National Rural Health Mission (NRHM)

State Institute of Health & Family Welfare, Jaipur
NRHM

• N…Newer Initiatives.
• R…Rural Poor Population
• H…Holistic Health Package.
• M…Monitoring mechanisms

To cater to the Primary health care needs of vulnerable segment of pop. to bring down IMR and MMR. to attain Pop. Stabilisation.
Mission Goal

Improve:
Access &
Availability to Health care
Quality
Equity
Simple reiteration of
NHP-1983,
HFA-2000,
NHP-2002, or a new paradigm

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NRHM Paradigm Shifts

- Decentralized planning
- Outputs and Outcome based
- Pro-Poor Focus: Equitable systems
- Quality of Care and the IPHS norms
- Bringing the public back into public health
  - At village level: ASHA, VHSC, SHGs, PRIs.
  - At the facility level: RMRS
  - At the management level: Health societies
NRHM Paradigm Shifts

• Governance reform
  ➢ Manpower, Logistics & Procurement processes.
  ➢ Decision making processes
  ➢ Institutional design, Accountability framework

• Convergence
  ➢ Water and sanitation
  ➢ Nutrition
  ➢ Education
An Opportunity for Centre–State Partnership

- Beginning with people and their problem.
- Flexibility to decide and to do.
- Human resource thrust.
- Decentralized management of health.
- Distrust to trust.
- Employment guarantee to service guarantee.
- Accepting the challenge of remoteness.
Why NRHM

- Declining Public Health expenditure (1.3% of GDP in 1990 to 0.9% in 1999)
- Limited synergism in Vertical and Horizontal Health Programs.
- Lack of community ownership
- Lack of integration of issues
Why NRHM

- Regional inequalities
- Population stabilization still not met
- Curative services favor rich
- Poor coverage by Health insurance (only 10%)
- Hospitalization eats 58% of annual income, 25 % pop. falls below poverty line following hospitalization expenses.
A Strategy, for Convergence Partnership
Goals:

- Reduction in IMR and MMR
- Universal access to public health services such as Women’s health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of CD & NCD, 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
# National Goals and MDGs

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<tr>
<th></th>
<th>1990</th>
<th>Current</th>
<th>NPP 2010</th>
<th>NRHM 2012</th>
<th>MDG 2015</th>
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<td>80</td>
<td>53 (SRS-2009)</td>
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<td>37 (NFHS-III)</td>
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<td>&lt;100</td>
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Critical Areas

- Well functioning health facilities
- Quality and accountability in the delivery of health services.
- Responsive health system meeting people's health needs.
- Convergence for effectiveness and efficiency.
NRHM Components

- Communitize
- Flexible Financing
- Improved management through capacity building
- Monitor progress against standards
- Innovation in human resource management
Core Strategies

- Capacity Building of PRIs to own, control & manage public health services.
- Access to improved healthcare through the female health activist (ASHA).
- Village Health Plan through Village Health Committee
- Strengthening sub-centre through an untied fund to enable local planning and action & more Multi Purpose Workers (MPWs).
PHCs and CHCs strengthening, to a normative standard (IPHS -personnel, equipment and management standards).

Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water,
 Integrating vertical programs 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.
➢ 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.
Supplementary Strategies:

- Regulation of Private Sector
- Promotion of PPP
- Mainstreaming AYUSH
- Reorienting medical education
- Regulation of medical care and medical ethics.
- Risk pooling and social health insurance for
  - Accessible,
  - Affordable, accountable and
  - Quality hospital care.
NRHM Focus

18 States, to start with

- Arunachal Pradesh, Assam, Bihar, Chhattisgarh,
- Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram,
- Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim,
- Tripura, Uttaranchal and Uttar Pradesh.
Where to Strike: Infrastructure Up-gradation

**Functional Sub Centres**
- Additional contractual ANMs
- Untied funds
- Community link worker
- Village Health Nutrition committees
- Expanded Medicines supply

**24 x 7 PHCs**
- Three staff nurses
- Annual maintenance grant
- Untied funds
- AYUSH Integration
- RMRS/RKS

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Where to Strike: Infrastructure Up-gradation

- CHCs up gradation
  - First Referral Units
  - Facility survey
  - IPHS
  - Untied funds
  - RMRS/RKS

- DH up gradation
  - Facility survey
  - IPHS
  - RMRS/RKS
Where to Strike:

**Manpower**
- Filling up vacant posts/Creating more posts
- Contractual positions to fill gaps
- Trainings / expanding training capacity
- SBA/ IMNCI/ HMIS Counseling/ Immunization / Planning
- Rational transfer and posting policy

**Health Sector Planning**
- Household surveys & Village Health Plans.
- Integrated Block & District Health Action Plans.
- Annual PIPs / Perspective Plans.
- SPMUs/ DPMUs/ Block PMUs
- NHSRC/ SHSRC
Where to Strike:

**Improved service delivery**
- Citizen’s charter
- Monthly Health & Nutrition Day
- Outsourcing critical service gaps
- Catch up rounds of Immunization
- Improved IP & OP utilization
- Mobility Support / Mobile Medical Units
- Maternity Benefit Schemes

**Systemic improvements**
- Improved logistics.
- Rational / Optimal positioning of manpower
- Rational delegation (financial & Administrative)
- Decentralized procurement
Where to Strike

- Monitoring & Evaluation
- Review meetings
- State visits – evaluation teams, RDs
- Integrated MIS
- External Surveys
- Immunization
- ASHA & JSY
- External Evaluations
- Community monitoring
- State level innovations/ Reforms
Decentralization

- Procurement
- Facility survey
- Village health plans
- Planning at Institutional levels
Operationalizing Functional FRUs

- 24-hour delivery services including normal and assisted deliveries
- Emergency Obstetric Care including surgical interventions like Caesarean Sections(*) and other medical interventions
- New-born Care
- Emergency Care of sick children
- Full range of family planning services including Laproscopic Services

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Operationalizing Functional FRUs

- Safe Abortion Services
- Treatment of STI / RTI
- Blood Storage Facility
- Essential Laboratory Services
- Referral (transport) Services
- 24-hour delivery services, both normal and assisted
- Essential newborn care
Referral for emergencies

Ante-natal care and routine immunization services for children and pregnant women (besides Fixed day services).

Post-natal care

Early and safe abortion services (including MVA)

Family planning services

Prevention and management of RTIs/STIs

Essential laboratory services
Institutional Mechanism

- Village Health & Sanitation Committee (VHSC)
- RKS/RMRS
- District Health Mission,
- State Health Mission,
- Integration of Departments of Health and Family Welfare, at National and State level
- National Mission Steering Group
- Empowered Program Committee
- Standing Mentoring Group
- Task Groups for Selected Tasks
Plan of Action-Components:

1. ASHA
2. Strengthening of Sub-Centers
3. Strengthening of PHCs
4. Strengthening of CHCs for First referral
5. District Health Plan
6. Converging Sanitation & Hygiene under NRHM
7. Strengthening Disease control program
8. Public-private partnership for public Health goals, including regulation of private sector
9. New health financing mechanisms
10. Reorienting health/medical education to support rural health issues
Plan of Action Component (A): ASHA

➢ One per village chosen by and accountable to the Panchayat
➢ Volunteer,
➢ performance-based compensation
➢ facilitate preparation and implementation of the Village Health Plan
➢ GOI-Cost of training, incentives and medical kits
➢ Drug Kit -generic AYUSH and allopathic formulations
Plan of Action Component (B): Strengthening SC

- Sub-centre - Untied Fund for local action @ Rs. 10,000 per annum.
- Joint bank account of the ANM & sarpanch
- Operated by the ANM, in consultation with the village health committee.
- Supply of essential drugs (allopathic AYUSH)
- In case of additional outlays,
  - Multipurpose workers (male)/additional ANMs wherever needed,
  - New sub-centers, and upgrading existing sub-centers, including buildings
Plan of Action Component (C): Strengthening PHCs

- supply of essential drugs and equipment
- Provision of 24 X 7 in 50% PHCs
- Observance of SOPs
- In case of additional Outlays,
  - Program intensification-Comm. Diseases
  - programs for control of NCDs,
  - up-gradation of 100% PHCs for 24 x 7
  - provision of 2nd doctor at PHC level (1 male, 1 female)
Plan of Action Component (D): Strengthening CHCs

- 4276 (March 31, ’09) existing CHCs (30-50 beds) as 24 Hour FRUs, including posting of anesthetists.
- Codification of new IPHS setting norms for:
  - infrastructure,
  - staff,
  - equipment,
  - management
- Promotion of Stakeholder Committees (RKS/ RMRS) for hospital management.
Plan of Action Component (D): Strengthening CHCs

- 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) and bearing their recurring costs
- District - core unit (planning, budgeting & implementation).
- Centrally Sponsored Schemes To be modified in consultation with States.
- All vertical Programs to merge into one common “District Health Mission”/ “State Health Mission”
- Provision of DPMUs
District Planning Components

- Plan Templates, checklists, appraisal criteria, planning tool
- Facilitation & Consultation
- Enabling Environment
- Facility, Manpower & Budget - Rationalizing & Role Clarification
- NGO involvement
- Focus on Community Needs and Participation
- Resource Materials for Planning & Implementation
- Orientation & Training
- Accountability, Monitoring & Evaluation
- Inter and intra sectoral Coordination & Communication
Plan of Action Component (F): Converging Sanitation & Hygiene

- Total Sanitation campaign (TSC) in all districts in X-FYP
- TSC through PRIs
- VHSCs to implement
- ASHA to be incentivized for TSC activities
- IEC
Expected Outcomes by 2012

- Universal Health care, well functioning health care delivery system.
- IMR :30
- MMR: 100
- TFR :2.1
- Malaria Mortality Reduction – 60%
- Kala Azar eliminated by 2010,
- Filaria 80 % by 2010
- Dengue Mortality reduced by 50%
- TB DOTS series – maintain 85% cure rate
- Responsive & Functional Health System
Accomplished So Far

- State and district mission have been setup.
- Health and family welfare have been merged.
- Finalization of State PIPs
- Following documents shared with the states:
  - Mission Document
  - Guidelines on IPHS
  - Guidelines on ASHA
  - Guidelines on State Health Mission and
  - Guidelines on District Health Mission
Accomplished So Far

- ASHAS: 861548 selected against six lacs
- Mgt. support: over 1500 professionals (CA/MBAs) appointed and 521 district level PMU and 2882 block level PMU’s support NRHM.
- Financial Management: Financial management Group set up under NRHM.
- Mother NGOs: 334 MNGOs appointed for 340 districts. Fully involved in ASHA training and other activities.
Accomplished So Far

- Health Action Plan: State PIP received from 31 states during 2006-07 and 35 states/ UTs PIP received during 11-12.
- PIPs appraised and funds released
- Integrated District Health Action Plans have been prepared in 636 districts in various states.
- Institutional Delivery: 49250358 women benefited since initiation

Source: MoHFW
Infant Mortality Rate (India)

Source: SRS, 2011
Infant Mortality Rate (Rajasthan)

Source: SRS

SIHFW: an ISO9001: 2008 certified institution
Maternal Mortality Ratio

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<th>Year</th>
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<th>Rajasthan</th>
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<td>2001</td>
<td>327</td>
<td>501</td>
</tr>
<tr>
<td>2003</td>
<td>301</td>
<td>445</td>
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<td>254</td>
<td>388</td>
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<td>2009</td>
<td>212</td>
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Source: SRS
Total Fertility Rate

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<tr>
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<th>NFHS I</th>
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<td>3.8</td>
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NRHM Rajasthan: Achievements

Source: www.rajswasthya.nic.in
NRHM: Rajasthan – Achievements

- 44858 ASHAs working
- 40476 VHSC constituted
- 1010210 JSY beneficiaries (2011-12)
- JSY helpline has been initiated
- Emergency Health Transport Scheme successfully implemented through 108 ambulance services

Source: www.rajswasthya.nic.in
Thank You

For more details log on to
www.sihfwrajasthan.com
or
contact: Director-SIHFW
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sihfwraj@yahoo.co.in