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

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.

NRHM ?

Program ?

Scheme ?

Project ?

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

	1990	Current	NPP 2010	NRHM 2012	MDG 2015
IMR	80	53 (SRS-2009)		<30	<27
N M R	53	37 (NFHS-III)		<20	<20
U5M Rate	107	74.3 (NFHS-III)		-	<36
ID(%)		45.5 (DLHS-3)	80	80	
TFR		2.7 (NFHS-III)	2.1	2.1	
MMR		254 (SRS-2006)		<100	<100

Critical Areas

- Well functioning health facilities
- Quality and accountability in the delivery of health services.
- Responsive health system meeting people health need.
- 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

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

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 (I 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

- Amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.
- 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)

Year	IMR
1951	134
1961	146
1971	138
1981	110
1991	80
2001	58.5
2011	47

Source:SRS,2011

Infant Mortality Rate (Rajasthan)

1981	1991	2001	2011
108	79	81	55

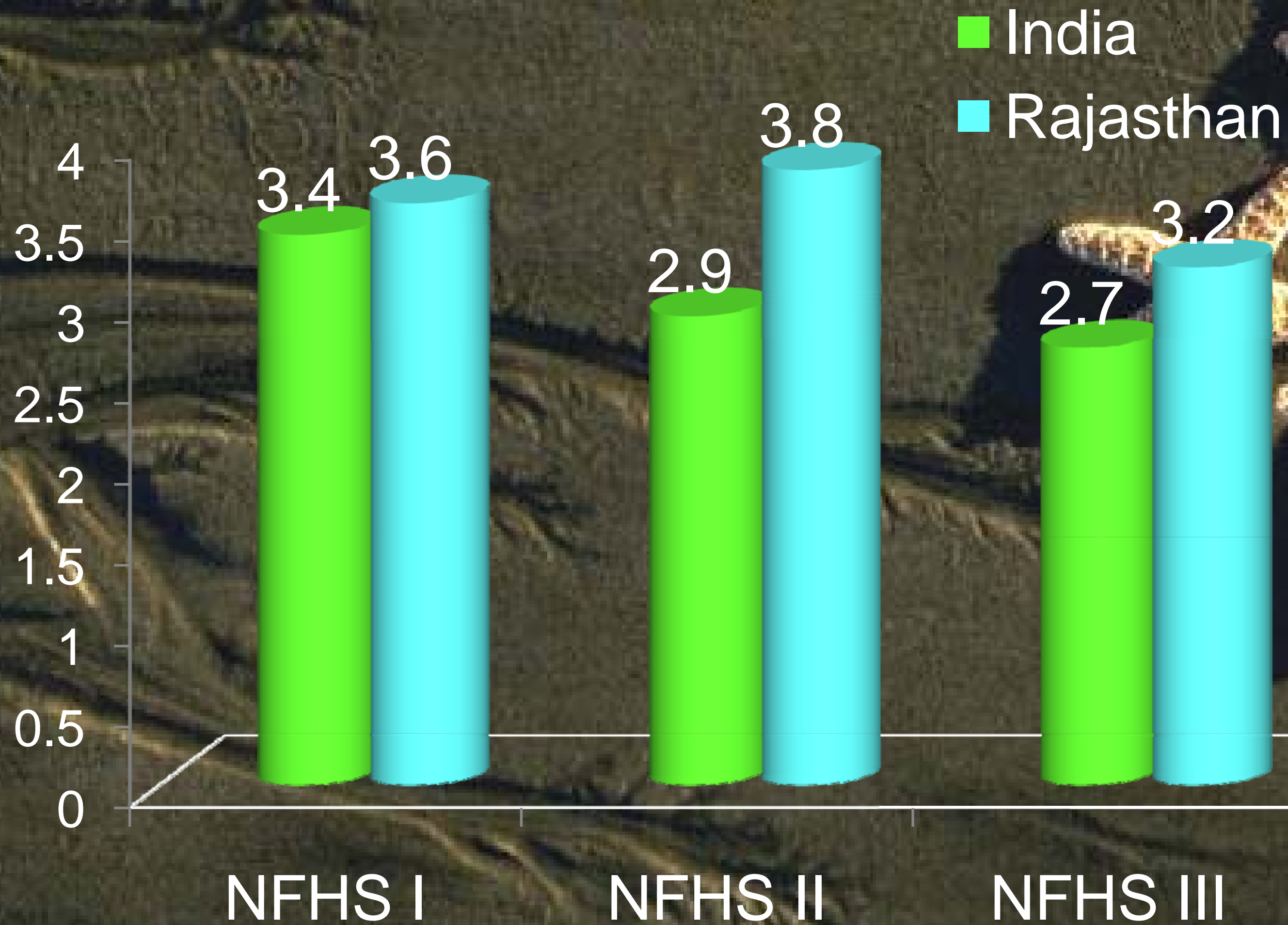
Source: SRS

Maternal Mortality Ratio

	India	Rajasthan
2001	327	501
2003	301	445
2006	254	388
2009	212	318

Source: SRS

Total Fertility Rate



NRHM Rajasthan: Achievements

	ID (in lakhs)	JSY Beneficiaries (in lakhs)
2006-07	7.22	3.88
2007-08	10.18	7.75
2008-09	11.36	9.17
2009-10	12.02	9.78
2010-11	12.07	9.86
2011-12	12.79	10.1

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

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