and bankruptcy.	▪ Large out of pocket expenditures even while attending free public health facilities- food transport, escort, livelihood loss etc. ▪ Economically catastrophic illness events like accidents, surgeries need coverage for everyone especially the poor.	▪ Innovations for risk pooling mechanisms that either cross subsidise the poor or are forms of more efficient demand side financing so that the economic burden of disease on the poor decreases. ▪ Guaranteeing hospitalization at functional facilities

ASHA - for every village

A trained female community health worker ASHA is being provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norm could be relaxed for one ASHA per habitation depending on the workload. ASHA must be a primary resident of the village with formal education upto Class VIII and preferably in the age group 25-45. She would be selected by the Gram Sabha following an intense community mobilization process. She would be fully accountable to Panchayat. Though she would not be paid any honorarium, she would be entitled for performance based compensation. It is expected that on an average an ASHA working with reasonable efficiency would be able to earn Rs. 1000 per month.

Since as per the existing approval, the compensation for ASHA is not factored in the scheme, it is proposed to modify the programmes mentioned in the ASHA compensation package, wherever necessary, to enable the payment of compensation to her. The cost of training and drug kits to ASHAs would be supported by the Centre in the 18 high focus states. The other states would have the flexibility to have Health link workers to support it out of the RCH II flexible fund. As a special case, ASHAs could be supported in very remote backward regions in non-focus States.

239,000 ASHAs & more

Already, 239000 ASHAs have been selected. ASHAs would reinforce community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. She will also help the villagers promote preventive health by converging activities of nutrition, education, drinking water, sanitation etc. In order that ASHAs work in close coordination with the AWW, she would be fully anchored in the Anganwadi system. ASHAs would also provide immediate and easy access for the rural population to essential health supplies like ORS,

ASHAs would reinforce community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable diseases.

contraceptives, a set of ten basic drugs and she would have a health communication kit and other IEC materials developed for villages.

At present Health Day's are organized every month at the Anganwadi level in each village in which immunization, ante / post natal check ups and services related to mother and child health care including nutrition are being provided. Space at each Anganwadi to serve as the hub of health activities in the village could be considered under other Rural Development Programmes. The space could also be utilized for dispensing OP services by any health provider. This space could also serve as depot for medicines and contraceptives. NRHM will try to establish a village level health institution collocated with AWC with a specific physical location.

Anganwadi worker & ASHA as a team

Anganwadi Centre will be the focal point for all health and nutrition services - ASHA & AWW working as team- leaders of the Village Health Team

- Organize village level health education activities.
- Fixed health day at AWC level for ante natal, post natal, family planning and child health services.
- AWW & ASHA to encourage and plan for institutional delivery & facilitate Referral care. Mapping of facilities. Help in accessing transport through community organizations, SHGs.
- AWW & ASHA be present at all home deliveries as second attendant to provide care & advice for the new born.
- AWW & ASHA could motivate newly married women & women who have had a recent delivery to use family planning. AWC as depot for pills & condoms. AWW & ASHA to facilitate referrals for other methods.
- AWW & ASHA for immunization, special social mobilization campaigns.
- AWW & ASHA to work with community as members of the Village Health and Sanitation Committee for preparation of Village Health Plans.
- Facilitate referral to appropriate health facilities particularly for institutional deliveries, RTI/STI, domestic violence, abortion, gynecological & other morbidity. ■

Anganwadi Centre will be the focal point for all health and nutrition services - ASHA & AWW working as team- leaders of the Village Health Team

287 Mother NGOs

The involvement of non-governmental sector organizations is critical for the success of the NRHM.

The Non-governmental Organizations are critical for the success of NRHM. The Mission has already established partnerships with NGOs for establishing the rights of households to health care. With the mother NGO programme scheme, 287 MNGOs covering nearly 404 districts have already been appointed. Their services are being utilized under the RCH-II programme. The Disease Control programmes, the RCH-II, the immunization and pulse polio programme, the JSY make use of partnerships of a variety of NGOs. Efforts are being made to involve NGOs at all levels of the health delivery system. Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas and aspects, working together with community organizations and Panchayti Raj institutions, and contributing to monitoring the right to health care and service guarantees from the public health institutions. The effort will be to support/ facilitate action by NGO networks of NGOs in the country which would contribute to the sustainability of innovations and people's participation in the NRHM.

A large number of models of partnership between Government and Non-governmental sector has emerged in the course of implementing health programmes. The participation of private sector to meet public health goals would be attempted under the NRHM in a transparent manner to ensure that states making full use of health care providers available in remote regions. Partnerships that enhance utilization of publicly owned health facilities will be encouraged to ensure full utilization of existing infrastructure. Similarly, shortages of human resources in key positions will be attempted through partnerships that allow service delivery guarantees from public health system.

Given the Panchayati Raj framework for decentralized participation, NRHM will seek partnership with NGOs within the umbrella of the Panchayati Raj framework. Decentralization is a key activity and NGOs can considerably improve advocacy for right to health care at the local level. Monitoring committees at Block, District and State level are provided under the NRHM with

NRHM has boosted immunization coverage

involvement of NGOs to encourage transparency and accountability in the health sector. Organization of public hearing on health will be encouraged through the NGOs to get a feed back on availability of health services for the poor.

NRHM will also support the preparation of public reports on health for each District and State in order to get an independent assessment of the quality of health services available. Under the framework for implementation, NRHM attempts to ensure that more than 70% of the resources are spent through bodies that are managed by community organizations and at least 10% of the resources are spent through grants-in-aids to NGOs.

Given the large scale non-governmental sector in health, there is a case for franchising for better standards and regulation. There are instances of franchising computing to reduction in costs and improvement in standards. NRHM will encourage any non-governmental partnerships that improve service guarantees in the health sector for the poor households. Partnerships will be pragmatic with full flexibility to ensure that local level decisions are taken in the context of service guarantees and availability of quality health services. ■

To make the decentralised planning process a success, there is an imperative need to put in a strong MIS network.

In order to enable the District Health Mission to take up the exercise for comprehensive district planning, a house hold and facility survey of SHC/PHC/CHC/Sub Divisional/District Hospitals would be conducted which would act as the baseline for the Mission. This exercise would be taken up at regular intervals to assess the progress under the Mission. For example, the baseline facility survey of any facility, say CHC, would indicate the interventions which are available at the beginning of the Mission.

This survey, when repeated after a gap, would provide us the details of improvement which came about due to the investments made under the NRHM. These surveys would provide valuable inputs for monitoring the progress. It is realised that considerable capacity building would be required for taking up this important initiative. A percentage of funds is therefore being earmarked for this purpose.

1000 MANAGEMENT PROFESSIONALS

The activities under the capacity building would involve recruitment of personnel with requisite skill, strengthening the training infrastructure at both the district as well as State levels. More then 1000 professionals (Chartered Accountants, MBAs, IT Experts) have already been inducted in various States. To make the decentralised planning process a success, there is an imperative need to put in a strong MIS network.To have IT enabled monitoring a computerised network is being set up under Integrated Disease Surveillance Project, linking all the districts of the country. This network would be used for monitoring the progress under the NRHM as well as for surveillance activities. Using the Mission funds, the District Headquarters would be linked up to the PHC level. ■

Immunization-an excellent investment

7000 Rogi Kalyan Samitis

Hospital Development Committees [HDC] or Rogi Kalyan Samitis [RKS] are being constituted at the PHC level within the overall Panchayti Raj framework. Already 7000 RKS have been established. To encourage the states to do so, a grant of Rs. 1,00,000 is being given to the states for each PHC for which a RKS/ Panchayati Raj body has been constituted and where the RKS has been authorized to retain the user fee at the institutional level for its day to day needs. The existing staff of vertical disease control programmes would be integrated at the PHC level and the RKS would be encouraged to rationalize the manpower and equipments available under the vertical programmes for greater synergy. One AYUSH doctor would be posted at the PHC level. AYUSH services would be part of the PHCs.

The RKS would develop annual plans to reach the IPHS standards and an agency trained to do accreditation/rating would evaluate outcomes achievements against IPHS and against their own goals annually

The RKS will be free to appoint an AYUSH doctor on contractual basis with its own funds. But fund requirement, if any, ought to be rejected in the district/State plan. AYUSH drugs would also be made available in adequate quantity. Every PHC will strive towards a broad framework for Public Health standards. NRHM resources could be used for new contractual and local criteria based recruitment of Medical/Para Medical/AYUSH practitioners if the State so desires. The States will have to justify the need and take responsibility for the outcomes while seeking additional human resources.

It will be for the States to decide on the configuration of PHCs to meet Indian Public Health Standards (IPHS) and offer 24X7 services including safe delivery. The RKS would develop annual plans to reach the IPHS standards and an agency trained to do accreditation/rating would evaluate outcomes achievements against IPHS and against their own goals annuallyand this would be used to incentivise good achievements. Besides, providing of services relating to RTI, STI, PHCs also would facilitate counseling, lab testing for HIV/AIDS protecting the confidentiality of the patients. IEC for all health programmes (preventive and curative) will be continued. Convergence of all programmes will be effectively attempted. The PHCs also prominently display services available, includingcomplete information on HIV/AIDS / Treatment / counseling / Rehabilitation etc. ■

Madhya Pradesh Making health care accessible to poor

Madan Mohan Upadhyay
Principal Secretary
Public Health & Family Welfare Deptt.
Govt. of Madhya Pradesh

The initiatives taken in the last one year under NRHM has made a substantial impact.

High MMR-IMR in the EAG states has been a much discussed subject for several years. Various initiative in the past decades have made some effect in the overall health picture in Madhya Pradesh but it didn't seem to make the giant leap, which a state like M.P. needed. Having a look at the comparative IMR-MMR picture in the EAG states would give an idea about the challenge before these states.

	Population year 2001	IMR year 2004	MMR	Institution Delivery
UP	1660.53	72	707	22.4
MP	603.85	79	498	28.2
Rajasthan	564.73	67	677	31.4
Bihar	828.78	61	451	23.0
Orrisa	367.07	77	361	34.4
INDIA	**10270.15**	**58**	**408**	**40.5**

It is a proven fact that high MMR has a direct correlation to poor institutional delivery. High MMR is generally associated with high IMR. The health of mother and child are also interlinked. With above scenario, the state launched NRHM programme in M.P. in April 2005. NRHM gave the state an opportunity to address the problems at a level befitting the challenge. The initiative in last 12 months have shown the desired effect. Not only a conducive atmosphere has been created in the state, a serious dent has also been made in the factors as that are responsible for the high MMR-IMR. The initiatives which have made the state take a quantum leap are -

1. **Decentralised planning Involving the team**:- Till 2005, the state plans were prepared at Bhopal by senior officials and conveyed to district for implementation upto the villages. For the first time decentralised district health plans were conceived in M.P. Each district prepared their plans on the priorities suggested under NRHM. These district plans were discussed at length with senior officials like Principal Secretary/ Health Commissioner/Directors etc. in a structured manner. Different district teams under the leadership of district collector were called to Bhopal, plans were discussed and updated, modified their plan and granted approval. Looking to the gigantic size the state the discussions have been shifted to division level from this year. These discussions not only clarified various aspects of operational details, it also gave the district collectors a sense of ownership to this mission. This ownership which had evolved out of detailed discussions at district level helped them develop a cohesive team of BMO, MO, CMHO, ANMs etc.

2. **Dhanvantri Yojna - A Pilot Programme in 50 Blocks** M.P. is the second largest state comprising of 48 districts. This is further complicated due to geo-cultural diversities. To quickly spread the messages we selected one pilot block in each district. In all 50 such blocks were selected. These were called Dhanvantri blocks after the great saint name Dhanvantri. Among other things we aimed at 100% institutional delivery. 100% vaccination, filling of vacancies at

SHC, PHC and PHC's particularly for Gynecologist, Anesthetist, Paediatrics etc, extensive IEC activities coupled with monthly monitoring at district and state level. The BMO's were personally called for a one to one interaction on all issues relating to vaccination, institutional delivery, infrastructure upgradation etc on a monthly basis. The results speak for itself. The selected blocks have shown a jump from 4826 in June'05 to 9899 in June'06.

3. Prasav Hetu Parivahan Evam Upchar Yojna M.P. Was the first to conceive a referral scheme for pregnant women. It provided for an incentive amount of Rs. 93 lac to meet the transport cost in rural areas. The performance of last 12 month is at annexure-A.

4. Operationalisation of CEmONC/BEmONC 500 BEmONC and 170 CEmONC have been identified for fully operationalisation. Through a concerted monitoring we could operationalise 364 of them. During the last 12 month we have also been able to reactivate all maternity facilities at 305 PHC's. This had been a great relief to the local public who has to go long distances for deliveries.

5. Training of ANM and ANC campaigns ANM's are a vital link in the MCH campaign. Regular block and sector meeting taken by senior officials ensured that they are updated on the mission and their needs addressed.

6. Maternity Insurance Scheme for BPL familes the state has nearly 40 lacs BPL families. An insurance scheme involving insurance company was devised covering hospital delivery coverage of Rs. 1000 and a coverage of Rs. 50,000 in case of death after delivery in hospital were provided for. This has greatly facilitated the institutional deliveries in the state.

The net result of all these initiatives was that we achieved the following growth in past 12 months.A jump of 105% in deliveries in Dhanvantri Blocks and all around growth of 7.4% for the state. A record for such a short span.

7. Mobile Public Private Partnership Hospital - 19% the state population is tribal, the largest in absolute numbers. These also happen to be the thickest of jungles, making health care difficult to reach. Mobile hospitals on 100% private partnership have been started for these areas. They have already provided relief to 54,000 persons in these blocks. It is now being extended to another 25 scheduled tribe blocks.

The state through these and other initiatives has created a road map which has put the state on a road to sound, safe motherhood.

The state through these and other initiatives has created a road map which has put the state on a road to safe motherhood. ■

Dear Sir,

I am working as a Civil Assistant Surgeon in upgraded Primary Health Centre in Andhra Pradesh. I have read your NRHM Newsletter. It was very resourceful to all the medical staff. Kindly keep me on your mailing list and also request you to send in all the previous issues also.

Dr. S. Joty Bapoole,
Civil Surgeon,
H.No. 3-3-98/1,
Sumitra Nagar, Kukatpally,
HYDERABAD 500 072

Dear Sir,

I am a Health Inspector in Health Department, Government of Karnataka working in very backward area. There are no facilities of bus, newspapers and TV. The people are also very poor and fall under BPL. Your newsletter is very useful to me in the field of work and discussion classes that I participate in my working area. You are requested to kindly put me in your mailing list.

Md. Mohiuddin Qureshi,
Health Department,
H.No. 8/78, Near C.P.S.,
Main Road,
CHITGUPPA 585412
Distt. BIDAR (Karnataka)

Dear Sir,

Our organization is based on females and works for water sanitation, health, save the foetus, education, agriculture etc. We found your NRHM Newsletter very informative. Kindly put us on your mailing list.

Smt. Anjani Rastogi,
President,
Arvind Mahila Vikas Club Samitte, Madhai Chowk,
Budaun (UP).

Dear Sir,

I shall be highly obliged if you kindly enroll my name in your mailing address for sending me the NRHM Newsletter regularly, as the same is really informative and highlight the health mission of our entire country.

Sri D. Deori,
Mass Education Information Officer,
O/o The District Medical Officer,
P.O. TEZU,
Distt. Lohit 792 001
Arunachal Pradesh

Dear Sir,

Ours is a registered voluntary organization and works for health related national pulse polio campaign, immunization, family planning, institutional delivery etc. You are requested to kindly send us at least one issue of NRHM newsletter positively.

Shri Narender Bahadur Mishra,
Pornima Bhavan,
Devkali road,
Faizabad (UP)

Dear Sir,

I got a copy of your newsletter through Nehru Yuva Kendra, Satana. We are working in the NGO in Satna Distt. Kindly send us your newsletter regularly.

Shri Sachin Tripathi,
Secretary,
Grameen Navyuvak Mandal,
254, Kitha, Via Jaitwara, Zila Satna
Madhya Pradesh

Dear Sir,

I am working as an Ophthalmic Assistant in a Rural Primary Health Centre in the Shivpuri Distt. of Madhya Pradesh. I read your newsletter and found it very useful. I enriched by the information. I keep others informed about the various issues of NRHM. Kindly send me the newsletter regularly.

Shri K.S. Sharma,
Ophthalmic Assistant,
Primary Health Centre,
Manpura, Distt. Shivpuri
Madhya Pradesh

Dear Sir,

The Mahavir Institute of Medical Sciences has been established in September 2003 with 300 Bedded Hospital attached to this Institution. The Institution is catering to the Medicare of rural masses. We have got full fledged library attached to this Institution. We request you enroll our Institution in your regular mailing list and send the copy of the Newsletter and other periodicals to this Institution for the benefit of faculty and the students.

The Principal,
Mahavir Institute of Medical Sciences,
Vikarabad,
Rangareddy,
Distt. A.P.

Dear Sir,

I would like to make a formal request for subscription of NRHM Newsletter for our institution. If it is available free kindly do the needful. The newsletter will definitely be useful to all faculty members, students and other paramedical staff.

Dr. Abhay Mane,
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ATTENTION

DOCTORS, CLINICS AND PUBLIC

The Pre-conception and Pre-natal Diagnostic Techniques (PC & PNDT) Act, 1994 is being Implemented in the country which prohibits sex selection and regulates pre-natal diagnostic techniques to prevent their misuse for sex determination leading to female foeticide. The Act prohibits the following:

- Conducting of pre-natal diagnostic techniques in units /clinics not registered under the Act. The registration is renewable after every five years.
- Determination of Sex of the foetus and its communication to the concerned pregnant woman or her relatives or any other person.
- Conducting of any test on a woman or man or both or on any tissue, embryo, conceptus, fluid or gametes from either or both of them for the purpose of ensuring or increasing the probability that the embryo will be of a particular sex.
- Sale of ultrasound machines or any other equipment capable of detecting the sex of the foetus to units /clinics not registered under the Act.
- Advertisements for the sex determination tests in any form such as notice, circular, label, wrapper, or any other document including advertisements through the internet or any other media in electronic or print form and also including any visible representation made by means of any hoardings, wall painting, signal, light sounds, smoke or gas.

⇒ Any person, clinic, hospital, company, firm, or association of individuals who violate the above provisions is punishable with imprisonment upto 5 years and fine upto Rs One lakh.

⇒ This will also lead to suspension of registration of the doctor by the State medical council if the charges are framed by the court and till the case is disposed off and on conviction for removal of name from the register of the Council for a period of five years for the first offence and permanently for the subsequent offence.

i) The chief Medical Officer (Appropriate Authority) of the concerned District ii) Director Family Welfare of the concerned State /UT *with a copy* Director (PNDT), Ministry of Health and Family Welfare Government of India, Nirman Bhawan New Delhi-110001.

Telefax: 011-23061089. Email: pndt@nic.in *Visit our website: www.mohfw.nic.in*

बेटी बचाओ
save the girl child

Sex test of foetus is illegal

Designed and issued by Ministry of Health & Family Welfare, Government of India