

# **NATIONAL RURAL HEALTH MISSION**

**Meeting people's health needs in rural areas**

**Framework for Implementation  
2005-2012**

**Ministry of Health and Family Welfare**  
Government of India  
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### TIME LINE FOR NRHM ACTIVITIES

	<b>Activity</b>	<b>Phasing and time line</b>	<b>Outcome Monitoring</b>
1	Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations.	50% by 2007 100% by 2008	Quarterly Progress Report
2	Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them.	30% by 2007 100% by 2008	Quarterly Progress Report
3	2 ANM Sub Health Centres strengthened/established to provide service guarantees as per IPHS, in 1,75000 places.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
5	6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 50% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
6	1800 Taluka/ Sub Divisional Hospitals strengthened to provide quality health services.	30% by 2007 50% by 2010 100% by 2012	Annual Facility Surveys. External assessments.
7	600 District Hospitals strengthened to provide quality health services.	30% by 2007 60% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
8	Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.	50% by 2007 100% by 2009	Annual Facility Surveys. External assessments.
9	District Health Action Plan 2005-2012 prepared by each district of the country.	50% by 2007 100% by 2008	Appraisal process. External assessment.
10	Untied grants provided to each Village	50% by 2007	Independent

	Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.	100% by 2008	assessments. Quarterly Progress reports.
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress Reports.
12	State and District Health Society established and fully functional with requisite management skills.	50% by 2007 100% by 2008	Independent assessment.
13	Systems of community monitoring put in place.	50% by 2007 100% by 2008.	Independent assessment.
14	Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.	50% by 2007 100% by 2008.	External assessment.
15	SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HOV/AIDS, etc.	30% by 2007 50% by 2008 70% by 2009 100% by 2012.	Annual Facility Surveys. Independent assessments.
16	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.	30% by 2007 60% by 2008 100% by 2009	Appraisal process. Independent assessment.
17	Facility and household surveys carried out in each and every district of the country.	50% by 2007 100% by 2008	Independent assessment.
18	Annual State and District specific Public Report on Health published	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
19	Institution-wise assessment of performance against assured service guarantees carried out.	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
20	Mobile Medical Units provided to each district of the country.	30% by 2007 60% by 2008 100% by 2009.	Quarterly Progress Report.

# I. BACKGROUND

## *The State of Public Health in India*

1. India has registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and material mortality over the last few decades. In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many States and regions is in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. India is in the midst of an epidemiological and demographic transition – with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to an ageing of the population. An estimated 5 million people in the country are living with HIV/AIDS, a threat which has the potential to undermine the health and developmental gains India has made since its independence. Non-communicable diseases such as cardio-vascular diseases, cancer, blindness, mental illness and tobacco use related illnesses have imposed the chronic diseases burden on the already over- stretched health care system in the country. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on the poor, and on women, scheduled castes and tribes especially those who live in the rural areas of the country. The inequity is also reflected in the skewed availability of public resources between the advanced and less developed states.

2. Public spending on preventive health services has a low priority over curative health in the country as a whole. Indian public spending on health is amongst the lowest in the world, whereas its proportion of private spending on health is one of the highest. More than Rs. 100,000 crores is being spent annually as household expenditure on health, which is more than three times the public expenditure on health. The private sector health care is unregulated pushing the cost of health care up and making it unaffordable for the rural poor. It is clear that maintaining the health system in its present form will become untenable in India. Persistent malnutrition, high levels of anemia amongst children and women, low age of marriage and at first child birth, inadequate

safe drinking water round the year in many villages, over-crowding of dwelling units, unsatisfactory state of sanitation and disposal of wastes constitute major challenges for the public health system in India. Most of these public health determinants are co-related to high levels of poverty and to degradation of the environment in our villages. Thus, the country has to deal with multiple health crises, rising costs of health care and mounting expectations of the people. The challenge of quality health services in remote rural regions has to be met with a sense of urgency. Given the scope and magnitude of the problem, it is no longer enough to focus on narrowly defined projects. The urgent need is to transform the public health system into an accountable, accessible and affordable system of quality services.

### **The Vision of the Mission**

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur , Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa , Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9% GDP to 23% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Address inter State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.



## **II. GOALS, STRATEGIES AND OUTCOMES OF THE MISSION**

3. The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.

### **The Objectives of the Mission**

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

**The expected outcomes from the Mission as reflected in statistical data are:**

- IMR reduced to 30/1000 live births by 2012.
- Maternal Mortality reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.
- Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
- Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
- Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
- Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012.
- Cataract operations-increasing to 46 lakhs until 2012.
- Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.
- Upgrading all Community Health Centers to Indian Public Health Standards.
- Increase utilization of First Referral units from bed occupancy by referred cases of less than 20% to over 75%.
- Engaging 4,00,000 female Accredited Social Health Activists (ASHAs).

**The expected outcomes at Community level**

- Availability of trained community level worker at village level, with a drug kit for generic ailments.
- Health Day at Aanganwadi level on a fixed day/month for provision of immunization, ante/post natal check ups and services related to mother and child health care, including nutrition.
- Availability of generic drugs for common ailments at sub Centre and Hospital level.
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level and assured referral-transport-communication systems to reach these facilities in time.

- Improved access to universal immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme.
- Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under the Janani Surakshya Yojana (JSY) for the below poverty line families.
- Availability of assured health care at reduced financial risk through pilots of Community Health Insurance under the Mission.
- Availability of safe drinking water.
- Provision of household toilets.
- Improved outreach services to medically under-served remote areas through mobile medical units.
- Increase awareness about preventive health including nutrition.

#### **The core strategies of the Mission**

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels)
- Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.

- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.
- Technical support to National, State and District Health Mission, for public health management
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.
- Promoting non-profit sector particularly in underserved areas.

### **The supplementary strategies of the mission**

- Regulation for Private sector including the informal Rural Medical Practitioners (RMP) to ensure availability of quality service to citizens at reasonable cost.
- Promotion of public private partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of medical care and medical ethics.
- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

### **The Special Focus States**

4. While the Mission covers the entire country, it has identified 18 States for special attention. These states are the ones with weak public health indicators and/or weak health infrastructure. These are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. While all the Mission activities are the same for all the States/UTs in the country, the high focus States would be supported for having an Accredited Social Health Worker (ASHA) in all villages with a population of 1000 and also in having Project Management Support at the State and District level. It also articulated a need for including the health needs of the urban poor while planning for health through District

Health Plans. The Mission is to be implemented over a period of seven years (2005-2012). The NRHM District Health Plans will cover District and Sub Divisional/Taluk Hospitals as well as they cater to rural households as well.

### **The efforts so far**

5. The emphasis in the first six months since the launch of the mission has been on the preparatory activities necessary for the laying the ground work for implementation of the Mission such as:

#### *Institutional Framework*

- State and District Missions have been set up in all States and UTs except UP, Goa, Delhi and Chandigarh.
- The Departments of Health and Family Welfare have been merged at the level of the Gol and the same is being replicated in the states.
- The institutional framework (Mission Steering Group, Empowered Programme Committee, Mission Directorate), at the Central and State levels have been put in place.
- State launch of the Mission has been organized in Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal and North Eastern States in which apart from the state level functionaries, the Chairmen, District Boards, District Collectors and Civil Surgeons of various districts have taken part. The State Launches have doubled up as orientation workshop for the district level functionaries.
- The Mission Document; Guidelines on Indian Public Health Standards; Guidelines for ASHA; Training Modules for ASHA; Guidelines for State Health Mission, District Health Mission and merger of societies have been shared with the States.
- MOU to be signed with States have been shared with the States. MOUs clearly spell out the reform commitment of the States in terms of their enhanced public spending on health, full staffing of management structures, steps for decentralization and promotion of district level planning and implementation of various activities, achievement of milestones under the leadership of Panchayati Raj Institutions.

- Five Task Groups set up on the goals of the Mission, Strengthening Public Health Infrastructure, Role of PRIs, ASHA, Technical support to NRHM have completed their work.
- Three Task Groups on Health Financing, District Planning and Public Private Partnerships are in the process of finalizing their recommendations. Three new Task Groups on Urban Health, Medical Education, and Financial Guidelines set up.

### Programmes

- Reproductive and Child Health Programme – II (RCH-II) and the Janani Suraksha Yojana (JSY) launched.
- Polio eradication programme intensified – cases reduced from 134 in 2004-05 to 63 (up to now).
- Sterilization compensation scheme launched.
- Accelerated implementation of the Routine Immunization programme taken up. Catch up rounds taken up this year in the States of Bihar, Jharkhand and Orisaa.
- Ground work for introduction of JE vaccine completed.
- Ground work for Hepatitis vaccines to all States completed.
- Auto Disabled Syringes introduced throughout the country.
- State Programme Implementation Plans for RCH II appraised by the National Programme Coordination Committee set up by the Ministry. Funds to the extent of 26.14% i.e. Rs. 1811.74 crore have been released under NRHM Outlay.

### Infrastructure

- Facility survey introduced.
- Repair and renovation of Sub Centres under RCH- II.
- untied fund of Rs. 10,000 to SHCs;
- Selection of 2 CHCs in each State for upgradation to IPHS.
- Upgradation of CHCs as First Referral Units and Primary Health Centres to 24X7 units taken up.
- Release of funds for upgradation of two CHCs per district to IPH Standards.

### District Plans

- Strengthening of planning process in 50% of the districts of the EAG states.
- ASHAs selected. Selection of ....ASHAs in progress in EAG States.
- Training of the state/district level trainers of ASHAs completed. District level training taken up.

### Procurement

- An Empowered Procurement Wing is being set up in the Ministry.
- Procurement procedures are being finalized and procedural assistance being provided to the states in the procurement activities.

### Technical Support to the Mission

- A National Health System Resource Centre (NHSRC) being set up at national level. A Regional Resource Centre set up for North Eastern States. Ground work prepared for State Resource Centres.
- 700 Consultants (MBA/CA) appointed for State/District level Programme Management Units.
- MOUs signed with the States clearly articulating the commitment of the States.

### Training and Capacity Building

- Finalized comprehensive training strategy.
- Training started on Skilled Birth Attendant.

### **III. CRITICAL AREAS FOR CONCERTED ACTION:**

6. The launch of NRHM has provided the Central and the State Governments with a unique opportunity for carrying out necessary reforms in the Health Sector. The reforms are necessary for restructuring the health delivery system as well as for developing better health financing mechanisms. The strengthening and effectiveness of health institutions like SHCs/PHCs/CHCs/Taluk/District Hospitals have positive consequences for all health programmes [TB, Malaria, HIV/AIDS, Filariasis, Family Welfare, Leprosy, Disease Surveillance etc.] as all programmes are based on the assumption that a functioning public health system actually exists. The submission of the Task Force Reports and the recently published Reports of the Commission on Macroeconomics and Health and Mid-Term Appraisal by the Planning Commission provide valuable insights on these issues. In order to improve the health outcomes, it is necessary to give close attention to critical areas like service delivery, finances (including risk pooling), resources (human, physical, knowledge technology) and leadership. The following are identified as some of the areas for concerted action:-

- Well functioning health facilities;
- Quality and accountability in the delivery of health services;
- Taking care of the needs of the poor and vulnerable sections of the society and their empowerment;
- Prepare for health transition with appropriate health financing;
- Pro-people public private partnership;
- Convergence for effectiveness and efficiency.
- Responsive health system meeting people's health needs.

#### **The priorities, the constraints, and action to overcome them**

7. The table given below brings out an analysis of the priorities, constraints in achieving progress in those priority areas and the action needed to overcome those constraints:-



Sl. No.	Priorities	Constraints	Action to overcome constraints
1	Functional facilities - Establishing fully functional Sub Health Centres / PHCs/ CHCs/Sub Divisional/District Hospitals.	<ul style="list-style-type: none"> <li>• Dilapidated or absent physical infrastructure</li> <li>• Non-availability of doctors/paramedics</li> <li>• Drugs/ vaccines shortages</li> <li>• Dysfunctional equipments</li> <li>• Untimely procurements</li> <li>• Chocked fund flows</li> <li>• Lack of accountability framework</li> <li>• Inflexible financial resources.</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Infrastructure/equipments</li> <li>• Management support</li> <li>• Streamlined fund flows</li> <li>• Contractual appointment and support for capacity development</li> <li>• Pooling of staff/optimal utilization</li> <li>• Improved MIS</li> <li>• Streamlined procurement</li> <li>• Local level flexibility</li> <li>• Community /PRI/RKS for accountability / M&amp;E</li> <li>• 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.</li> </ul>
2	Increasing and improving human resources in rural areas	<ul style="list-style-type: none"> <li>• Non-availability of doctors</li> <li>• Non-availability of paramedics</li> <li>• Shortage of ANMs/MPWs.</li> <li>• Large jurisdiction and poor monitoring.</li> <li>• No accountability</li> <li>• Lack of any plan for career advancement or for systematic skill upgradation.</li> <li>• No system of appraisal with incentives/disincentives for good/poor performance and governance related problems.</li> </ul>	<ul style="list-style-type: none"> <li>• Local preference</li> <li>• Contractual appointment to a facility for filling short term gaps.</li> <li>• Management of facilities including personnel by PRI Committees.</li> <li>• Train and develop local residents of remote areas with appropriate cadre structure and incentives.</li> <li>• Multi-skilling of doctors / paramedics and continuous skill upgradation</li> <li>• Convergence with AYUSH</li> <li>• Involvement of RMPs.</li> <li>• Partnership with non-State Stakeholders.</li> </ul>

3	Accountable health delivery	<ul style="list-style-type: none"> <li>• Panchayati Raj Institutions / user groups have little say in health system</li> <li>• No village / hamlet level unit of delivery</li> <li>• No resources for flexible community action</li> </ul>	<ul style="list-style-type: none"> <li>• Referral chain from hamlet to hospital</li> <li>• Control and management of Health facilities by PRIs</li> <li>• Budget to be managed by the PRI/User Group</li> <li>• PRI/User Group mandate for action</li> <li>• Untied funds and Household surveys</li> </ul>
4	Empowerment for effective decentralization and Flexibility for local action	<ul style="list-style-type: none"> <li>• Only tied funds</li> <li>• Local initiatives have no role</li> <li>• Centralized management and schematic inflexibility</li> <li>• Lack of mandated functions of PRIs / User Groups</li> <li>• Lack of financial and human resources for local action</li> <li>• Lack of indicators and local health status assessments that can contribute to local planning.</li> <li>• Poor capability to design and plan programmes.</li> </ul>	<ul style="list-style-type: none"> <li>• Untied funds at all levels including local levels with flexibility for innovation.</li> <li>• Increasing Autonomy to SHC/PHC/CHC/Taluk/ District Hospital along with well monitored quality controls and matched fund flows.</li> <li>• Hospital Management Committees</li> <li>• Evolving diverse appropriate PRI / User framework</li> <li>• PRI/User group action at Village / GP / Block and District level</li> </ul>
5	Reducing maternal and child deaths and population stabilization	<ul style="list-style-type: none"> <li>• Lack of 24X7 facilities for safe deliveries.</li> <li>• Lack of facilities with for emergency obstetric care.</li> <li>• Unsatisfactory access and utilization of skilled assistance at birth</li> <li>• Lack of equity/sensitivity in family welfare services/ counseling.</li> <li>• Non-availability of Specialists for anaesthesia, obstetric care, paediatric care, etc.</li> <li>• No system of new born care with adequate referral support.</li> <li>• Lack of referral transport systems.</li> </ul>	<ul style="list-style-type: none"> <li>• Functional public health system including CHCs as FRUs, PHC-24X7, SHCs, Taluk/District Hospital</li> <li>• Trained ANM locally recruited</li> <li>• Institutional delivery</li> <li>• Quality services at facility</li> <li>• Expanding facilities capable of providing contraception including quality sterilization services on a regular basis so as to meet existing demand and unmet needs.</li> </ul>

		<ul style="list-style-type: none"> <li>• Need for universalization of ICDS services and universal access to good quality ante-natal care.</li> <li>• Need for linkage with parallel improvement efforts in social and gender equity dimensions.</li> <li>• Lack of linkages with other dimensions of women's health and women friendliness of public health facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Thrust on Skilled Birth Attendants/local appointment and training</li> <li>• Training of ASHA</li> <li>• New born care for reducing neo natal mortality;</li> <li>• Active Village Health and Sanitation Committee;</li> <li>• Training of Panchayat members.</li> <li>• Expanding the ANM work force especially in remote areas and in larger village and semi-urban areas.</li> <li>• Planned synergy of ANM, AWW, ASHA work force and where available with local SHGs and women's committees.</li> <li>• Linkage of all above to the Panchayat committee on health.</li> </ul>
6	Action for preventive and promotive health	<ul style="list-style-type: none"> <li>• Poor emphasis on locally and culturally appropriate health communication efforts.</li> <li>• No community action &amp; household surveys</li> <li>• No action on promoting healthy lifestyles whether it be fighting alcoholism or promoting tobacco control or promoting positive actions like sports/yoga etc.</li> <li>• Weak school health programmes</li> <li>• Absence of Health counseling/early detection.</li> <li>• Compartmentalized IEC of every scheme</li> </ul>	<ul style="list-style-type: none"> <li>• Untied funds for local action</li> <li>• Convergence with other departments/institutions</li> <li>• IEC Training and capability building</li> <li>• Working together with ICDS/TSC/CRSP/SSA/MDM</li> <li>• Improved School Health Programmes</li> <li>• Common approach to IEC for health</li> <li>• Involvement of PRIs in health.</li> <li>• Oral hygiene movement.</li> </ul>
7	Disease Surveillance	<ul style="list-style-type: none"> <li>• Vertical programmes for communicable diseases</li> <li>• No integrated / coordinated action for disease surveillance at various levels in place yet.</li> </ul>	<ul style="list-style-type: none"> <li>• Horizontal integration of programmes through VH&amp;SC,SHC,PHC,CHC.</li> <li>• Initiation and Integration of IDSP at all levels.</li> </ul>

		<ul style="list-style-type: none"> <li>No periodic data collection and analysis and no district and block specific epidemiological data available</li> </ul>	<ul style="list-style-type: none"> <li>Building district / Sub-district level epidemiological capabilities.</li> </ul>
8	Forging hamlet to hospital linkage for curative services	<ul style="list-style-type: none"> <li>Entitlements of households not defined</li> <li>No community worker</li> <li>No well defined functional referral/transport/communication system.</li> <li>No institutionalized feedback mechanism to referring ASHA/peripheral health facility in place</li> </ul>	<ul style="list-style-type: none"> <li>ASHA/AWW/ANM</li> <li>Household /facility surveys/survey of non – governmental providers for entitlements.</li> <li>Linkages with SHC / PHC / CHC for referral services</li> </ul>
9.	Health Information System.	<ul style="list-style-type: none"> <li>Absence of a Health Information System facilitating smooth flow of information.</li> <li>Not possible to make informed choices</li> </ul>	<ul style="list-style-type: none"> <li>A fully functional two way communication system leading to effective decision making.</li> <li>Publication of State and District Public Reports on Health.</li> </ul>
10.	Planning and monitoring with community ownership	<p>No local planning, no household surveys, no Village Health Registers.</p> <p>Lack of involvement of local community, PRI, RKS, NGOs in monitoring of public health institutions like SHC/PHC/CHC/Taluk/District Hospitals.</p>	<p>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 &amp; Health. Promote education of women SC/ST &amp; other vulnerable groups.</p>
11	Work towards women's empowerment and securing entitlements of SCs /STs /OBCs /Minorities	<p>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.</p>	<p>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.</p>

12.	Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water etc. with community support.	<ul style="list-style-type: none"> <li>• Vertical implementation of programme.</li> <li>• Only curative care.</li> <li>• Inadequate service delivery.</li> <li>• Non-involvement of community.</li> </ul>	<ul style="list-style-type: none"> <li>• Convergence of programmes.</li> <li>• Preventive care.</li> <li>• Health &amp; Education</li> <li>• Empowering Communities.</li> <li>• Providing functional health facility [SHC], PHC [CHC] for effective intervention.</li> </ul>
13.	Chronic disease burden.	<ul style="list-style-type: none"> <li>• Double disease burden.</li> <li>• Lack of stress on preventive health.</li> <li>• Lack of integration of programmes with main health programmes.</li> <li>• No IEC/advocacy.</li> <li>• Inadequate Policy interventions.</li> </ul>	<ul style="list-style-type: none"> <li>• Village to National level integration .</li> <li>• Stress on preventive Health</li> <li>• IEC/Advocacy</li> <li>• Help of NGOs</li> <li>• Policy measures.</li> </ul>
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,	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Guaranteeing hospitalization at functional facilities</li> </ul>

## **IV. BROAD FRAMEWORK FOR IMPLEMENTATION**

8. Based on the analysis of the priorities, constraints and the action to overcome them, a broad framework of implementation of NRHM is proposed as follows:

### **A. Action at the Central level**

9. For development of an effective health system, a broad overview of the current health status, and development of appropriate policy interventions is necessary. Regulations and setting standards for measuring performance of public/private sector in health, issuing guidelines to help the states, development of partnership with non governmental stakeholders, developing framework for effective interventions through capacity development and decentralization including transfer of schemes and financing in the states are areas where the Central Government would continue to play a role. Effective monitoring of performance, support for capacity development at all levels, sharing the best national and international practices, and providing significantly more financial resources to drive reforms and accountability, disease surveillance, monitoring & evaluation will be the thrust of the Central Government's interventions.

### **B. Leadership of States**

10. The NRHM is an effort to strengthen the hands of States to carry out the required reforms. The Mission would also provide additional resources to the States to enable them to meet the diverse health needs of the citizens. While recognizing the leadership role of the states in this regard, it is proposed to provide necessary flexibility to the States to take care of the local needs and socio-cultural variations. In turn, States will decentralize planning and implementation arrangements to ensure that need based and community owned District Health Action Plans become the basis for interventions in the health sector. The States would be urged to take up innovative schemes to deal with local issues. Keeping in view the decentralization envisaged under the NRHM, the States would be required to devolve sufficient administrative / financial powers to the PRIs. At the same time, the States are also required to take action to increase their expenditure on health sector by at least 10% every year over the Mission period. The States would also be expected to adhere to mutually agreed milestones which would be reflected in a MOU to be signed with each State. The MOU and its indicators are placed

at Annex-VII. It may be mentioned here that even though under RCH-II, an effort has been made to integrate a number of schemes, there still exists many schemes for which the funds flow to the States in a tied manner thus hampering flexibility and presenting difficulties in monitoring them. Verticality of the programmes has also led to duplication of efforts and thereby wastage of scarce resources. The Central Government on its part would decentralize most, if not all of the schemes to the states. The States would also be supported in their endeavour to build capacity for handling the complex health issues.

**C. Institutionalizing community led action for health**

11. Nearly three fourth of the population of the country live in villages. This rural population is spread over more than 10 lakh habitations of which 60% have a population of less than 1000. If the Mission of Health for All is to succeed, the reform process would have to touch every village and every health facility. Clearly it would be possible only when the community is sufficiently empowered to take leadership in health matters. The Panchayati Raj institutions, right from the village to district level, would have to be given ownership of the public health delivery system in their respective jurisdiction. Some States like Kerala, West Bengal, Maharashtra and Gujarat have already taken initiatives in this regard and their experiments have shown the positive gains of institutionalizing involvement of Panchayati Raj institutions in the management of the health system. Other vibrant community organizations and women's groups will also be associated in communitization of health care.

12. The NRHM would seek to empower the PRIs at each level i.e. Gram Panchayat, Panchayat Samiti (Block) and Zilla Parishad (District) to take leadership to control and manage the public health infrastructure at district and sub district levels.

- The Village Health and Sanitation Committee (VHSC) will be formed in each village (if not already there) within the over all framework of Gram Sabha in which proportionate representation from all the hamlets would be ensured. Adequate representation to the disadvantaged categories like women, SC / ST / OBC / Minority communities would also be given.
- The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of VHSCs.
- The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located. All other Gram

Panchayats covered by the PHCs would be suitably represented in its management.

- The block level PHC and CHC will have involvement of Panchayati Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.
- The Zilla Parishad at the district level will be directly responsible for the budgets of the health sector and for planning for people's health needs.
- With the development and capacities and systems the entire public health management at the district level would devolve to the district health society which would be under the effective leadership and control of the district panchayat, with participation of the block panchayats.

13. To institutionalize community led action for health, NRHM has sought amendments to acts and statutes in States to fully empower local bodies in effective management of the health system. NRHM would attempt to transfer funds, functionaries and functions to PRIs. Concerted efforts with the involvement of NGOs and other resource institutions are being made to build capacities of elected representatives and user group members for improved and effective management of the health system. To facilitate local action, the NRHM will provide untied grants at all levels [Village, Gram Panchayat, Block, District, VHSC, SHC, PHC & CHC]. Monitoring committees would be formed at various levels, with participation of PRI representatives, user groups and CBO / NGO representatives to facilitate their inputs in the monitoring planning process, and to enable the community to be involved in broad based review and suggestions for planning. A system of periodic 'Jan Sunwai' or 'Jan Samvad' at various levels would empower community members to engage in giving direct feedback and suggestions for improvement in Public health services.

#### **D. Promoting Equity**

14. This is one of the main challenges under NRHM. Empowering those who are vulnerable through education & health education, giving priority to areas/hamlets/households inhabited by them, running fully functional facilities, exemption for below poverty line families from all charges, ensuring access, risk pooling, human resource development / capacity building, recruiting volunteers from amongst them are important strategies under the Mission. These are reflected in the planning



process at every level. Studies have revealed the unsatisfactory health indicators of socially and economically deprived groups and NRHM makes conscious efforts to address this inequity. The percentage of vulnerable sections of society using the public health facilities is a benchmark for the performance of these institutions.

**E. Promoting Preventive Health**

15. As stated earlier, the Health System in the country is oriented towards curative Health. The NRHM would increase the range and depth of programmes on Health Education / IEC activities which are an integral part of activities under the Mission at every level. In addition it would work with the departments of education to make health promotion and preventive health an integral part of general education. The Mission would also interact with the Ministry of Labour for occupations health and the Ministry of women and child for women and child health to ensure due emphasis on preventive and promotive health concerns.

**F. Dealing with Chronic Diseases**

16. India has one of the highest disease burdens in the world. The number of deaths due to chronic diseases are expected to rise from 3.78 million in 1990 (40-47% of all deaths) to 7.63 million by 2020 (66.7% of all deaths). Tobacco, cancer, diabetes and renal diseases, cardio vascular diseases, neurological diseases and mental health problems and the disability that may arise due to the chronic diseases are major challenges the Mission has to deal with. The already over stretched health system has to absorb the additional burden of chronic diseases, especially in the rural areas. Both preventive and curative strategies along with mobilization of additional resources are needed. It is proposed to integrate these with the regular health care programmes at all levels.

**G. Reducing child and maternal mortality rates and reducing fertility rates – population stabilization through quality services**

17. NRHM provides a thrust for reduction of child and maternal mortality and reduce the fertility rates. The approach to population stabilization is to provide quality health services in remote rural areas along with a wide range of contraceptive choices to meet the unmet demand for these services. Efforts are on be to provide quality Reproductive Health Services (including delivery, safe abortions, treatment of Reproductive tract

infections and Family Planning Services to meet unmet needs, while ensuring full reproductive choices to women). The strategy also is to promote male participation in Family Planning. Reduction of IMR requires greater convergent action to influence the wider determinants of health care like female literacy, safe drinking water, sanitation, gender and social empowerment, early child hood development, nutrition, marriage after 18, spacing of children, and behavioral changes etc. Within the health sector, the thrust is on promoting Integrated Management of Neo natal and child care (IMNCI). The main strategy for maternal mortality focuses on safe/institutional deliveries at functional health facilities in the governmental and non-governmental sectors. Efforts to develop competencies needed for Skilled Birth Attendants (SBAs) in the entire cadre of Staff Nurses and ANMs as also in select medical officers will also be undertaken. Regular training of select Medical Officers to administer anesthesia has been taken up. Also multi skill training of Medical Officers, ANMs and Para-medics will be initiate to close specialist skill gaps. Intensified IEC would be pursued to ensure behavioral changes that relate to better child survival and women's health i.e. breast feeding, adequate complementary feeding of the young child, spacing, age at marriage, education of the girl child. Adolescent health is another area of action under the NRHM. CHCs are being upgraded to FRUs for providing referral services to the mother and child and taking care of obstetric emergencies and complications for provision of safe abortion services and for prevention, testing/counseling in respect of HIV AIDS. Reduction in IMR/MMR will also be closely monitored through social audit, which is being introduced at the Panchayat level.

#### **H. Management of NRHM activities at State / District / Sub district level**

##### **Block Level Pooling**

18. The success of decentralization experiment would depend on the strength of the pillars supporting the process. It is imperative that management capacities be built at each level. To attain the outcomes, the NRHM would provide management costs upto 6% of the total annual plan approved for a State/district as has been introduced under the RCH-II programme. Apart from medical and para-medical staff, such services would include skills for financial management, improved community processes, procurement and logistics, improved collection and maintenance of data, the use of information technologies, management information system and improved monitoring and evaluation etc. The NRHM would also establish strong managerial capacity at the block level as

blocks would be the link between the villages and the districts. At the district level the Mission would support and insist on developing health management capacities and introducing policies in a systematic manner so that over time all district programme officers and their leadership are professionally qualified public health managers. Management structures at all levels will be accountable to the Panchayati Raj institutions, the State Level Health Mission and the National Level Missions/Steering Group.

19. The amount available under the management cost could also be used for improving the work environment as such improvements directly lead to better outcomes. The management structure holds the key to the success of any programme and efforts to develop appropriate arrangements for effectively delivery of NRHM with detailing, will be a priority. Clarity of tasks, fund flows, powers, functions, account keeping, audit, etc. will be attempted at all levels.

20. Based on the outcomes expected in NRHM, the existing staff of Health Departments at SHC, PHC, CHC, Block, District, State and National levels are being carefully assessed to see how structures can be reoriented to deliver more efficiently and effectively. States will constantly undertake review of management structure and devolution of powers and functions to carry out any mid course correction. Block Level Pooling will be one of the priority activity under the NRHM. Keeping in view the time line needed to make all facilities fully functional, Specialists working in PHCs would be relocated at CHCs to facilitate their early conversion to FRUs. Outreach programmes are being organized with “block pooled” CHCs as the nodal point. NRHM will attempt to set up Block level managerial capacities as per need. Creation of a Block Chief Medical Officer’s office to support the supervision of NRHM activities in the Block, would be a priority. Support to block level CHCs will also aim at improving the mobility and connectivity of health functionaries with support for Ambulances, telephones, computers, electric connection, etc.

#### **I. Human resources for rural areas**

21. Improvement in the health outcomes in the rural areas is directly related to the availability of the trained human resources there. The Mission aims to increase the availability through provision of more than 4 lakh trained women as ASHAs / Community Health Workers (resident of the same village/hamlet for which they are appointed as

ASHA). The Mission also seeks to provide minimum two Auxiliary Nurse Mid-wives (ANMs) (against one at present) at each Sub Health Centre (SHC) to be fully supported by the Government of India. Similarly against the availability of one staff nurse at the PHC, it is proposed to provide three Staff Nurses to ensure round the clock services in every PHC. The Out-patient services would be strengthened through posting/ appoint on contract of AYUSH doctors over and above the Medical Officers posted there. It will be for the States to decide whether they would integrate AYUSH by collocation at PHC or by new contractual appointment. GOI support will be for all new contractual posts and not for existing vacancies that States have to fill up. The Mission seeks to bring the CHCs on a par with the Indian Public Health Standards (IPHS) to provide round the clock hospital-like services. As far as manpower is concerned, it would be achieved through provision of seven Specialists as against four at present and nine staff nurses in every CHC (against seven at present). A separate AYUSH set up would be provided in each CHC/PHC. Contractual appointment of AYUSH doctors will be provided for this purpose. This would be reflected in the State Plans as per their needs.

22. Given the current problems of availability of both medical as well as paramedical staff in the rural areas, the NRHM seeks to try a range of innovations and experiments to improve the position. These include incentives for compulsory rural posting of Doctors, a fair, transparent transfer policy, involvement of Medical Colleges, improved career progression for Medical / Para Medical staff, skill upgradation and multi-skilling of the existing Medical Officers, ANMs and other Para Medical staff, strengthening of nursing / ANM training schools and colleges to produce more paramedical staff, and partnership with non governmental stakeholders to widen the pool of institutions. The Ministry has already initiated the process for the upgradation of ANMs into Skilled Birth Attendants (SBA) and for providing six month anaesthesia course to the Medical Officers. Convergence of various schemes under NRHM including the disease control programmes, the RCH-II, NACO, disease surveillance programme, would also provide for optimum / efficient utilization of all paramedical staff and help to bring down the operational costs.

**J. National and State level Resource Centres for capacity development**

23. Decentralized Planning, preparation of District Plans, community ownership of the health delivery system and inter-sectoral convergence are the pillars on which the super-structure of the NRHM would be built. The implementation teams particularly at district and state levels would require development of specific skills. Even at the Central level, the program management unit within the MOHFW would need technical and management support from established professionals in the field. The institutions like National and State Institutes for Health and Family Welfare which were primarily conceived as research and training organizations may not fit the bill for this purpose. The National Health System Resource Centre (NHSRC), which is envisaged as an agency to pool the technical assistance from all the Development Partners, would be ideal for this purpose. Mandated as a single window for consultancy support, the NHSRC would quickly respond to the requests of the Centre/ States /Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general. It is proposed to have one NHSRC at the national level and another Regional Centre for the North Eastern region. State level Resource Centres will be provided for EAG States on a priority to enable innovations and new technical skills to develop in the health system. In addition to the above a number of already existing reputed bodies with national caliber may be strengthened and facilitated to mentor state health resource centres and district resource groups so that they are able to support the state level planning efforts.

24. The NRHM would also require a comprehensive plan for training at all levels. While efforts are being made to strengthen the NIHFW, the States have been asked to closely examine the training infrastructure available within the state including State Health & Family Welfare Institute, ANM Training Centres, Medical Colleges, Nursing Colleges etc. and identify the investment required in them to successfully carry out the training/sensitization programmes. Comprehensive training policy is being developed to provide support for capacity building at all levels including PRIs/Community. NRHM will particularly encourage involvement of Medical Colleges and Hospitals to strengthen systems of capacity building in the rural health care set up.

**K. Drug supplies and logistics management**

25. Timely supply of drugs of good quality which involves procurement as well as logistics management is of critical importance in any health system. The current system in most states leaves much to be desired. However, there are a few notable exceptions like Tamil Nadu which has developed a very effective system of supplies and logistics. Under most of the Centrally Sponsored Programmes, it is the Central Government which does the procurement of equipments and medicines on behalf of the States. Most States are reluctant to take responsibility for procurement primarily because they lack the capacity to take up large scale procurement of goods and services.

26. At the level of the Central Government, with the support of the World Bank and the DFID, an Empowered Procurement Wing (EPW) has been set up which would be the nodal agency for all procurement matters. While as an interim measure, till such time that the capacities are built in the States, the EPW would get rate contracts for drugs, quality testing etc. with the assistance of public sector agencies like HLL, HSCC prepared and share them with the States for their use. In the long run, NRHM would like the procurement to take place in a decentralized manner at the district level. It would take up the capacity building exercise for this purpose in right earnest. It supports State led initiatives for capacity building and setting up State Procurement Systems and Distribution Networks for improved supplies and distribution. In order to take informed procurement decisions, market intelligence is of utmost importance. The EPW is getting a market survey done to collect information about the drugs and vaccines which are procured under the RCH-II. This database, which this market survey would generate, would be updated through annual market surveys. These would be shared with the states to help them in taking informed procurement decisions.

**L. Monitoring / Accountability Framework**

27. The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring. Facility and Household Survey, NFHS-II, RHS (2002) would act as the baseline for the mission against which the progress would be measured.

28. While the process of communitization of the health institutions itself would bring in accountability, the NRHM would help this process by wide dissemination of the results of the surveys in a language and manner which could be understood by the general population. It would be made compulsory for all the health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, user charges to be paid (if any) etc, as envisaged in the Right to Information Act. The community as well as the Patient Welfare Committee would be expected to monitor the performance of the health facilities on those parameters. Health Monitoring and Planning Committees would be formed at PHC, Block, District and State levels to ensure regular community based monitoring of activities at respective levels, along with facilitating relevant inputs for planning. Organisation of periodic Public hearings or dialogues would strengthen the direct accountability of the Health system to the community and beneficiaries. The Mission Steering Group and the Empowered Programme Committee at the Central and the State level will also monitor progress periodically. The NRHM is committed to publication of Public Reports on Health at the State and the district levels to report to the community at large on progress made. The Planning Commission will also carry out periodic monitoring and concurrent evaluation of NRHM. The Mission will also appoint Special Rapporteurs to carry out field visits and supervision of programmes. The NRHM would involve NGOs, resource institutions and local communities in developing this monitoring arrangement. The Mentoring Group on ASHA, the National Advisory Committee on Community Action (which have been constituted with the leading NGOs as their members) and the Regional Resource Centres would provide valuable inputs to the Mission. A wide network of MNGOs, FNGOs / SNGOs would also be providing feedback to the Mission.

29. The periodic external, household and facility surveys would track the effectiveness of the various activities under the NRHM for providing quality health services. Beside these surveys, Supervision Missions would be conducted twice in every state to help monitor the outcomes. A computer based MIS would be developed using the network being set up by the IDSP for rigorous monitoring of the activities.

30. The requirements of audit will apply to all NRHM activities. The National, State and District Health Missions will be subject to annual audit by the CAG as well as by a Chartered Accountant and any special audit that the Mission Steering Group may deem fit. Special audit by agencies like the Indian Public Auditors of India could also be

undertaken. Every State will also be supervised by one or more research and resource institutions who may be contracted for this purpose. All procedures of government regarding financial grants including Utilization Certificates etc. would apply to the State and District Health Societies.

31. For the accountability framework to be truly community owned, the effort will be to ensure that at least 70 percent of the total NRHM expenditures are made by institutions and organizations that are being supervised by an institutional PRI/community group.

#### Monitoring outcomes of the Mission

- Right to health is recognized as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health services to all the citizens as guaranteed entitlements will be attempted under the NRHHM.
- Preparation of Household specific Health Cards that record information on the following - record of births and deaths, record of illnesses and disease, record any expenditure on health care, food availability and water source, means of livelihood, age profile of family, record of age at marriage, sex ratio of children, available health facility and providers, food habits, alcohol and tobacco consumption, gender relations within family, etc, (by ASHA/AWW/Village Health Team).
- Preparation of Habitation/Village Health Register on the basis of the household Health Cards. ( By the Village Health Team)
- Periodic Health Facility Survey at SHC, PHC, CHC, District level to see if service guarantees are being honoured.[By district /Block level Mission Teams/ research and resource institutions].
- Formation of Health Monitoring and Planning Committees at PHC, Block, District and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.
- Sharing of all data and discussion at habitation/ village level to ensure full transparency.



- Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.
- Sample household and facility surveys by external research organizations/NGOs.
- Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

**M. Convergence within the health department**

32. The Ministry of Health & Family Welfare [MOHFW] has a large number of schemes to support states in a range of health sector interventions. Many of these programmes pertain to disease specific control programmes. Many others relate to programmes for Family Welfare. Special programmes have been initiated as per need for diseases like TB, Malaria, Filariasis, HIV/AIDS etc. While the disease specific focus has helped in providing concerted attention to the issue, the weak or absent integration with other health programmes has often led to lack of coordination and convergent action. All central programmes have worked on the assumption that there is a credible and functional public health system at all levels in all parts of the country. In practice, in many parts of the country, the public health system has not been in a satisfactory state. The challenge of NRHM, therefore, is to strengthen the public health institutions like SHC/PHC/CHC/Sub Divisional and District Hospitals. This will have positive consequences for all health programmes. Whether it is HIV/AIDS, TB, Malaria or any other disease, NRHM attempts to bring all of them within the umbrella of a Village/District/State Health Plan so that preventive, promotive and curative aspects are well integrated at all levels. The intention of convergence within the Health Department is also to reorganize human resources in a more effective and efficient way under the umbrella of the common District Health Society. Such an integration within the Health Department would make available more human resources with the same financial allocations. It would also promote more effective interventions for health care. To help the States achieve inter sectoral convergence, appropriate guidelines would be issued to the districts.

33. The pandemic of HIV/AIDS requires convergent action within the health system. By involving health facilities in the programme at all stages, it is likely to help early detection, effective surveillance and timely intervention wherever required. The NACO has presence only from district level upwards. The NRHM would enable the NACO to

provide necessary investment and support to the programme at district and sub district levels. While NACO will provide Counsellors at CHCs and PHCs as also testing kits as a part of the NACP – III, it would also help to integrate training on HIV/AIDS to Medical Officers, ANMs, para medicals and lab technicians. Common programmes for condom promotion and IEC are also planned. NRHM seeks to improve outreach of health services for common people through convergent action involving all health sector interventions.

**N. Convergence with other departments**

34. The indicators of health depend as much on drinking water, female literacy, nutrition, early childhood development, sanitation, women's empowerment etc. as they do on hospitals and functional health systems. Realizing the importance of wider determinants of health, NRHM seeks to adopt a convergent approach for intervention under the umbrella of the district plan. The Anganwadi Centre under the ICDS at the village level will be the principal hub for health action. Likewise, wherever village committees have been effectively constituted for drinking water, sanitation, ICDS etc. NRHM will attempt to move towards one common Village Health Committee covering all these activities. Panchayati Raj institutions will be fully involved in this convergent approach so that the gains of integrated action can be reflected in District Plans. While substantial spending in each of these sectors will be by the concerned Department, the Village Health Plan/District Plan will provide an opportunity for some catalytic resources for convergent action. NRHM household surveys through ASHA, AWW will target availability of drinking water, firewood, livelihood, sanitation and other issues in order to allow a framework for effective convergent action in the Village Health Plans. The Ministry has constituted an inter Departmental Committee on convergence with the Mission Director as Chairman. This Committee reports to the EPC. Convergence is also envisaged at the level of the MSG which has representation of all the concerned Ministries. Similar mechanisms are available at the State level. Convergence with the Department of Women and Child Development and with AYUSH has been clearly outlined and shared with States. Necessary guidelines on inter sectoral convergence are being issued by the Ministry.

35. The success of convergent action would depend on the quality of the district planning process. The District Health Action Plans will reflect integrated action in all section that determine good health – drinking water, sanitation, women’s empowerment, adolescent health, education, female literacy, early child development, nutrition, gender and social equality. At the time of appraisal of District Health Plan, care would be taken to ensure that the entire range of wider determinants of health have been taken care of in the approach to convergent action.

**O. Role of Non Governmental Organizations**

36. 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, 215 MNGOs covering nearly 300 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 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 Panchayati 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.

37. A Mentoring Group has already been set up at the national level for ASHAs to facilitate the role of NGOs. Grants-in-aid systems for NGOs will be established at the District, State and National levels to ensure their full participation in the Mission.

**P. Risk pooling and the poor**

38. Household expenditure on Health Care in India was more than Rs.100, 000 crore in 2004-05. Most of it was out of pocket and was incurred during health distress in unregulated private facilities, leading to the vicious circle of indebtedness and poverty. As a matter of fact, in a country of over a billion people, barely 10 million are covered under the private health insurance schemes. Even if we take into account Social Health Insurance Schemes like CGHS, ESIS etc., the coverage increases only to 110 million of which only 30 million are poor. In order to reduce the distress of poor households, there is therefore an imperative need for setting up effective risk pool systems. Involvement of NGOs and community based organizations as insurance providers and as third party administrators can help to generate more confidence in the risk pooling arrangement being pro-people and in the interests of poor households. Innovative and flexible insurance products need to be developed and marketed that provide risk pooling from government and non governmental facilities.

39. While setting up of effective health insurance system is clearly a very important mission goal, it is realized that the introduction of such a system without the back up of a strong preventive health system and curative public health infrastructure would not be cost effective. Such a venture would only end up subsidizing private hospitals and lead to escalation of demand for high cost curative health care. The first priority of the Mission is therefore to put the enabling public health infrastructure in place.

40. While the private insurance companies would be encouraged to bring in innovative insurance products, the Mission would strive to set up a risk pooling system where the Centre, States and the local community would be partners. This could be done by resource sharing, facility mapping, setting standards, establishing standard treatment protocols and costs, and accreditation of facilities in the non-governmental sector.

41. Primary health care would be provided without any charge. However, in the case of need for hospitalization, CHCs would be the first referral unit. Only when the CHC is not in a position to provide specialized treatment, a patient would be referred to an accredited private facility/teaching hospital. The patient would have the choice of selecting any provider out of the list of hospitals accredited by the District Health

Mission. Reimbursement for the services would be made to the hospitals based on the standard costs for various interventions decided by the experts from time to time.

42. It is envisaged that the hospital care system would progressively move towards a fully funded universal social health insurance scheme. Under such a system, the government facilities would also be expected to earn their entire requirement of recurring expenditure including the salary support out of the procedures they perform, while taking care that access to those who cannot pay is not compromised. This system would obviously work only when the personnel working in the CHCs are not part of a state cadre but are recruited locally at the district level by the District Health Mission on contract basis. Since evolving such a system is likely to take some time, at the first instance, it is proposed to give control of the budget of the CHC/ Sub Divisional and District Hospitals to the Rogi Kalyan Samitis or equivalent public bodies set up for efficient management of these health institutions. Efforts to develop risk pooling arrangements as partnerships of the Central, State and local Governments along with community organizations, will be attempted. A possibility of two thirds of the resource support coming from government and one third to be collected from those who can afford to run a public health system based risk pool arrangement would also be experimented with, in partnership with states.

**Q. Reforms in Medical/Nursing Education**

43. In para 21 of this note, the need for trained human resources, medical as well as para medical for rural areas has already been brought out. The medical / para medical education system would require a new orientation to achieve these objectives. While the existing colleges would require strengthening for increased seat capacity, a conscious policy decision would be required to promote new colleges in deficient states. A fresh look also needs to be given on the norms for setting up new medical colleges under the regulations framed under Indian Medical Council Act to see whether any relaxation is necessary for such areas. The viability of using the caseload at district hospital for setting up Govt / private medical colleges would also be examined. Apart from creating teaching infrastructure at the district level, it would also promote much needed investment and improvement in tertiary care in the district hospitals.

44. The curriculum in the Medical Colleges perhaps give undue emphasis on specialization and tertiary care which is available only in large cities. In the syllabus, the primary health care as well as preventive aspects of health are largely ignored. It is therefore natural for the students to aspire for a career in a big hospital in urban setting. In the process the health care in the rural areas suffers. The Mission would look at ways and means to correct the situation.

45. The NRHM also recognizes the need for equipping medical colleges and other suitable tertiary care centres – including select district hospitals, select not for profit hospitals and public sector undertaking run hospitals for a variety of special courses to train medical officers in short term courses to handle a large number of essential specialist functions in those states where medical colleges and postgraduate courses are below recommended norms. This includes courses from multi skilling serving Medical Officers, specially for anaesthesia, emergency obstetrics, emergency pediatrics especially newborn care, safe MTP services, mental health, eye care, trauma care etc. Further short term programmes are needed to upgrade skills of nurses and ANMs to that of nurse-practitioners for those centres/regions which potentially have adequate nurses, but a chronic shortage of doctors over at least two decades.

46. The Mission would support strengthening of Nursing Colleges wherever required, as the demand for ANMs and Staff Nurses and their development is likely to increase significantly. This would be done on the basis of need assessment, identification of possible partners for building capacities in the governmental and non governmental sectors in each of the States/UTs, and ways of financing such support in a sustainable way. Special attention would be given to setting up ANM training centres in tribal blocks which are currently para-medically underserved by linking up with higher secondary schools and existing nursing institutions.

47. Efforts to improve skills of Registered Medical Practitioners would also be introduced. The NRHM recognizes the need for universal continuing medical education programmes which are flexible and non threatening to the medical community, but which ensures that they keep abreast of medical advances, and have access to unbiased medical knowledge, and adequate opportunity to refresh and continuously upgrade existing knowledge and skills.

## **R. Pro-people partnerships with the non-governmental sector**

48. The Non-governmental sector accounts for nearly 4/5 of health expenditure in India. In the absence of an effective Public Health System, many households have to seek health care during distress from the Non-governmental sector. A variety of partnerships are being pursued under the existing programmes of the Ministry, especially the RCH-II and independently by the States with their own resources with non governmental partners. Under NRHM, Task Forces are set up with experts, institutional representatives and NGOs. The RCH-II has development partners, including UN agencies. Under this the States are trying contract in, contract out, out sourcing, management of hospital facilities by leading NGOs, hiring staff, service delivery, including family planning services, MTP, treatment of STI/RTI, etc. Franchising and social marketing of contraceptives are already built into the FW programmes. The Immunization and Polio Eradication Programmes effectively make use of partnerships with WHO, UNICEF, the Rotary International, NGOs etc. The Janani Suraksha Yojana (JSY) has also factored in accreditation of private facility for promotion of institutional delivery. The Disease Control programmes make use of NGO partnerships in a big way. The Ministry also has strong relations with FOGSI, IMA, IPHS etc. which are professional Associations for dissemination of information, advocacy, creating awareness, HRD etc.

49. The Non-governmental sector being unregulated, the rural households have to face financial distress in meeting the costs of health care. The NRHM attempts to provide people friendly regulation framework that promotes ethical practice in the non-governmental sector. It also encourages non-governmental health providers to provide quality services in rural areas to meet the shortage of health facilities there. Such efforts will involve systems of accreditation and treatment protocols so that ethical practice becomes the basis for health interventions. NRHM encourages training and up-gradation of skills for non-governmental providers wherever such efforts are likely to improve quality of services for the poor. Arrangements for demand side financing to meet health care needs of poor people in areas where the Public Health System is not effective will also be attempted under the NRHM. The NRHM recognizes that within the non-governmental service there is a large commercial private sector and a much smaller but significant not for profit sector. The not-for-profit centres which are identified as setting an example of pro-poor, dedicated community service would be encouraged used as role model, benchmark, site of community centered research and training to strengthen the public health system and improve the regulatory frameworks for the non governmental sector as a whole.

## **V. KEY STRATEGY OR INSTRUMENT: DISTRICT HEALTH PLAN**

### **DECENTRALIZED ACTION THROUGH DISTRICT PLANS**

#### **A. The Planning Process in NRHM**

- District Health Plans are to be prepared by an aggregation and consolidation of Village Health Plans. Block Plans will be the basis for the District Plan.
- This requires setting up of planning teams and committees at various levels – Habitation/Village, Gram Panchyat (SHC), PHC (Cluster level), CHC/Block level, District level. At Village, PHC and Block levels, broadly representative committees would perform both planning and ongoing monitoring functions. A similar committee at District level would be involved in reviewing plans, based on drafting by the specialized district planning team. The monitoring and planning committee at State level would be supported by a State health planning cell a similar cell being required at the State and National level to provide support as needed.
- Besides large scale consultations, planning teams have to conduct household surveys, help select ASHAs, organize training for community groups and health functionaries. NGOs have a role in the entire planning process.
- Orientation of planning team and contractual engagement of professionals as per need has to be the starting point for the planning process.
- Village Health Plans are likely to take time and therefore District, Block and Cluster level consultation may have to form the basis for initial District Plans. The initial plans could be adhoc and for a year. The perspective plans must be on the basis of Village Health Plan. Even then, Block will be the key level for development of decentralized plans.

#### **B. Levels of planning and the key functionaries**

- Village level Health and Sanitation Committee will be responsible for the Village Health Plans. ASHA, the Aanganwadi Sevika, the Panchayat representative, the SHG leader, the PTA/MTA Secretary and local CBO representative will be key



- persons responsible for the household survey, the Village Health Register and the Village Health Plan.
- The Gram Panchayat Level Health Plans, comprising a group of villages in many states and a single village in a few, will be worked on at the Sub Health Centre Level. The Gram Panchayat Pradhan, the ANM, the MPW, a few Village Health & Sanitation Committee representatives will be responsible for the Gram Panchayat Health Plan. They will also be responsible for over view and support for the household survey, preparation of Village Health Registers and preparation of Village Health Plans- the Gram Panchayat /SHC level would also organize activities like health camps to facilitate the planning process.
  - The Cluster level will be led by the PHC/Additional PHC. Ordinarily there will be 1-4 Clusters in a Block. The PHC Health monitoring and planning committee will facilitate planning inputs of Panchayat representatives, along with other inputs from the community to formulate a broad plan. In this context the Medical Officer in charge of PHC will work in close coordination with the Pradhan/s of the Gram Panchayat/s covered in that Cluster. The Cluster level would be responsible for over viewing the work of Gram Panchyat/s and for organizing surveys and activities through the SHCs.
  - The Block/CHC level monitoring and planning committee will review the Block Health Plan. The Adhyakisha of the Block Panchayat Samiti, the Block Medical Officer, the Block Development Officer, NGO/CBO representative, head of the CHC level Rogi Kalyan Samiti will be key members of this team. Additional social mobilization professionals and planning resource persons will also be contracted at the Block level to develop a good Resource team at that level. The Block level Health Mission Team will finalize the Block Health Plans. The Block Health Teams would also supervise household and health facility surveys. They would also organize public hearings and health camps in order to make the planning process activity intensive.
  - The District Level Health Mission will have a Health monitoring and planning committee responsible of providing overall guidance and support to the planning process. A draft plan will be formulated by the District Health Team, and presented for discussion to the broader committee. After relevant discussion and modifications in the committee, the district plan will be finally streamlined by the District health team, which, besides a few existing government functionaries, the

District Health Teams will also have NGO representatives and a few professionals specially recruited to meet planning and implementation needs. The District Planning team will be responsible for household Surveys and Health facility surveys. They would also facilitate organization of health camps and public hearings in order to make the planning process activity intensive. The Zila Parishad Adhyaksha, the District Medical Officer, the District Magistrate will be key functionaries of the District Team. Every district health society would be assisted by a technical support agency, which they can choose from a number of options.

- The State Level Health Mission will have a State Health monitoring and planning committee to give overall guidance to the planning process. The State Resource Centre/Planning Cell will propose the draft plans to the Committee. After relevant discussion, the State Resource Centre / Planning Cell will finally streamline the plans as part of its resource support. The Resource Centre/Planning Cell will have to supervise the work of all the District Health Missions by scrutinizing and providing feedback on the plans so that adequate quality of plans and processes are ensured. The State Resource Center will also finalize survey formats and formats for preparation of plans at various levels. It will also finalize with guidance and directives from the ministry, the criteria for prioritization and indication of resources likely to be available for each Block and convey these to the district these details as also help develop the financial norms in conformity with these guidelines and on the basis of inputs from Blocks and Districts.

**C. The basis for Annual Work Plans and Perspective Plans**

- The NRHM has a seven year time frame (2005-2012). The Perspective Plan will be a 7 year plan outlining the year wise resource and activity needs of the district.
- The Annual Plan will be based on resource availability and a prioritization exercise.
- As far as possible, States should let districts know by October of the resources likely to be available in the coming financial year.
- The District should disaggregate likely budget availability on the basis of needs at village/cluster/block levels by November. The Village, Gram Panchayat, Cluster & Block Plans should come to district based on a prioritization exercise.

- The District Health Mission Society will recommend the Annual Work Plan and Budgets and the Perspective Plan to the State level Health Mission under the Chief Minister.

**D. Essential requirements for preparation for Village, Block, and District Health Plans**

- Constitution of planning team and committees with clearly demarcated responsibility at each level.
- Engagement of professionals on contract at State, District and Block level urgently to meet planning needs.
- Broad norms for planning activities. Some idea on what is to be taken up and the space for diversity and innovations.
- Preparation of training modules for planning teams, and finalization of survey format for household survey, Family Health Cards, Village Health Register, mapping of non-governmental providers, and Health facility surveys.
- Survey of non-governmental health providers to assess their possible role in the District Health Plan.
- Organization of large scale activities like health camps, Public hearings to make the planning process activity intensive.
- Involvement of Women's groups and Community based organizations in planning activity.
- Release of untied grants to SHCs/ Gram Panchyats to facilitate activities.
- Recruitment and relevant training of ASHAs/ANMs.
- Orientation of existing health department functionaries on new ways of working.
- Convergent local action along with other departments.

50. The format for household and facility surveys may be seen at Annex- III. As will be evident, these surveys are planning and monitoring instruments and not for any national reporting system. The intention is to use the household and facility surveys to construct a base line and to make annual plan for each health facility with a clear assessment of financial and human resources and clear commitments of service guarantees.

## **FRAMEWORK FOR DISTRICT ACTION PLANNING**

The following framework for assessing the present situation is proposed:

- **Resources** – Including Health humanpower, logistics and supplies; Community resources and Financial resources, Voluntary sector health resources
- **Access to services** – including public and private services and informal health care services; also look at levels of integration of services within Public health system
- **Utilisation of services** – including outcomes, continuity of care; factors responsible for possible low utilization of public health system
- **Quality of Care** – including technical competence, interpersonal communication, client satisfaction, client participation in management, accountability and redressal mechanisms
- **Community needs, perceptions** and economic capacities, PRI involvement in health, existing community organizations and modes of involvement in health
- **Socio-epidemiological situation:** Local morbidity profile, major communicable diseases and transmission patterns, health needs of special social groups (e.g. adivasis, migrants, very remote hamlets)

### **Broad outline of Planning process**

51. District health planning is viewed as an iterative and two-way process, where District planning teams provide overall planning framework and financial parameters, along with arranging training inputs for the Block and Village planning teams. The Village teams would need to develop draft plans to be collated and approved at the Block level. Similarly Block plans would be collated and approved at the District level.

52. It is desirable as the ongoing model of planning, for such a process to build upwards as Village health plans ? Block health plans ? District health plan. However, this would not be possible in a full fledged manner in the first year, since formation and orientation of planning capable bodies at Village and Block levels will take time.

53. Hence, **during the first year**, the District planning team will have to arrange five types of activities:

- a. Preparation of broad framework of planning based on assessment of current situation, resources, NRHM priorities; drafting outline of block health plans; disseminating these to Block health authorities, PRIs and block level NGOs
- b. Consultative process involving discussion of draft block plans with Block health authorities, PRI representatives and block level NGOs
- c. Consultative process, involving discussion of key block planning issues with a few groups of selected village stakeholders such as Panchayat heads, ANMs and CBO representatives in each block, to get community level feedback about major local priorities and issues
- d. Consolidation of block and district health plans based on a,b and c; presentation of the proposed District health plan to the District health society and Zilla Parishad for final approval
- e. Facilitating formation and capacity building of Village and Block planning teams throughout the district

#### **A. Preparatory Activities**

- Introductory meeting with District Collectors and CMO at the Commission level
- Orientation Workshop with CMOs / Dy CMOs of all districts
- District Level Orientation Meeting
- Training of District Planning teams

#### **B. Desk Review**

1. District RCH status compared with State average and NRHM objectives
2. Listing of Health care facilities available with services available ( NRHM priority services) in public and private sector
3. List of public health care facilities with staffing, status of infrastructure, proximity to habitation, population served etc..
4. Mapping of health care facility with community habitation – separately for blocks and urban centres
5. Listing of PHCs and CHCs with last years monthly outpatient and inpatient figures
6. Review of the performance of different National Programmes in the last year

7. Listing of ANM/ MPW last year's monthly performance on key NRHM related indices – ANC registration, Labour supervision, PNC, Routine Immunisation, ARI and AGE treatment, Contraceptive services provided ( including counseling) etc..
8. Mapping of TBA- AWW-ANM- LHV linkages – geographically blockwise
9. Listing of NGOs – geographic outreach and focus of work
10. Community level groups existing in the district – block and activity- wise
11. Last year's budget and expenditure analysis

**C. Facility and Provider Assessment**

1. Facility Checklist – Self administered – ANMs and MOs
2. Roles and Needs of the Provider – Self administered questionnaire - ANMs and MOs
3. Problems faced and suggestions for improvement – Focus Group discussion with ANMs and Medical Officers
4. Understanding Community linkages, needs for support and supervision – Indepth Interview

**D. Community Assessment**

1. Resource Mapping – service providers, communication facilities , drinking water sources, sanitation, nutritional status, levels of poverty.
2. Understanding main health problems of women and children, providers used, perception of public health services and providers – Focus group discussion
3. Main illnesses in the community, Health care related expenditure, problems faced in referral and transport, perceptions about family planning and gender, Role of PRI in health related areas ( water, sanitation)
4. Understanding process of Pregnancy, labour and post natal care, beliefs and practices – Key informant interview with elderly women, TBA.

**E. Understanding Community Participation and Ownership**

1. Meeting at the Block level with PRI members to understand their perception of health needs and role of PRI in addressing these
2. Meeting at the District level with PRI members to understand their perception of health needs and role of PRI in addressing these

**F. Additional information**

1. Have there been any special health related studies in the district by any other agency – government, international, academic, NGO?
2. Any Health NGO active in the district? What are their key activities and achievements? Are they willing to partner in this process
3. Other Community Based Organizations in the district , SHG federation, Milk Cooperative, etc

**G. What a District Plan ought to have**

- i) Background
- ii) Planning Process
- iii) Priorities as per the background and planning process
- iv) Annual Plan for each of the Health Institutions
- v) Community Action Plan
- vi) Financing of Health Care
- vii) Management Structure to deliver the programme
- viii) Partnerships for convergent action
- ix) Capacity Building Plan
- x) Human Resource Plan
- xi) Procurement and Logistics Plan
- xii) Non-governmental Partnerships
- xiii) Community Monitoring Framework
- xiv) Action Plan for Demand generation
- xv) Sector specific plan for maternal health, child health, adolescent health, disease control, disease surveillance, family welfare etc.

**H. What all the State component plan should have**

- (i) Monitoring and MIS framework
- (ii) Human Resource Plan
- (iii) Capacity Development Plan
- (iv) Procurement & Logistics Plan
- (v) Financing of Health Care
- (vi) Service Guarantee Plans
- (vii) Annual Deliverables

- (viii) Non-governmental Partnerships
- (ix) Plan for Behaviour Change & Communication
- (x) Plan for involvement of Medical Colleges and other tertiary health institutions
- (xi) Plan for involvement of Professional Associations like Fogsi, IMA etc.
- (xii) Management Structure & Accounting Systems
- (xiii) Systems for Financial Management & Audit
- (xiv) System for conduct of State Health Mission
- (xv) Setting up of State level Health Systems Resource Centre

## **I. ADVOCACY THROUGH COMMUNITY ACTION – GUARANTEEING RIGHT TO HEALTH CARE**

### Why community action?

- Community action is the only guarantee for right to health care- putting community pressure on health system.
- Communities suffer denial of healthcare in many ways – human power (doctor, nurse) not available at the time of reporting, medicines not available; referred outside for investigations; non availability of essential equipment/infrastructure; no transport facility available for referring the patient; charges more than specified /corruption; denial on grounds of inability to pay user fees; treatment not given or patient not attended on time; insulting or discriminatory behavior of staff; inadequate attention given to the patient resulting in poor quality of care; failure of health care facility to provide preventive health services e.g. inadequate coverage, outreach or inefficient surveillance, etc.
- Consequences of denial can be serious- death of the patient, adverse health consequence or complications due to denial; temporary or permanent physical damage or disability; financial loss to family/patient.
- Community action involving Panchayat Raj Institutions, Community based organizations, NGOs, etc. can create a more accountable public and private health care system.
- Community action organizes people to demand quality health services.



### How to trigger Community action?

- Through household and health facility survey that involve Village Health Teams and discuss findings locally.
- Through Health Camps that bring a range of health services to the community and makes them aware of their entitlements.
- Through “Public Hearings” or Jan Sunawai organized periodically where people share their experience of seeking health care. Such Jan Sunwais may be organized twice a year, or at least once a year at PHC, block and district levels.
- Through training and orientation of village Health Teams for community action.
- By building team of Community Workers like Aangan Wadi Sevika , ASHA, School Teacher, Mahila Samakhya worker, PTA/MTA’ members, etc.
- By involving group like SHGs, Community based organizations, MTAs, PTAs, literacy volunteers, Continuing Education Centre volunteers, etc. who have motivation for Community action.
- By making local level health functionaries visit households frequently.
- By making Block and District level Health Mission teams, including NGOs, organize a series of activities like health camps, public hearings, etc.

### Need for Institutionalizing community action

- Community events fitter away if they are not institutionalized.
- Institutionalization requires clear definition of powers and functions of community organizations/PRIs at various levels. Acts need to be amended to make rules that institutionalize community action.
- Follow up on community action has to be quick to give legitimacy and effectiveness to the consultation process-things must change.
- Village Health Registers prepared on the basis of household survey is a useful tool for preparation of village Health Plan. ASHA and Aangan Wadi Sevika together are in a position to update VHR regularly.
- Village Health & Sanitation Committees must be constituted through intensive process of training and deliberation. They must have untied resources for organizing activities and for meeting household’s health care needs.
- Series of activities lend credence to community action-effectiveness is the key to change.

How would public hearings (Jan Sunwai) or public dialogue (Jan Samvad) be conducted?

- These hearings would need to be conducted at PHC, Block and District levels once or twice in a year, as events open to all, which would enable the general public and various groups and organisations to give independent feedback about health services.
- The hearings should be announced with at least one month's public notice, with Panchayats and community organisations being entrusted with the task of publicizing the hearing. These hearings should preferably be preceded by group interviews in some of the concerned villages / PHCs, where both positive incidents and possible negative events should be documented.
- Testimonies of possible denial of health care could be presented by individuals or groups during the hearing. Similarly testimonies by individuals who received exceptional or exemplary good care, due to dedicated work by any public health functionary could also be presented.
- The panel for these hearings should include, appropriate level Panchayat institution representatives (Block Panchayat Samiti / Zilla Parishad) and civil society representatives (Community organisations, People's organisations, NGOs involved in monitoring of health services). Respondents would be the appropriate level Health officials (MO-PHC / BMO / DHO) whose presence would be mandated as essential.
- The panel would take note of and recommend action regarding any cases of denial of health care; similarly it would recognize providers whom the public acknowledges as providing exemplary good services. Both kinds of recommendations would be taken up for appropriate action, and would be included in the formal service records and annual evaluation reports of the concerned persons.

What issues should public hearings discuss?

- People's perceptions about existing health care services.
- Health needs of the community.
- Specific cases of denial of health services.
- Problems related to accessing health care services, especially problems faced by women. Barriers faced by vulnerable sections of the community (including dalits,

adivasis and poorer households) in accessing health services, including possible discriminatory behaviour and charging of user fees from genuinely poor households.

- Suggestions for improving service delivery which will make services more accessible for women.
- Availability of services like immunization, family planning services etc.
- Involvement of village health committee in monitoring of village level health services.
- People's perceptions about behavior/attitude of PHC/CHC staff and their availability in the health centres.

#### Some initial activities for community action

- Organization of health camps in every Sub Health Centre feeder area.
- Organization of a Public hearing in every Cluster (PHC area) within a Block.
- Putting in place Block level team with a mandate for holding health camps and public hearings.
- District level team to support household survey and survey of health facilities.

### MEETING LOCAL NEEDS THROUGH INNOVATION – THE PROCESS OF APPROVAL FOR DIVERSITY

#### How to plan for diversity?

- Household and facility survey should provide a basis for mapping the diversity.
- Village Health Register is a tool for planning regarding all incidents of people's health needs round the year.
- There is no substitute to context specific and habitation/household specific planning.
- This requires a vibrant Village Health Team with an ASHA and an Anaganwadi Worker playing the critical role of recording people's needs. It also requires a resource support at the district level that the village health team can consult whenever it feels the need. It also requires a database of a wide variety of planning experiences so as to fire the imagination with possibilities of what can be done in diverse situations.
- The broad based Health Monitoring and Planning committees at PHC, Block, District and State levels would provide opportunities for civil society representatives to suggest special situations or needs that should be addressed

in the planning process. Cluster and Block level teams can facilitate articulation of people's needs through fora like 'public' hearings, training and orientation of health workers, and community leaders, and by generating a confidence that diverse planning as per needs will be respected.

- Village Health Plans, reflecting local needs have to be aggregated at Gram Panchayat, Cluster and Block levels, to ultimately feed into the District Health Plan.
- Availability and earmarking of financial resources for innovation at each level can trigger local thinking or appropriate interventions.
- District Health Plans should be appraised by the State Health Mission keeping diversity of people's needs in mind. The appraisal should not become a system of imposing uniformity, but instead should be an assistance to helping the planning team recognizing the gaps between what is the situation as they have identified and the outcomes likely from the plans they have proposed.
- The National Health Mission should be able to take up such diverse needs. This requires greater thrust on provision of more and more untied grants.
- The planning process itself should come up with the appropriate monitoring and evaluation arrangement for the innovation.

#### What should be the appraisal process for meeting diverse needs?

- Innovation fund at each level and thrust on building capacity at local level for planning will facilitate articulation of local needs.
- Appraisal process should not kill local initiative. It should on the other hand help local initiative even where it is inadequate to gain effectiveness. If an intervention is worth taking up, a way should be found of doing so. Respecting local needs should be a priority for the planning process.
- The approval process should be an empowering one where there is scope for approving diversity of demands.
- Approval should immediately lead to action in the Annual Work Plan and Budget.
- A short and well defined planning to implementation cycle will greatly facilitate local action.

### Developing an effective habitation/village level health team

- Identify the key persons.
- Look for community leaders with motivation, whom households look up to.
- Constitution of habitation/village level health teams must be activity intensive [camps, public hearings, etc], and process based. Nomination form above will not help.
- Equip ASHA, Aanganwadi Sevika, Panchayat representative, other health functionaries to plan health with local needs.
- Women's Group and habitation level homogeneous community groups must have a role in building the local team.
- Specify clearly what the role and function of the Village Health team will be.
- Allow for local initiatives
- Participation of women, dalits, tribals, old persons, handicapped persons, children in the planning process is critical.

54. The delivery of public health services in the rural areas take place at the village level, Sub-Centre level, Primary Health Centre level and at the Community Health Centre level. The quality of services at these levels would improve only when the elements described in the Framework for Implementation are incorporated in the plan of action at each of the above levels. While some of the initiatives under the Mission find mention in the Implementation Framework itself, the following paragraphs comprehensively bring out the initiatives to be taken up under the Mission.

**a. Village level**

55. 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.

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

57. 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.

58. A revolving fund would be set up at the village level for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization. The fund would be operated by the VHSC. Untied fund would also be made available to VHSC for various health activities including IEC, household survey, preparation of health register, organization of meetings at the village level etc. Since VHSC would be asked to play a leading role in the health matters of the village, its members would be given orientation training to equip them to provide leadership as well as plan and monitor the health activities at the village level.

59. For those villages which are far away from the Sub-Centre, a TBA with requisite educational qualifications would be identified for training and support. She would assist the ANM at the Sub Centre. ASHAs willing to play this role would be given preference. In places where even an ANM's services are not reaching and there is no accredited ASHA available, the RMPs would be identified for training so that they could upgrade their skills and get accredited. Efforts would also be made to regulate quacks and untrained dais. Village is the first level of convergence of programmes of the Ministry i.e. AYUSH & NACO as well as that of the other Ministries. ASHA will assist the villagers in referral services for AYUSH/testing HIV/AIDs, STI, RTI also preventive, promotive health already with AWW/SHGs etc. ASHA will provide them information on the treatments available under AYUSH.

**b. Sub-Centre level**

60. The Sub-Centres are currently provided on the population norm of 1 per 5000 population in general areas and 1 per 3000 population in tribal areas. Even by 1991 population norms, against a requirement of 1.34,108, if we ignore the excess sub-centres in some of the states, there is a shortfall of 4822 sub-centres. Going by the population of 2001, the requirement increases to 1,58,702 and the deficit increases to 21, 983. Of the existing sub-centres, only 63,800 are in government buildings. If we further exclude those buildings which are currently functioning from Panchayat and other voluntary society buildings, buildings need to be constructed for as many as 59,226 of them. The vacancy position at the Sub-Centres is equally unsatisfactory. Against a requirement of one ANM (funded by the GOI) and one MPW (funded by the states)

positions of as many as 11,191 and 67,261 respectively are vacant. Population density in the country is not uniform. Application of same norm all over the country has therefore resulted in very wide variance in the number of sub-centres. Since the position of ANMs is linked to the number of sub-centres, it has resulted in inadequate availability of health services. It would therefore make eminent sense to link the number of ANMs not only to the population but also to caseload and the distance of village / habitations which comprise the sub-centre. It is therefore proposed to revisit the population norms and an effort would be made to link the number of ANMs at any sub-centre not to the population but to the caseload at that sub-centre.

61. As already mentioned above, one ANM at a sub-centre has not been found to be adequate to attend to the complete needs of maternal and child care in any village. It is therefore proposed to extend the funding support from the GOI for two ANMs per sub-centre. This support for the second ANM would be extended upto a ceiling of Rs. 7000 per month subject to the condition that the states agree to appoint her on contract basis as part of a block cadre to be controlled by the District Health Mission. Besides, apart from fulfilling the other criteria, she must be a resident of a village falling under the jurisdiction of the sub-centre. An undertaking would also be needed from the state that she would not be transferred before completing ten years at the same sub-centre. It would also be made clear to the states that the second ANM is not a substitute for the MPW (Male) and they are expected to fill up those vacant posts on an emergent basis in the beginning of the year 2006.

62. Construction of buildings would be taken up as a Mission activity. The new buildings would be of an area of around 500 square feet and in addition would have staff quarters for the ANMs. The States would also be supported in their efforts to renovate the existing buildings. The Centre would contribute 75% of the total fund requirements for the construction of the sub-centres in a phased manner over the mission period. The states would be expected to contribute the additional funds through other centrally sponsored schemes like EGS, SJGSY or through NABARD / HUDCO loan. The Central support to the states would be based on their requirements meaning thereby that those states which have a higher shortfall would be entitled for a greater support.

63. Besides the usual recurring cost support to the sub-centres, they also would be given an untied support of Rs. 10,000 per annum. The fund would be kept in a joint



account to be operated by the ANM and the local Sarpanch. The detailed guidelines regarding use of this fund have already been shared with the states. To bring in greater community control, the sub-centres would be brought fully under the Panchayati Raj framework.

64. Two Trainers of ASHAs or especially successful ASHAs or TBAs/RMPs would be attached to every Sub-Centre without any financial liability. These TBAs/RMPs/ASHAs or their trainers would be selected with a view to train them subsequently to the level of SBA by further skill upgradation. Some degree of simple laboratory skills like testing for anemia and some curative skills to assist the ANM can also be provided. Care would be taken to identify TBAs/RMPs who have basic functional literacy and whose skills can be improved through orientation.

65. The Sub-Centre building could also be utilized for dispensing OP services by any health provider. Adequate provision of medicines would be made, not only pertaining to RCH but also of other communicable diseases. Contractual appointment of AYUSH practitioners at the sub-centre level and dispensing AYUSH drugs for ordinary ailments would be explored. The introduction of a standard treatment guideline for paramedicals posted in sub-centres and training the staff on these would be another major step forward. This recognizes the fact that MPWs and ANMs are already providing access to curative care in a significant way, and when ASHA and TBAs and RMPs are being considered for curative care roles, it is anomalous not to so equip the ANM who is much more trained (a regular intensive 18 month training), and much easier regulated. Even for RMPs, and upgraded ASHAs, dais etc. the insistence on following a vernacular paramedical standard treatment guideline is a way forward to ensure quality of services and a regulatory framework. The States however will have to include specific proposals in their State Plan. Sub centres also will be utilized in providing information on HIV/AIDS and help villagers access referral services at the PHCs. Sub centres would co-ordinate outreach activities especially to underserved areas. It would also pay special attention to the health status of the marginalized.

**c. PHC Level**

66. The PHCs are currently provided on the population norm of 1 per 30,000 population in general areas and 1 per 20,000 population in tribal / desert areas. Even by 1991 population norms, against a requirement of 22,349, if we ignore the excess in some of the states, there is a shortfall of 1374 PHCs. Going by the population of 2001, the requirement goes up to 26022 and the deficit increases to 4436. Of these PHCs, as many as 1693 do not have their own buildings. The PHCs are expected to have two doctors. However, even if we work out the requirements on the basis of one doctor alone, there are 880 vacancies which clearly imply that many of the PHCs are without doctors. Population density in the country is not uniform. Therefore, as in the case of Sub-Centres, it would make eminent sense to link the number not to the population but to caseload. The PHC should become a 24 hour facility with nursing facilities. Select PHCs, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing number of Medical Officers.

67. Construction of buildings would be taken as a Mission activity. Currently, the PHCs have a space of 4000 square feet. Looking at the utilization of space of the PHCs, it is felt that the constructed area is on the higher side. The new buildings would therefore be of an area of around 1600 square feet. The balance space would be utilized for the construction of staff quarters for all the three Staff Nurses. Provision for labour rooms and space for new born care are being provided. The states would also be encouraged to examine the design of the existing buildings to see whether a portion of it could be converted as residential quarters for the Staff Nurses. As already mentioned in para 18, in order to make the PHC functional for 24 hours, it is proposed to increase the number of staff nurses in the PHCs to three. There would also be an Lady Health Visitor. The availability of the three staff nurses within the PHC premises would address the health needs of the rural population in a very significant manner. The Government of India would bear the entire capital expenditure for construction / redesign of the buildings in a phased manner over the mission period. Initially, even at induction, all of them would have both basic emergency obstetric care and sick neonatal and child care skills and over time with proper training all of them would be able to function as nurse-practitioners, in addition to their obstetric roles.

68. The support under NRHM for recurring expenditure will be for the two new posts of Staff Nurses, on condition that the appointment is on the basis of local criteria and on

contract. The support for other recurring expenditure would be for all additional provisioning, over and above the existing sanction/allocation. As a principle, NRHM funds are for meeting additionality and not substituting existing State Government expenditures.

69. Hospital Development Committee[HDC]/Rogi Kalyan Samiti[RKS] would be constituted at the PHC level within the overall Panchayati Raj framework. To encourage the states to do so, a grant of Rs. 1,00,000 would be given to the states for each PHC for which a RKS/Panchayat 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 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 IPH Standards 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 annually – and 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, including complete information on HIV/AIDS/Treatment/counseling/Rehabilitation etc.

**d. CHC level**

70. The CHCs are currently provided on the population norm of 1 per 1,20,000 population in general areas and 1 per 80,000 population in tribal / desert areas. Even by 1991 population norms, against a requirement of 5587, if we ignore the excess in some of the states, there is a shortfall of 2474 CHCs. Of these CHCs, as many as 318 do not have their own buildings. Going by the population of 2001, the requirement goes up to 6491 and the deficit increases to 3332.

71. Under the Mission, the CHCs are conceived as the first major curative health service providers addressing 80% of all ailments requiring out-patient services or hospitalization. Of course, PHCs would handle all services that an MBBS doctor is qualified to provide but without the specialist support, the ability to provide care as per current norms, would be limited. Since the credibility of any health institution is generally determined by the standard of curative services it provides as benchmarked to the best institutions, the Mission attaches utmost importance to strengthen the existing CHCs and build up new ones to bring the number of CHCs broadly in conformity to the ratio of one per one lakh population. The Centre would support the entire capital expenditure for the construction of the new CHCs and the renovation of the existing CHC buildings. In some places, there are multiple health facilities being controlled by different agencies. As a result, because of the manpower and equipment shortage, none of the facilities function in an optimal manner. The States would be asked to merge these facilities existing at the CHC headquarter for better cohesion.

72. Lack of accountability in the CHCs has been the main reason for patients preferring private facilities over them. To bring in quality accountability in the health services, Indian Public Health Standards (IPHS) have been set up for the CHCs. These standards have been fixed by a high powered task group through a consultative process with the states and other experts. IPHS is a novel concept to fix benchmarks of infrastructure including building, manpower, equipments, drugs, quality assurance through introduction of treatment protocols. Most important they also define the level of services that a CHC would be expected to provide. Under the RCH II, upgradation of CHCs as FRUs is being attempted to provide for basic Emergency Obstructive Care for women and ARI treatment for children. It will also have an Ayush clinic. If Government Ayush doctors are not available, AYUSH practitioners will be appointed on contractual basis so that Ayush becomes a part of primary health care. Ayush medicines would be dispense. The RKS would use its won funds; if however support is necessary such requirement are to be reflected in the district/state plans. Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs would be operationalized as FRUs with all facilities for emergency obstetric care. As a part of the IPHS, AYUSH units would be set up in every CHC. The Govt. of India would bear the additional expenditure to be incurred by the states on account of the implementation of the IPHS fully during the Eleventh Plan and in the ratio of 75:25 during the Twelfth Plan. Under these standards, the services to be provided in any CHCs and their protocols have been laid down.

73. The CHCs would be brought under the community ownership through the system of Rogi Kalyan Samiti (RKS). To start with the RKS would be a group of users with PRIs, NGOs and health professionals represented in them. However, once the PRIs gain experience in controlling the SHC and PHC, the composition of the RKS would be changed to bring CHCs also under the fold of the PRIs. To motivate the states to set up RKS, a support of Rs one lakh per CHC would be given to these societies through states. The societies would be eligible for this grant only where they are authorized by the states to retain the user charges at the institution level.

74. A Charter of Citizen's Health Rights would be prominently displayed outside all the CHCs. While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination. The transparency would help the community to better monitor the health services.

75. Sub Division/District level Hospitals will also be provided support to upgrade their infrastructure as a large number of rural households seek their services. Support will also be provided to the HDC/RKS at these Hospitals. For user fee charges to be used more effectively, efforts should be made to develop a district level confederation of HDC/RKS.

76. Many of the areas are inaccessible in the States, even if fully functional facilities have been provided for. Outreach activity would therefore be an important activity under the Mission. Many of the States are already providing outreach services through ambulances under RCH II programme. The first priority would be to carefully map and publicly notify medically underserved areas. This would then be followed up by the provision initially of one mobile medical unit to each district of the country. The mobile units would consist of two vehicles - one equipped with the necessary diagnostic facility and the other for carrying the medical and paramedical staff. The mobile unit would help in providing healthcare services to far flung areas of the district. This mobile unit would be attached to the district hospital / CHC. In especially difficult districts where mapping and public notification shows a large number of underserved remote areas even more mobile hospitals may be sanctioned accordingly. To operationalize the scheme, the states would be given the option to choose any of the models suggested in the guidelines to be issued by the Central Government or propose a viable model. The mobile units would be operationalized through the RKS or with the help of NGOs as the case may be. The support to the state for this mobile unit would be in accordance with the norm indicated in the normative framework.

## **VI. PLAN OF ACTION OF THE MISSION – 2005-2012**

### **Planning and implementing NRHM**

77. The concept of decentralized planning has already been touched upon in the Framework for Implementation. The subject would be elaborated in somewhat greater detail here. It has already been mentioned in para 10 that even though some effort has been made to integrate schemes under RCH-II, there is still scope for further integration. The disease control programmes are run in a vertical manner. As a result the funds flow to the States is in a tied manner hampering flexibility. Verticality of the programmes has also led to duplication of efforts and thereby wastage of scarce resources. The need for horizontal integration of these schemes has been repeatedly emphasized in various reports. It is therefore proposed that there would be a single NRHM budget head from the Eleventh Plan. The minimum amount which would have to be provided for the vertical programmes would however be indicated. The intention of NRHM is to make every health facility fully functional by decentralized action.

78. The Central Government would provide to the states an indication of the quantum of funds under NRHM budget head including funding for programmes like TB, Vector Borne diseases, Leprosy, Malaria, Disease Surveillance etc, over the Mission period as well as on an annual basis. The availability of funds would be indicated to the states after deducting the portion of funds which would have to be retained at the Central level for activities to be taken up at that level. The criterion of allocation of funds to the states has been indicated in the Annex pertaining to norms. The Centre would also indicate the priorities and the normative framework under which the planning exercise is to be taken up. The states in turn would indicate the sub allocations to the districts. The districts would be expected to prepare perspective plan for the entire mission period as well as annual plan on yearly basis. The District Health Action Plan is the key strategy for integrated action under NRHM.

79. The village would be an important unit for planning. The VHSC would be responsible for preparation of the plan. It is however realized that extensive capacity building would have to be undertaken before the villages are in a position to take up the planning exercise. The Mission therefore would not insist on village plans at least during the first two years of Mission. The Block Health Action Plan would continue to form the basis for District Health Action Plans.

80. The district plan would be an aggregation of block plans. These plans would cover health as well as its other determinants like nutrition, drinking water, sanitation etc. The exercise would be taken by the District Health Society under the leadership of the District Health Mission. As far as the other determinants are concerned, the funds for the implementation of the programmes related to them would continue to flow through the existing channels but the District Plan would clearly bring out the convergent efforts being made for the improvement of the status of health as well as its other determinants. The District Health Plan would comprise plans on RCH-II, Disease Control Programmes, Immunization and other NRHM activities. The Plan would also delineate the steps being taken up for convergence in the vertical health programmes including surveillance activities at the District, CHC and PHC levels and also the rationalization of manpower and resources being brought out in the process. It will also reflect on the wider determinants of health and the interventions therein.

81. 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 base line for the Mission. Illustrative format may be seen at Annex – V. 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. 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. It may be mentioned here that 700 professionals (Chartered



Accountants, MBAs, IT Experts) have already been inducted in the EAG 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 IDSP 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.

82. Appraisal of the District Health Plan would be jointly taken up by the national/state Mission. The representatives of the National Mission would be nominated by the Mission Director. The States would be encouraged to nominate PRI representatives, institutions, NGOs, etc. as participants in the appraisal process. Funds on normative basis are being set apart for taking up the appraisal process. Since resource allocation between different items of expenditure and between districts and regions would also need to incorporate the overall strategic and policy considerations, there would need to be clear guidelines and norms fixed for this at the outset, to be revised mid-term if required and appraisal teams may need to look at adherence to some norms with powers to over rule norms where a case is made out. Thus for example the funds allotted to community processes or intersectoral areas may be quite low and to infrastructure or drugs quite high, unless such norms are in place.

83. Based on the appraised District Health Plans, the State Health Mission would get the State Plan prepared. After it is approved by the State Health Mission, the Plan would be appraised by the National Programme Coordination Committee chaired by the Mission Director already set up for appraising the PIPs prepared under the RCH II (programme) involving all Programme Directors of the Ministry. The appraised Plan will be approved by the Secretary, Health & FW (Chairman of EPC) for approval as is followed for the approval of PIPs under RCH-II. This entire process would be completed well before the beginning of the financial year so that the implementation of the Plan could begin in the right earnest from the start of financial year itself. The first installment of the funds to the States would be made in April/May. The second installment would be released in September/October based on the progress in each State including submission of audited statement/utilization certificate of the previous year.

84. As has already been mentioned, the funds required for vertical programmes would now flow through the common NRHM budget head. Apart from the vertical programmes which would stand merged in the NRHM budget head, the funds under this head would be utilised for core activities of the Mission approved in the Cabinet Note for NRHM dated 29<sup>th</sup> December 2004, activities recommended by the task groups constituted for the NRHM and approved by the EPC, activities included in the State PIPs including specific interventions for the North East States. The details of the activities and the norms of expenditure in regard to these activities have been spelt out in the Annex – .

85. The funds under the NRHM budget head would flow through the integrated Health Society at the State and the District levels. The norms under which the funds would be allocated by the Centre to the States and by the States to districts will be developed on the basis of population, disease burden, health indicators, state of public health infrastructure, etc. While submitting the statement of expenditure (SOE), the Districts and the States would be asked to indicate programme-wise utilization of funds so that booking of expenditure at the Central level could be done accordingly.

86. Regular supervision of the Mission activities is sine qua non for their successful implementation. At least two supervision visits would be conducted in each State every year. Like in the appraisal process, the supervision team would consist of the representatives of the national as well as State Health Missions.

87. The Mission as stated in para 24 would aim at extensive up-gradation of the training infrastructure both at the State and District levels. The funds under the NRHM budget head would be used for the purpose of up-gradation of training infrastructure as well as for conducting the training programmes.

88. As has already been mentioned, the Mission aims to emphasise on the preventive aspects of health as compared to the curative aspects. The IEC has a very important role in creating awareness amongst the rural population for changing the unhealthy habits. The IEC activities so far have been mostly at the Central and State levels. Under the decentralised model it would be ensured that more and more funds are given to the district, block and village levels to take up IEC activities.

## VII. INSTITUTIONAL ARRANGEMENT

89. The biggest challenge for the success of any programme is to establish accountable and effective implementation arrangements. Clarity regarding tasks, teams, roles, functions, powers at all levels of the system will facilitate effective action. Every state will have to carry out detailed analysis of the implementation arrangements required to implement NRHM. Additional skills would have to be brought into the system wherever required to ensure that all activities of NRHM are satisfactorily managed at the field level. The most important requirement for the success of the NRHM is to be able to develop a block level health management team along with a strong District Health Mission. Decentralized district health action plan is the key corner stone of NRHM and all efforts to build capacities and develop appropriate implementation arrangements at these levels are a priority for NRHM. Accordingly, modifications in statutes, rules and Acts will have to be carried out to provide statutory authority to NRHM structures at block and District level. Functionaries would have to be relocated and job charts redefined along with contractual appointment of functionaries with skills that the system does not have. At the district and the block levels there is a need for a total clarity about the following set of activities:

- Disease Control
- Disease Surveillance
- Maternal & Child Health
- Accounts and Finance Management
- Human Resources & Training
- Procurement, Stores & Logistics
- Administration & Planning
- Access to Technical Support
- Monitoring & MIS
- Referral, Transport and Communication Systems
- Infrastructure Development and Maintenance Division
- Gender, IEC & Community Mobilization
- Block Resource Group
- Block Level Health Mission
- Coordination with Community Organizations, PRIs
- Quality of Care systems

90. Accordingly, State and National level structures has to be reoriented to be able to provide guidance and support to the functional areas identified for blocks and districts. The biggest challenge of NRHM is to establish an effective implementation arrangement at block and district level as without it all the efforts at decentralized public health action will remain difficult to operationalize.

91. An effort to identify broad institutional mechanisms at various levels and the role of various levels has been attempted and is placed below.

The proposed institutional mechanisms of the Mission – local to be national

- Village Health and Sanitation Committee (at village level) comprising of Panchayat representatives, ANM/MPW, Aanganwadi Worker, teacher, ASHA, Community Health Volunteers.
- Gram Panchayat/Sub Health Centre level Committee of Panchayat.
- PHC/Cluster of Panchayat level PRI committee.
- Block level PRI Committee for approval of Block Health Plan.
- Zila Parishad for approval of District Health Plan.
- Independent monitoring committees at Block, district and national levels.
- Hospital Management Committee /Rogi Kalyan Samiti for community management of public hospitals.
- District Health Mission, under the leadership of Zila Parishad with District Health Head as Convenor and all relevant departments, NGOs, private professionals, etc represented on it.
- State /Health Mission chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convenor – representation of related Departments, NGOs, private professionals, etc.
- Integration of Department of Health and FW at National and State level.
- National Mission Steering Group Chaired by Union Minister for Health and Family Welfare with Deputy Chairman Planning Commission, Minister of Panchayati Raj , Rural Development, Human Resource Development and Public Health professionals as members, to provide policy support and guidance to the Mission.

- Empowered Programmed Committee chaired by Secretary Health & Family Welfare to be the Executive Body of the Mission.
- National Programme Consultative Committee under AS & Mission Director.
- Standing Mentoring Group shall guide and oversee the implementation of ASHA initiative.
- Task Group for selected tasks (time bound).

#### The role for the Block level Health Mission

- Creating a network of functionaries who can meet people's health needs.
- Amalgamating primary, secondary and tertiary care.
- Ensuring integration of AYUSH and allopathic system of medicine.
- Supervising and supporting work of ASHA, ANM, MPW, etc.
- Ensuring proper distribution of supplies- from bed nets to drugs- to the villages and facilities
- Ensuring proper and prompt communication, transport and referral linkages from the habitation to the sub-center and PHC and CHC and where needed district and tertiary care centers
- Facilitating Household Surveys, preparation of Village Health Registers and Village/ Gram Panchayat /Cluster level Health Plans.
- Organizing public hearings and conducting health facility surveys.
- Finalizing Block Level Health Plans to meet people's local felt needs - suggesting innovations.
- Providing hospital like service at CHC/Block level,
- Conducting training and orientation programmes for community leaders and health functionaries.
- Organizing health camps.

#### The role of the District Health Mission

- Responsible for planning, implementing, monitoring and evaluating progress of Mission.
- Preparation of Annual and Perspective Plans for the district.
- Suggesting district specific interventions.

- Carrying out survey of non-governmental providers to see what contribution they can make.
- Partnerships with NGOs, Panchayats for effective action.
- Strengthening training institutions for ANMs/Nurses, etc.
- Provide leadership to village, Gram Panchayat, Cluster & Block level teams.
- Establish Resource Group for Professionals also can facilitate implementation of core strategies of the Mission.
- Experiment with risk pooling for hospitalization.
- Ensure referral chain and timely disbursement of all claims.
- Arrange for technical support to the blocks teams and for itself.
- Arrange for epidemiological studies and operational research to guide district level planning.
- Nurture community processes.
- Transparent systems of procurement and accountability.
- Activate women's groups, adolescent girls' fora to ensure gender sensitive approach
- Provide data analysis and compilation facility in order to meet regular MIS needs.
- Carry out Health Facility Surveys and supervision of household surveys.

#### The role for the State Health Mission

- To provide support to District Health Mission as per need.
- To ensure support for development of capacity at all levels.
- To appraise District Health Plans and finalize them based on resource availability.
- To determine planning norms and suggested interventions for the State, keeping space for innovation.
- To release resources to Districts and to meet accounting and auditing standards and requirements.
- To engage professionals, NGOs, as per need to ensure that the finest human resources meet the needs of the Mission.
- To guide and train health team at all levels and to arrange for quality technical assistance to districts.
- To get independent studies done to see progress against benchmarks.

- To establish transparent, timely and quality procurement procedures.
- To finalize formats for survey and reports and to ensure timely submission.
- To converge with other departments and seek facilitating administrative instructions for effective action.
- To promote culture of transparency, accountability and effectiveness.
- To involve non-governmental providers and to develop models of effective risk pooling.

### **National level management of NRHM**

92. In order to carry out the functions under the Mission, the Mission requires an empowered structure, The Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) has already been established under the respective Chairmanship of the Health and Family Welfare Minister and the Union Health and Family Welfare Secretary. To carry out the functions mandated by MSG/EPC, the Mission Directorate has been established in the Ministry of Health and Family Welfare. The Directorate is headed by a Mission Director who is of the level of Additional Secretary to Govt. of India. Under the Mission Directorate, there would be 5 Joint Secretary level officers, the roles and functions of whom would be clearly articulated to ensure that their tasks and responsibilities are clearly defined. Besides, the technical divisions like Maternal Health (MH) and Child Health(CH), Immunization etc. would also be reporting to the Mission Director through the Joint Secretary concerned.

93. The States would be divided amongst the 5 Joint Secretaries. There would be a Programme Management Group(PMG) which would be responsible for all interactions with a cluster of States so that the States need to interact with just one nodal officer in the Ministry. The Programme Management Group would comprise 5 State Facilitation Units with each Unit reporting to the Joint Secretary concerned for the cluster of those States. Each State Facilitation Unit would comprise a Deputy Secretary / Director level officer, one technical officer at the level of Assistant Commissioner from the technical divisions and one officer drawn from the Statistical Division. The State Facilitation Unit would be responsible for interacting with the States, the administration, Technical Division and the Monitoring and Evaluation (M&E) Division.

94. A National Health Systems Resource Centre (NHSRC) is being set up to serve as an Apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the Centre and the States in the Programme. The NHSRC would provide necessary technical assistance to the Mission Directorate. The Mission Directorate would not only handle the day-to-day administrative of the Mission but also will be responsible for Planning, Implementation and Monitoring of the Mission activities.

95. Adequate administrative financial powers would be delegated to the Mission Directorate to enable it to function in Mission mode.

96. Given the huge requirement for technical support one NHSRC would be unable to cater to all of the demand. There is a need to enable many other national institutions to respond to requests from states and districts for technical support in planning and implementation of programmes. This would not only help programme implementation, but it would also improve the quality and relevance of work done in these institutions. Examples of such institutions are the NIHF, the all India institute of tropical medicine and hygiene, the national institute of nutrition and other ICMR funded research institutions, the schools of public health and health administration as well as technical support NGOs active in health like VHAI, PFI, FRCH etc. Enabling these institutions would require both grant in aid to some institutions to expanding their manpower and skills as well as ensuring policies by which they can respond to such requests for assistance with incentives for those experts who invest their efforts in playing such demanding roles without detriment to their core research work. Some technical institutions like the PFI or FRCH or CEHAT may be encouraged to take up the provision of mentoring support to specific state or district resource centers. Other specialized institutions like the NIN or the NICD may provide support to states and districts on incorporating areas of their concern into district plans and staying with them through the entire period of programme implementation till these goals are met as part of the integrated district plan.

### **Need for empowerment**

97. The modalities for operating NRHM budget heads and the preparation of District / State Action Plan have already explained in the Note. These Plans would be prepared and approved in accordance with the normative framework which has been discussed in the above paragraphs. Even though in general the State Action Plan would be in



accordance with the normative framework, there could be situations where deviations would have to be made from the norms to achieve the Mission Goals. There could also be situations where new schemes are to be taken up and the existing schemes of the Department of Health and Family Welfare would need modifications to tailor them better for achievement of the Mission Goals. These could include modifications to the existing centrally sponsored schemes such as Routine Immunization, Sterilization Beds, Family Welfare linked Health Insurance Plan, procurement of materials, Pulse Polio Programme, Immunization, Training, IEC, Area Projects, compensation for sterilization etc. Since the process of seeking modification from the EFC is time consuming one, it would be necessary to empower the EPC to have the same powers as the EFC. Since the Department of Expenditure is represented in both the EPC and MSG at the level of Secretary (Expenditure) as well as at the level of AS & FA of the Ministry, there would be adequate financial scrutiny of the proposals. In any event, if it is felt that any proposal involves major deviation from the existing norms, that proposal can always be referred back to the Department of Expenditure for scrutiny and concurrence. It is proposed to empower the EPC, have the powers of EFC to approve schemes under the broad framework already approved by the Cabinet and to modify existing schemes to meet the needs of the Mission, as well as to approve deviations in the norms, wherever necessary. The empowerment required for NRHM is on the lines of empowerment already provided for Sarva Siksha Abhiyaan.

98. The need for capacity building at various levels has already been highlighted. Within the overall norm of not more than 6% of the total outlay to be spent on management cost, the services of experts and other functionaries may have to be hired on contractual basis to carry out the activities under the Mission. The Mission would also need to be vested with authority to strengthen management structures without creating any new permanent posts.

99. Health is a State subject and Family Welfare a concurrent one. The role of the Central Government level Mission therefore becomes even more difficult as it has push reforms in States with its additional financial and human resources. The Central Government will carry credibility with States if it is able to meet the diverse needs of States within its overall broad framework for implementation. Flexibility requires closer monitoring and detailed scrutiny of every proposal placed as part of the Annual Work Plan and Budget. The Mission structure has been proposed keeping these needs in

mind. It has to have the flexibility to carefully appraise and approve State Plans under the NRHM and also the ability to carry out rigorous monitoring and evaluation of the programme from time to time. The Mission also has to work with States to improve their capacities in planning and implementing the programme better.

100. Health and Family Welfare is a sector where a large number of external agencies participate within the overall framework of government programmes. The proposed higher allocations to the health sector for NRHM will also require seeking higher levels of external assistance for the sector. The Mission has to be empowered to negotiate and take decisions regarding such proposals within the framework approved by the Cabinet. The intention of empowerment of the Mission structure is to ensure that no time delays take place in achieving the time bound objectives and outcomes of the Mission. Since resource mobilization will also be a significant part of the proposal, it is important to provide powers to the MSG/EPC to take forward deliberations on the subject, within the framework provided by the Ministry of Finance and the Planning Commission. Since both the Planning Commission and the Finance Ministry is involved at the highest level in the deliberations of the Mission, all concerns of these departments/commissions will be taken on board, before arriving at a decision, to meet the Mission outcomes.

- 101. For purposes of efficient financial management and improved utilization of resources, the special features of a decentralized programme that has to incur expenditures at the community level, some special dispensation is required in the management and release of finances.

## VIII. SUPPORTIVE ACTION: COLLABORATIVE AGENCIES

### CONVERGENCE FRAMEWORK FOR EFFECTIVENESS

#### 8.1 Why convergence?

- Convergence with all Departments that influence outcomes of wider determinants of health is necessary for improved health indicators.
- District level Zila Parishad framework allows convergent action of all Departments under one umbrella.

- State and National level should allow more flexibility and more untied financial resources to districts for them to forge solidarity of diverse departments.
- Bringing development functionaries under the control of the district facilitates greater co-ordination in deployment and integration. Need to develop district specific cadres of functionaries.
- Women & Child Department, Education & Literacy Department, Panchyati Raj and Rural Development Department, Water & Sanitation Department, other interventions in health care like HIV-AIDS, AYUSH, etc, need to be better integrated with interventions for health care.
- Programmatic integration, and convergence is easier to effect at district, sub district, Block levels.

## 8.2 Convergence with Panchayati Raj Institutions.

- Panchyat has mandated role in family welfare, health & sanitation, public health, education, women & child programmes, etc.
- Mandated role not in practice in most states due to centralized Budget and centralized bureaucracies – Panchayats not adequately involved in decision making and supervision.
- Commitment to decentralization of health sector in the National Health Policy 2002, Planning Commission Report & the Tenth Plan Document.
- In August 2003, the Central Council of Ministers of Health and Family Welfare had resolved “that the State would involve PRI in the implementation of Health & Family Welfare Programmes by progressive transfer of funds, functions and functionaries, by training, equipping and empowering them suitably to manage and supervise the functioning of health care infrastructure and manpower and further to coordinate the activities of the works of different departments such as Health & Family Welfare, Social Welfare and Education which have functionaries in at the village and Block levels.”

## 8.3 Decentralization – Six key issues addressed in Kerala

- Functional clarity - all development functions transferred from district level to local Government.

- Transfer of human resources - balance between disturbing staff cadres, dual control, authority to penalize for non-performance, fair and open transfer policy, and protection of professional interest through 'Code of Conduct' . .
- Transfer of funds – One third of Plan funds devolved to PRI, 90% in untied form within a broad policy framework, with 30% in productive sectors, not more than 30% in roads, and at least 10% in gender sensitive schemes.
- Decentralized participatory planning – needs identification, situation assessment, plan development and approval.
- Good governance- transparency, right to information, debureaucratization, especially in technical matters, code of conduct, Citizen's Charter, simple office Management system.
- Capacity building – general and theme based training.

#### 8.4 Key issues in PRIs making a difference

- Empowerment of Panchayat and the assured availability of adequate funds, clear articulation of functions, & transfer of requisite functionaries to carry out such functions.
- Enlisting NGO support in building capacity among PRI members to efficiently handle development related functions.
- Repealing penalties and disincentives such as the two child norm, which violate individual rights.
- Critical role of Panchayati Raj Institutions in the success of the NRHM- planning, implementing, monitoring, inter sectoral convergence, community ownership.

#### 8.5 Key Convergence areas with the Department of Women & Child Development Department – An illustrative framework

- Aanganwadi Centre as 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.

#### 8.6 Convergence for women's empowerment, and gender equity.

- Promotion of collective action by women- in the form of women's committees, health committees, self help groups etc. and incorporating an understanding of women's health rights and its relation to patriarchy in such collective functioning.
- Enhancing the access to knowledge and skills for women
- Questioning negative stereotypes of women, especially those harmful to health and equity and promoting positive images of women.
- Intervention for adolescent girls - knowledge & skills to women's groups (SHG, to act as a collective on issues of social importance such as prevention of early child marriages, female foeticide, the Pre Natal Diagnostic Test Act (PNDT), domestic violence, dowry, and women's empowerment initiatives.
- Intervention for adolescent girls - knowledge & skills to women's groups (SHG, to act as a collective on issues of social importance such as prevention of early child marriages, female foeticide, the Pre Natal Diagnostic Test Act (PNDT), domestic violence, dowry, and women's empowerment initiatives.
- Promote community ownership through women's groups to maintain key facilities like water and sanitation, health centres, schools, & other common properties and monitor their use and misuse. .

- Serve as a forum for discussion of sectoral issues such as nutrition, sanitation, education & drinking water and enhancing womens participation in decision making at all levels in these areas.
- Joint planning for convergence
- Common Behaviour Communication Change strategy for convergence.
- Common monitoring and information system.

8.7 Convergence for drinking water and sanitation – with programmes in those sectors – Total Sanitation Campaigns, drinking water provision, etc.

8.8 Convergence with programmes for food, nutrition, social security, etc.

#### **A. GOVERNMENT NON GOVERNMENTAL PARTNERSHIPS**

102. NRHM seeks partnership with non-governmental health care providers through better regulation and transparent systems of accreditation for quality health services at agreed costs and norms. Given the wide diversity in the quality and costs of non-governmental providers, NRHM emphasizes the need for ethical partnerships based on delivery of quality services. Involvement of community groups in the process of partnerships will facilitate a more open and transparent relationship with the non governmental sector.

103. The rates for hospital procedures and health consultation vary widely across states and regions. Standardization of quality health services, establishment of standard treatment protocols, agreements regarding costs of health services require wider consultation and agreements. The legal framework to ensure minimum standards of all Government and Non-government health care facilities is necessary. The legal framework protects citizens' rights and also determines minimum standards for quality services. NRHM will provide a platform for improved regulation, setting up standards, dissemination of standard treatment protocols, franchising for seeking standard rates and costs for agreed services, etc.

104. 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.

105. Accreditation of non-governmental hospitals would be required to extend health care services in remote areas. Given the NRHM commitments regarding maternal and child health, partnerships with the non-governmental sector to increase institutional deliveries and to facilitate improvement of standards in the Government and non-governmental system would be attempted. Various models and inventions in Government and non-governmental partnerships have emerged in the States to ensure quality health services to the citizens. Contracting out and contracting in of services has been attempted. Arrangements for availability of diagnostic services etc. through partnerships is being experimented in many states. The NRHM will encourage a diversity and plurality of Government and non-governmental partnerships in a transparent way so that quality of services, rates of services and treatment protocols are widely known under the umbrella of a robust monitoring and accountability framework.

106. The involvement of non-governmental sector organizations is critical for the success of the NRHM. Many non-governmental organizations play an important role in advocacy for a right of health care and for effective community action. Some other NGOs are service delivery NGOs and many good hospitals in our country are run by Trusts. Many of these hospitals are excellent in the process of capacity building of health functionaries especially nurses. Many others provide service guarantees in remote regions specially in the far and

distant tribal areas. NRHM would support linkages with the large number of trust and society managed hospitals and dispensaries in remote areas to see how best they could provide service guarantees to the poor.

107. NRHM also recognizes the need for funding of activities by the NGOs at the District, State and National levels. To ensure better accountability and thrust for capacity building, the NRHM would support co-option of NGOs in Block and District teams and will facilitate setting up of grants-in-aids systems for NGOs at the National, State and District levels.

108. Given the Panchayati Raj framework for decentralized participation, NRHM will seek the 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 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.



## TAMIL NADU'S SUCCESSFUL INITIATIVES IN THE HEALTH SECTOR

*(Based on T. V. Anthony's article in "Population Policy and Reproductive Health" and the Tamil Nadu Case in Jean Dreze and Amartya Kumar Sen's India – Development and Participation)*

Tamil Nadu has been one of the best performers with regard to reduction in fertility rates and a large number of indicators of women's and children's well being like IMR, MR, Nutrition, schooling, etc. While Kerala has had an advantage of good social indicators over a long time frame, Tamil Nadu is a better example for other states as it demonstrates that even with high poverty ratios, large population, and poor nutrition statistics, etc, it is possible to improve the performance in a short span of only a few decades. Some of the factors identified to explain the improved performance are as follows:

- Female Age at Marriage has risen significantly in Tamil Nadu. This has been possible due to a strong social awareness programme created by a popular reformer called "Periyar" Ramaswamy whose influence was felt all over Tamil Nadu, particularly by people of the poorer strata. Periyar emphasised the need to 'liberate women from frequent delivery by the use of contraception' and 'not to allow marriage of a woman before 22, so that 3 to 4 births could be averted'. The initial push given by Periyar for raising the age at marriage continues to be given support by the Tamil Nadu government. Welfare schemes for girls provide grants if girls complete 8<sup>th</sup>/10<sup>th</sup> Standard of education and marry after the age of 20. The amount is forfeited if either condition is not fulfilled.
- The Chief Minister's Noon Meal Programme launched in 1982 all over the State (It covered some areas in Kamaraj's time), has given a tremendous boost for health, welfare and for the acceptance of the small family norm. It was launched against administrative advice as it was expected to be very expensive, involving Rs. 100 crores, at 85000 feeding centres, for 85 lakh children in the 2-15 age group, requiring 2 lakh additional staff, and huge logistic issue of supplies. MGR's will pushed the scheme. He said – "When hunger haunted my home a lady next door extended to us a bowl of rice, and saved us from

extinction....Today as CM it is my duty to provide at least one meal to every child every day, to eliminate the agony of their helpless mothers.”

- Expected and unexpected benefits of the Noon Meal programme have been many. It is a crèche for the 2-5 age kids; school attendance has improved and drop out reduced; child nutrition has improved; Centres serve as immunization/ antenatal care/ supplemental feed centres for 6 month to 2 year children covered under TINP; provides employment for about 2,00,000 women, mostly widows and destitutes, as mid day meal organisers. These women helped carrying the health message to the poorest households as they came from that social background. Provided an all women focus.
- Serious efforts at raising female literacy and status. Kamaraj in 1961 introduced the concept of one school for every village. Assistance for education up to Class – VII is provided by the State by free education, mid – day meal, free textbooks, one set of uniforms, one set of chappals, and free bus pass.
- Since 1987, assignment for Government land both for cultivation and for house site is issued only for women. Commission for women established in 1993 to go into issues concerning women; Schemes for marriage assistance, nutritional support for pregnant women, grants for widow remarriage, and special schemes for girl child are there in Tamil Nadu.
- Improvement in IMR reduction and Child Survival has also been on account of intensive training of ANMs, establishment of Rural Health training Centres in selected PHCs to provide such training, creation of new post of Chief Health Nurse to monitor all MCH activities in a Block, special training of dais in antenatal care, provision of Disposable Delivery Kits (DDKs), adoption of fixed day schedules for ANMs (Mondays for antenatal care, Tuesday for review meetings in the PHC, Wednesday for immunisation, Thursday for School Health Programme, Friday for IEC activities for expectant mothers.
- Acceptance of Contraception and Birth Spacing is another feature in Tamil Nadu. Sterilization has been a very high priority for Collectors. At the district level, most Collectors roped in the entire resources and manpower at their disposal for the family welfare programme.

- A large part of the success of Tamil Nadu in reducing Crude Birth Rates from 1984 onwards can also be attributed to the very effective IEC programmes – many messages emphasised – small family, spacing, age at marriage, ideal weight of the new born child , etc.
- Recent studies point out a number of enabling factors that have facilitated Tamil Nadu's rapid demographic transition. Commonly cited factors include a good infrastructure, a rich history of social reform movements, high literacy rates in the younger age groups, wide popular exposure to mass media, and strong 'political will'. Less widely discussed is the relatively liberated status of women in contemporary Tamil society. Tamil Nadu has a high female – male ratio, little gender bias in school attendance, and high levels of female labour force participation. Also interesting is some recent information from the second round of the national Family Health Survey ( 1998-99) relating to different aspects of 'female autonomy'. Whether we look at the proportion of adult women who work outside the household ( 43 percent ), or who have independent access to money ( 79 percent ), or who are able 'to go to the market without permission' from other family members ( 79 percent again ), Tamil Nadu is ahead of all other major states ( with one exception – Himachal Pradesh – in the case of independent access to money). Bearing in mind the role of women's agency in the demographic transition, this feature of gender relations is crucial to our understanding of what happened in Tamil Nadu.
- Leela Visaria's study on Tamil Nadu contains a wealth of insights into the practical, day – to- day measures that have helped to enhance the quality of health services in Tamil Nadu. To illustrate: (1) primary health care centers in Tamil Nadu are well supplied with basic drugs; ( 2 ) about 40 to 45 percent of medical officers are women; (3) ANMs meet the Medical officer typically six times a month; (4) many primary health centers ( more than 250) are open 24 hours a day. In all these respects, the situation in Tamil Nadu contrasts quite sharply with the situation in most other States.

	<b>Tamil Nadu</b>	<b>National Average</b>
Female Literacy	64.55	54.16
Decennial growth in population	11.19	21.34
School Attendance 6-17 age	79.7	72.1
Infant Mortality Rate	48.2	67.6
12-23 month children who have received all vaccinations	88.8	42.0

## **KERALA'S SUCCESS**

*(Based on Vijay Chandran's study for ICRIER)*

Kerala has been a global flag bearer of human development. Human development indicators comparable with many developing countries have been achieved with a fairly modest level of economic activity. The 1990s has seen a more than the national average per capita real growth in Kerala for the first time, largely with the growth of the services sector during the decade. It is expected that the trend will continue given the contribution of the services sector in the over all growth of transition economies.

Many factors have been identified to explain the extraordinary health care performance of Kerala. Some of these are –

- Spread of literacy and education
- Mass movements for up lifting the backward classes
- Political awakening leading to effective land reforms so that every household got homestead land. This has created a people's stake in development.
- Food security through a large subsidised and effective Public Distribution System and the non – negotiability of minimum wages.
- Prevalence of indigenous systems of medicine. More than 700 of the 960 villages in Kerala have an Ayurvedic Dispensary.

- A well developed health infrastructure in public and the private sector. All the Panchayats ( villages) are served by a facility in modern medicine.
- Migration leading to remittances that supported rural prosperity in the form of better infrastructure and housing.
- The rural – urban continuum facilitating the deployment of health functionaries even in villages.
- Clustered large villages with high population density making the outreach easier.
- Serious efforts at decentralisation through a People's Plan campaign leading to development of capacities in Panchayati Raj Institutions for managing public health system.
- Adequate provision of financial resources for health care.
- A very motivated bureaucracy accountable to the people.

The private sector has also contributed meaningfully to an improvement in the health infrastructure with the total beds in the private sector being about one and a half times the beds in the public sector. The private sector has been viable on account of the large remittances flowing in from migrants of Kerala.

The State has taken some initiative in resource mobilization. The Hospital Development Committees were set up in the 1980s for all the major public Hospitals. The Committees represented the civil society including all the political parties. The idea was that they would find local solutions to felt needs. The HDCs were permitted to collect user charges for some services and spend it on the development of the Hospital as decided by them. Hospital charges are also collected through the Treasury and on both these parameters of cost recovery, Kerala's performance has been one of the best in the country.

Autonomisation of Hospitals has also been tried in Kerala in recent years. Registering of Hospitals as a separate society helps in collecting user fees in a more systematic manner. Such processes can always build protection for the poor.

Non resident status of doctors in spite of available accommodation, under utilisation of sub centres, under utilization of the in patient facilities in the Primary Health Centres, and shortage of manpower are identified as some of the problems in the health care system in Kerala.

Decentralisation of powers to Panchayats, incentives for serving in remote rural areas, attempts to have separate streams of specialist and administrator doctors are some efforts being currently made to improve the system.

V. Vijaychandran's conclusion on the Kerala experience is very apt: "The experience of Kerala is one of empowerment of health empowerment of the people. That is the route for health for all."

## **IX. HUMAN RESOURCES SUPPORT FOR THE MISSION**

### MEETING THE HUMAN RESOURCE NEEDS

#### 9.1 Some standard human resource issues

- Staff shortages of all key cadre - Doctor, Para Medics, ANM, Nurses, Lab Technicians, OT Assistants, etc.
- Irregular staff attendance and absenteeism especially in remote areas.
- Lack of opportunities for Continuing Education, skill upgradation and adoption of standard Protocols.
- Lack of a supportive system or a career plan to provide adequate motivation to cadre.
- Lack of use of standard Protocols to promote quality affordable care and full utilization of human resources

- Dysfunctional procurement systems leading to under utilization of human resources. Non – availability of drugs and diagnostic tests at health facility leading to wastage of doctors' time and demotivation.
- Lack of orientation to needs of rural areas.
- Weak on non-existent accountability framework leading to powerlessness of local communities and Panchayat vis-a-vis the health system functionaries.
- Non-transparent transfer and posting policy leading to demoralization and corruption.
- Inadequate systems of incentive for difficult area postings.
- Lack of transparency in career progression leading to demotivation & corruption.
- Under-utilization of MBBS doctors and Specialists an account of two narrow a focus of health system around few vertical health programmes.

## 9.2 How to tackle the crises of human resources?

- Needs a clear state specific human resource management policy and a strong political and administrative will to ensure transparency in management of cadres.
- Accept the need for engaging more para-medics and doctors to meet the growing health care needs in rural areas.
- Compulsory rural postings / Rural Health Service
- Develop incentives for difficult areas and system for career progression that categorizes postings into different grades.
- Accept accountability framework where local communities/Panchayats have a role.
- Devolve power and function to local health care institution- provide resource and flexibility to ensure service guarantees.
- Train bright young doctors as Managers of Health System and offer opportunities for training in IIMs etc. on condition that they return as District Health Manager and serve a minimum three-year term.
- Increase avenues for training and development so that standard treatment protocols can be operationalized.
- Provide resources, flexibility and powers to ensure that IPHS standards are achieved at CHCs. Develop similar standards for Sub Health Centers and PHCs.
- Revisit single doctor PHC idea- is it better to post doctors to Block/ CHC with mobility to do fixed day clinics or should we go for two doctor PHCs with adequate

staff nurses and ensuring a minimum OPD attendance and service provision to justify this investment

- Provide improved telephone linkages to SHCs, PHCs, for consultations.

### 9.3 What will a good human resource policy require

- Induction of Management experts into the system, in District and State level Health Mission.
- Undertake cadre and institutional reviews to ensure best utilization of manpower and removal of constraints to decision making.
- Integrate field functionaries under various disease control programmes, AYUSH, etc. under a common frame of village, SHC, PHC, CHC/ Block structure. Break vertical systems and forge horizontal linkages.
- Make Para Medical Cadre a District specific cadre. Offer incentives for multi - skilling to improve outreach of diagnostic tests.
- Having a separate cadre of Sections i.e. Rural Health Service
- Re-orient medical education so that doctor is geared to rural to needs.
- Focus on key shortages of Anaesthetists, Gynecologists, Surgeons, Paediatricians, etc. alongside strengthening of diagnostic facilities.
- A policy of regular in service training that ensures that skills and motivation levels of all staff are periodically assessed and upgraded.
- Adequate training infrastructure to achieve the training goals outlined above.

### 9.4 Improving effectiveness of human resources.

- Increasing density of health care providers per geographical area
- Building referral chains of Medical Professionals and Habitation level health workers.
- Develop trust and partnership between the Medical Professional and the Community Health Worker.
- Develop credible accountability framework.
- Adopting professional management principles.



## **X. FINANCES FOR THE MISSION**

### NRHM as overarching framework and as a programme with distinct funding

109. As the above discussions indicate, the NRHM will be an over arching framework which would encompass all interventions for health care as well as those for wider determinants of health care. The financing through the NRHM budget head would provide the much needed funds to the district level to facilitate better health outcome. At the cutting edge i.e. district level, convergent action within the umbrella of the Zila Parishad is expected to improve efficiency, effectiveness and outcomes of interventions in the health, women and child, drinking water, sanitation, youth and adolescent, and the school education sector. The framework for local specific decentralized action involving community organizations and PRIs, is expected to provide a thrust for outcome based approach to this vital sector.

### NRHM and sustainable financing of States

110. Looking at the ambitious plan of action under the NRHM, the requirement of funds are likely to be considerable. However, in view of the fact that the current public health expenditure is a paltry 1% of the GDP, this quantum jump is indeed timely. Moreover, this is in line with the NCMP which seeks to increase the public health expenditure to 2-3% within the next five years. The above target however cannot be achieved unless the states also step up their expenditure on health very significantly as they together contribute almost four-fifth of the current expenditure. The fiscal stress under which the states work is too well known to be elaborated here. The major burden of the additional expenditure would therefore have to be borne by the Central Government at least during the mission period. **It would be the aim of the NRHM to increase the share of central and State Governments on health care from the current 20 – 80 to 40 – 60 sharing in the long run.** With this in view, it is proposed that under the Mission, 100% grants be provided to States in the remaining period of the X Plan. During the XI Plan period the states would be expected to contribute 15% to make the share of the Central Government 85%. From the XII Plan onwards the relative share of the Centre and the states could be a sustainable 75 – 25. It would however be insured that all along the state expenditure on health increases in real terms and there is no substitution of the state expenditure by Central expenditure. An MOU is being signed with the states which seeks inter-alia a commitment to increase the state share of expenditure on health by at least 10% every year. The 75-25 arrangement needs to be sustainable to ensure that the gains of the Mission are not dissipated and furthered away. Public health infrastructure requires all sustainable financing from the Central Government on a longer time frame.

#### Financial Resource Assessment

111. As regards costing of additional resource needs, the National Commission on Macro Economics and Health has made a detailed assessment of investment requirements, based on bare minimum standards, costs and needs, largely at Government prices that are 30-50% lower than in the private sector. The Commission has recommended additional non-recurring investment of Rs. 33811 crores and a recurring investment of Rs. 41006 crores. This expenditure would be made over a period of five to seven years. The additional recurring requirement is worked out for the 7<sup>th</sup> year. This includes health promotion, regulatory systems, enforcement of regulations, human resources for health, training, research and development, delivery of health care

services, and social health insurance. It covers the entire health sector including establishment of new medical colleges, etc., that are not the focus in the National Rural Health mission, The investment needs for some of the key areas that are covered under the NRHM are as follows:

Activity	Non-recurring additional investment	Recurring additional investment
1. Health Promotion including publicity and dissemination and community involvement for preventive activities.		Rupees 4000 crores
2. Training – of Village Health Committees, unqualified RMPs, Village level workers, in service health personnel, fellowships, rural allowance for health personnel, etc.	Rs. 853 crores	Rs. 765 crores.
3. Delivery of health care services (Bare minimum requirements)	Rs. 23968.92 crores	Rs. 20,958.86 crores
4. Social Health insurance, including premium - subsidy for BPL families.		Rs. 9000 crores
5. Human Resources for Health - Opening, upgrading and strengthening Nursing Colleges.	Rs. 3923 crores	Rs. 526.50 crores
<b>TOTAL</b>	<b>Rs.28744.92 crores</b>	<b>Rs.35,250.26 crores</b>

112. This comes to an additional investment of Rs. 28744.92 crores of non-recurring investment and an additional recurring investment of Rs. 35,250.26 crores. **If we broadly agree with the over all calculation of the NCMH and allow for local variations within the over all resource envelope, the broad resource need for NRHM will be an additional Rs. 30,000 crores of non-recurring resources and a recurring need of Rs. 36000 crores, over and above the current allocations for NRHM in 2005-2006. The cost of construction and maintenance of infrastructure in the North Eastern States, the hilly regions, etc., is higher and additional provision within the overall resource envelope will have to be made. Also, the cost of seeking health care from non-governmental providers may be higher than the costs worked out by the NCMH ( The NCMH Report itself mentions it.).**

Annual Resource needs for NRHM broadly as per NCMH Assessment

113. A total additional investment of Rs. 30000 crore non - recurring and Rs. 36000 crore recurring is projected as per the NCMH. The actual absorptive capacity may be

much lower. The XI Plan period will also involve 85-15 sharing between the Centre and the States. Assessing a 7% annual rate of growth of GDP, in GDP terms, a larger allocation would be required to reach 2-3% GDP by 2012.

**114. Given the current absorptive capacities in the States as also the structures for managing accountability at various levels, it is likely that the demand for resources will be less than what is suggested by NCMH. While agreeing to the resource envelope suggested by NCMH in principle, the actual need year to year will depend on the pace at which States push reforms in order to remove the constraints on expenditure and its effective utilization. The Department of Health and Family Welfare would make its annual demand for finances in the light of the resource need as also the absorptive capacity in the States. It is likely that the increased allocations will be required with enhanced implementation and absorptive capacities. A clear in principle indication of additional financial resources upto 2012 (end of XI Plan) would facilitate states in planning better.**

115. Clearly a major stepping up of financial resources for the health sector is required if the promised 2-3% GDP public expenditure on health has to be attained before the end of the 12<sup>th</sup> Plan (2012). Assuming a 7% rate of growth of the economy as also a modest 4-5% rate of inflation, the actual financial need at current prices of 2012 will be much higher than the financial needs articulated in terms of the current prices (2005). Given the fact that the public expenditure on the health sector was about 32,000 crores in 2004-05, the commitment to raise it to 2-3% GDP implies total expenditure on health at current prices to be in the range of 60,000 cr. to 90,000 cr. This would mean an additional annual commitment of 30,000 cr. to 60,000 cr. 2012 at current prices. Since a substantial amount of the additional resources need is likely to be provided by the Central Government, it is clear that the Central Government share has to go up substantially. Given absorptive capacity in the states and the time it may take to improve implementation capacity should be fair to assume an annual 30% increase in health sector allocations up to 2007-08 and an annual increase of 40% from 2009-2010 to 2011-2012. Following this broad assessment the Central Government resources needs are likely to be as follows:

<b>Year</b>	<b>Central Govt. NRHM Allocation</b>	<b>Recurring</b>	<b>Non-Recurring</b>	<b>State Contribution</b>	<b>Total</b>
<b>2005-06</b>	6,500			-	6,500
<b>2006-07</b>	9,500	9000	500	-	9,500
<b>2007-08</b>	12,350	11000	1350	2,179	14,529
<b>2008-09</b>	17,290	13000	4290	3,051	20,341
<b>2009-10</b>	24,206	16206	8000	4,272	28,478
<b>2010-11</b>	33,884	23884	10000	5,980	39,864
<b>2011-12</b>	47,439	42439	5000	8,372	55,811

#### Normative Framework under NRHM

116. It is clear from the details of the plan of action under NRHM that very diverse activities would have to be taken up at various levels extending right from the village level to the Central Government level. These activities would also have to be planned and appraised at decentralized level. It is therefore necessary to provide a normative framework under which the activities would be taken up.

117. The financial norms under NRHM are derived from three sources:

- (i) The approved norms of all the schemes that are subsumed under the NRHM. These include National Disease Control Programmes, all Family Welfare programmes and Integrated Disease Surveillance programmes;
- (ii) The norms suggested by the National commission on Macro Economics and Health. As the norms of the Commission make it clear, these are worked out for Government hospitals and at Government costs. The cost in

the non-Governmental sector is likely to be higher than what is projected by the Commission;

- (iii) Specific financial norms included in the current proposal. These are however broad norms. Flexibilities may be necessary to take care of the needs and priorities of the states.

118. While approving any proposal included in any State Action Plan, the NPCC, EPC/MSG would rely on the financial norms derived from all the above sources. The States would be encouraged to use these norms conjunctively. For providing quality health care in the rural areas, these would provide a vast menu of options to the States to choose from.

119. There is no difficulty in using the norms derived from the first source as they already stand approved. Specific approval would be required for the norms described in the second and the third parts.

120. The second part pertains to the norms recommended by the National Commission on Macroeconomics and Health. The Commission has suggested a structure and fund requirement for SHC/PHC/CHC. The illustrative structure and costs for SHC/PHC/CHC is placed at Annex – \_\_\_\_\_. The norms derived from the NCMH pertain to essential medical interventions. To arrive at the figure of per capita expenditure on health services, the report has worked out the unit cost as well as total cost of each intervention included in the packages for core essential health care services, basic health care services to be provided at CHC and secondary care services at District Hospital. The details of the three components are as follows:-

- A core package to be made accessible at public cost viz. all vector borne diseases, TB, Leprosy, HIV / AIDS (excluding treatment) and other STDs, childhood diseases, preventive and promotive health education that includes immunization against vaccine preventable diseases, ante-natal and postnatal

care of mothers, family welfare, information dissemination on health as well as its determinants.

- A basic package consisting, in addition to the above, surgery and investment for hypertension, diabetes, respiratory diseases such as asthma and injury.
- A secondary care package consisting of treatment for vascular diseases, cancer and mental illness over and above the referrals from the CHCs those need to be handled at district hospitals.

121. The unit costs and resource requirements as worked out by the NCMH for the core, basic and secondary care package is placed at Annex- III. The above norms would help in reimbursement to accredited private establishments for taking up these interventions. The Mission would like to adopt these norms. It may however be mentioned here that the costs assessed by NCMH are for government hospitals and facilities. The cost in the private sector is likely to be 30-50 percent higher (as mentioned in the report itself). The Mission Steering Group at the State level will have the authority to increase costs by up to 25 % for private facilities. Any further escalation will require the approval of the National level Mission Steering Group.

122. The norms included in the third part comprise pattern of assistance to states and districts; activities to be taken up under the mission as well as the functional and financial norms under which those activities are to be taken up. The norms for which approval of EFC is sought are indicated in Annex-

123. It would be necessary to clarify that many of these norms are only indicative. For instance, even though norms for physical construction of health facilities have been indicated, these would be subject to the physical and financial norms prevalent in that state. If the schedule of rates prevalent in that state indicates a lower or higher cost as compared to the costs indicated here, the state rates would prevail. Similarly, mere inclusion of an activity in the framework does not imply that the states would have to take up that activity. No activity is to be taken up without a clear understanding of its outcome or effect. The accountability framework under the NRHM would ensure that the communities keep a strict control on the cost and quality of the services being provided.

## **XI. MONITORING AND REVIEW**

### **Community Monitoring Framework**

124. We have discussed the overall monitoring framework in an earlier section (IV L). The basic change that NRHM wishes to bring about in the monitoring framework is to involve local communities in planning and implementing programmes with a framework that allows them to assess progress against agreed benchmarks. While external institutions will also assess progress, they will do so on benchmarks that have been agreed with local communities and health institutions. The intention is to move towards a community based monitoring framework that allows continuous assessment of planning and implementation of NRHM. Besides the issues already mentioned earlier on the monitoring framework, the broad principles for community based monitoring are listed below.



125. Given the overall objective that people should have complete access to rational, appropriate and effective health care, community based monitoring should preferably fulfill following objectives:

- It should provide regular and systematic information about community needs, which would guide related planning
- It should provide feedback according to the locally developed yardsticks for monitoring as well as key indicators. This would essentially cover the status of entitlements, functioning of various levels of the Public health system and service providers, identifying gaps, deficiencies and levels of community satisfaction, which can facilitate corrective action in a framework of accountability.
- It should enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active *subjects* rather than passive *objects* in the context of the public health system.
- It could be used for validating the data collected by the ANM, Anganwadi worker and other functionaries of the public health system.

(i) Ownership of Community monitoring process

- The health department functionaries need to be involved in the preparation and mobilization phase of the initiative so as to enable 'ownership' of the process and outcomes among the providers and users.
- PRIs, community based organizations and NGOs, along with health department functionaries should be involved in the preparation and mobilization phase of the initiative so as to enable ownership of the process and outcomes among the providers and users.
- The government can enable such interactive processes through issuing relevant Government Orders, and by ensuring effective communication to all levels of public health functionaries.

- All the members of any committee that is formed (for example the Village Health Committee) must have their roles and responsibilities clearly defined and articulated.

(ii) Powers and capacity building

126. The committees that are formed at various levels **must have concomitant authority i.e. they must have the power to initiate action**. The capacities of the members of a village level committee have to be built continuously for them to be able to function effectively. This would require allocation of resources and capacity building inputs. This process must begin with full and ready access to information.

127. The intent of the newly launched NRHM as mentioned in the core strategy is that it will promote community ownership and decentralised planning from village to district level. This is supposed to be through participatory processes, by strengthening evidence based effective monitoring and evaluation. In order to actually do so it will be imperative that:

- The government should enable such interactive processes by issuing relevant Government Orders. One example of such orders is the one passed by the Government of Rajasthan for the formation of Convergence Committees at the district and PHC level. A similar example is the response of the Gujarat Government to the National Human Rights Commission, wherein coordination bodies at various levels of the Public Health System are proposed for operationalising a State level health services monitoring mechanism.
- All the members of any committee that is formed must have their roles and responsibilities clearly defined and articulated.
- Effective and quality monitoring requires institutional mechanisms at various levels beginning at the community and going upwards. Adequate investment (time and resources) must be made in capacity development at various levels.
- Analysis of the collected information must be undertaken at various levels so as to enable prompt action and corrections. The committees that are formed at

various levels must have concomitant authority i.e. they must have the power to take action.

- The monitoring system must be directly linked to corrective decision making bodies at various levels. The information and issues emerging from monitoring must be communicated to the relevant official bodies responsible for taking action (from PHC to state level) so that monitoring results in *prompt, effective and accountable remedial action*.

(iv) Further, some overall points to be kept in mind are:

- Effective Community Monitoring would change the status of community members from passive beneficiaries to active rights holders, enabling them to more effectively access health services.
- We must be realistic in setting indicators and planning activities. Communities need few and simple indicators for monitoring, and the time devoted by members, especially community representatives involved in various committees must be utilized optimally.
- Community Monitoring must be seen as an integral part of the Public Health System at all levels and for all activities, and not as a stand-alone process.
- Panchayati Raj Institutions are not synonymous with the community. For community ownership and effective monitoring, even if PRI representatives are involved, one still needs to involve user groups and beneficiaries, and to include Community Based Organisations.

(v) Involvement of the general public by means of regular 'Public dialogue' or Public hearing

(Jan Samvad / Jan Sunwai)

128. Most of the public participation in the monitoring process would be mediated by representatives of the community or community-linked organisations. However, to enable *interested community members to be directly involved* in exchange of information, and to improve transparency and accountability of the health care system,

'Public dialogues' (Jan Samvad) or Public hearings ('Jan Sunwai') would be need to organised at regular intervals (once or twice in a year, depending on the initiative of the local organisations) at PHC, block and district levels (see section V-I).

(vi) What should the community monitor?

129. The community and community-based organisations should monitor demand / need, coverage, access, quality, effectiveness, behaviour and presence of health care personnel at service points, possible denial of care and negligence. This should be monitored related to outreach services, public health facilities and the referral system.

Some roles of the Village Health Committee

**Activities**

- Create Public Awareness about the essentials of health programmes, with focus on People's knowledge of entitlements to enable their involvement in the monitoring.
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha
- *Participatory Rapid Assessment:* to ascertain the major health problems and health related issues in the village. Estimation of the annual expenditure incurred for management of all the morbidities may also be done. The mapping will also take into account the health resources and the unhealthy influences within village boundaries. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village. These would be Village information (number of households – caste, religion and income ranking, geographical distribution, access to drinking water sources, status of household and village sanitation, physical approach to village, nearest health facility for primary care, emergency obstetric care, transport system) and the morbidity pattern
- Maintenance of a *village health register and health information board/calendar:* The health register and board put up at the most frequented section of the village

will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar. These will be the most important document maintained by the village community about the exhibition of health status and health care services availability. This will also serve as the instrument for cross verification and validation of data

- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW
- Get a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action
- Take into consideration of the problems of the community and the health and nutrition care providers and suggest mechanisms to solve it.
- Discuss every maternal death or neonatal death that occurs in their village, analyze it and suggest necessary action to prevent such deaths. Get these deaths registered in the Panchayat.
- Managing the village health fund.

#### Composition of the Village Health committee

This committee would be formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat).

Composition: The Village Health Committee would consist of:

- Gram Panchayat members from the village
- ASHA, Anganwadi Sevika, ANM
- SHG leader, the PTA/MTA Secretary, village representative of any Community based organisation working in the village, user group representative

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convenor would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

### **Some yardsticks for monitoring at the village level**

- Village Health Plan
- NRHM indicators translated into Village health indicators

### **Some tools for monitoring at the village level**

- Village Health Register
- Records of the ANM
- Village Health Calendar
- Infant and maternal death audit
- Public dialogue (Jan Samvad)

### **Powers of the committee**

- The convener will sign the attendance registers of the AWWs, Mid-Day meal Sanchalak, MPWs, and ANMs.
- MPWs and ANMs will submit a bi-monthly village report to the committee along with the plan for next two months. Format and contents of the bi-monthly reports would be decided village health committee.
- The committee will receive funds of Rs.10,000 per year. This fund may be used as per the discretion of the VHC.

## **2. PHC Health Monitoring and Planning Committee**

### **Role and Responsibilities of the Committee**

- Consolidation of the village health plans and charting out the annual health action plan in order of priority. The plan should clearly lay down the goals for improvement in health services and key determinants.
- Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the

access to health facilities in the area of that particular PHC. The discussion could include:

- Sharing of reports of Village Health Committees
  - Reports from ANM, MPW about the coverage of health facilities
  - Any efforts done at the village level to improve the access to health care services
  - Record and analysis of neonatal and maternal deaths.
  - Any epidemic occurring in the area and preventive actions taken.
- 
- Ensure that the **Charter of citizen's health rights** is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action.
  - Monitoring of the physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it.
  - Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organisations
  - Share the information about any health awareness programme organized in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.
  - Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area.
  - Review the functioning of Sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning
  - At the end of the meeting brief minutes of the meeting will be developed along with the action plan emphasizing the actions to be taken by different committee members, which will be shared at the District level committee. The minutes will also serve as a reference point, while sharing the progress done between two committee meetings.

- Initiate appropriate action on *instances of denial of right to health care* reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The report may become a part of the performance appraisal of the concerned staff member. The committee may recommend corrective measures to the next level (block/district). The decisions taken in the committee need to be forwarded to higher concerned officials and a copy to the corresponding health committee of that level who will be responsible to take necessary decision for action to be taken on the inquiry within a period of three months.

#### Constitution of the PHC Health committee

The PHC Health committee would function as the health monitoring and planning arm of the Panchayats coming under the PHC area. It is recommended that the PHC Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

- 30% members should be representatives of Panchayat Institutions (Panchayat samiti member from the PHC coverage area; two or more sarpanchs of which at least one is a woman)
- 20% members should be non-official representatives from the village health committees, coming from villages under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the area covered by the PHC
- 30% members should be representatives of the Health and Nutrition Care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area

The chairperson of the PHC committee would be one of the Panchayat representatives, preferably a Panchayat Samiti member belonging to the PHC coverage area. The executive chairperson would be the Medical officer of the PHC. The secretary of the PHC committee would be one of the NGO / CBO representatives.

#### Power of the committee



- Contribute to annual performance appraisal of Medical officer / other functionaries at the PHC.
- Take collective decision about the utilization of the special funds given to PHC (say Rs.25,000) for the repairs, maintenance of equipments, health education etc and any other aspects, which will facilitate the improvement of access to health care services. The MO can utilize this fund after the discussion and approval from the committee.

***Some yardsticks for monitoring at the PHC level***

- Charter of Citizens Health Rights
- IPHS or similar standards for PHC (this would include continuous availability of basic outpatient services, indoor facility, delivery care, drugs, laboratory investigations and ambulance facilities)
- PHC Health Plan

**Some tools for monitoring at the PHC level**

- *Village health registers / calendars*
- *PHC records*
- *Discussions with and interviews of the PHC committee members*
- *Public dialogue (Jan Samvad) or Public hearing (Jan Sunwai)*
- *Quarterly feedback from village Health Committees*
- *Periodic assessment of the existing structural deficiencies*

**3. Block Health Monitoring and Planning Committee**

***Role and Responsibilities:***

- Consolidation of the PHC level health plans and charting out of the annual health action plan for the block. The plan should clearly lay down the goals for improvement in health services.
- Review of the progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to

be taken for further improvement of health facilities in the block, including the CHC.

- Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunization and other national programmes.
- Monitoring of the physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC.
- Coordinate with local CBOs and NGOs to improve the health services in the block.
- Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning
- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level.

### ***Constitution of the Block committee***

It is recommended that the Block Committee have the following broad pattern of representation, including members from Panchayats, health care service providers and civil society:

- 30% members should be representatives of the Block Panchayat Samiti (Adhyaksha / Adhyakshika of the Block Panchayat Samiti or members of the Block Panchayat samiti, with at least one woman)
- 20% members should be non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services
- 20% members should be officials such as the Block Medical Officer, the Block Development Officer, selected Medical Officers from PHCs of the block
- 10% members should be representatives of the CHC level Rogi Kalyan Samiti

The chairperson of the Block committee would be one of the Block Panchayat Samiti representatives. The executive chairperson would be the Block medical officer. The secretary would be one of the NGO / CBO representatives.

#### ***Yardsticks for monitoring at the Block level***

- IPHS or similar standards for CHC (this would include continuous availability of basic outpatient services, indoor facility, community outreach services, referral services, delivery and antenatal care, drugs, laboratory investigations and ambulance facilities)
- Charter of Citizens Health Rights for CHC
- Block Health Plan

#### ***Some tools for monitoring at the Block level***

- PHC and CHC records
- Discussions with and interviews of the CHC RKS members
- Report of Public dialogue (Jan Samvad)
- Quarterly feedback from village and PHC Health Committees
- Periodic assessment of the existing structural and functional deficiencies

#### ***4. District Health Monitoring and Planning Committee***

##### ***Role and Responsibility***

- Discussion on the reports of the PHC health committees
- Financial reporting and solving blockages in flow of resources if any
- Infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies.
- Progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs.
- Ensuring proper functioning of the Hospital Management Committees.

- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal.

### **Constitution of the District committee**

It is recommended that the District Committee have the following broad pattern of representation, including members from Panchayati Raj Institutions, health care service providers and civil society:

- 30% members should be representatives of the Zilla Parishad (esp. convenor and members of its Health committee)
- 25% members should be district health officials, including the District Health Officer / Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals
- 15% members should be non-official representatives of block committees, with annual rotation to enable successive representation from all blocks
- 20% members should be representatives from NGOs / CBOs and People's organizations working on Health rights and regularly involved in facilitating Community based monitoring at other levels (PHC/block) in the district
- 10% members should be representatives of Hospital Management Committees in the district

The chairperson of the District committee would be one of the Zilla Parishad representatives, preferably convenor or member of the Zilla Parishad Health committee. The executive chairperson would be the CMO / CMHO / DHO or officer of equivalent designation. The secretary of the PHC committee would be one of the NGO / CBO representatives.

### Some yardsticks for monitoring at the District level

- Charters of Citizens Health Rights
- District Action Plan
- NRHM guidelines

- Indian Public Health Standards

### **Some tools for Monitoring at the District level**

- Report from the PHC Health committees
- Report of the District Mission committee
- Public Dialogue (Jan Samvad)

## **5. State Health Monitoring and Planning Committee**

### ***Role and Responsibilities***

- ♦ The main role of the committee is to discuss the programmatic and policy issues related to access to health care and to suggest necessary changes.
- ♦ This committee will review and contribute to the development of the State health plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State health plan.
- ♦ Key issues arising from various District health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc) would be discussed an appropriate action initiated by the committee. Any administrative and financial level queries, which need urgent attention, will be discussed.
- ♦ Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports
- ♦ Operationalising and assessing the progress made in implementing the recommendations of the NHRC, to actualize the Right to health care at the state level.
- ♦ The committee will take proactive role to share any related information received from GOI and will also will share achievements at different levels. The copies of relevant documents will be shared.

### ***Composition of State Health Monitoring and Planning committee***

- 30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation
- 15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state
- 20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring
- 25% members would belong to State Health Department:
  - Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with Technical experts from the State Health System Resource Centre / Planning cell
- 10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development.
- The Chairperson would be one of the elected members (MLAs).
- The executive chairperson would be the Secretary Health and Family Welfare.
- The secretary would be one of the NGO coalition representatives.

#### Some yardsticks for monitoring at the State level

- NHRC recommendations and National Action Plan on Right to Health Care; responses of state health departments and actions to which the State Government has committed itself
- NRHM state level plan and the State Health Mission guidelines
- IPHS

#### ***Tools for monitoring at the State level***

- Reports of the District Health committees
- Periodic assessment reports by various taskforces / State level committees about the progress made in formulating policies according to IPH Standards, NHRC recommendations and its implementation status etc.

Concrete Service Guarantees that NRHM will provide:

- Skilled attendance at all Births
- Emergency Obstetric care
- Basic neonatal care for new born
- Full coverage of services related to childhood diseases / health conditions
- Full coverage of services related to maternal diseases / health conditions
- Full coverage of services related to low vision and blindness due to refractive errors and cataract.
- Full coverage for curative and restorative services related to leprosy
- Full coverage of diagnostic and treatment services for tuberculosis
- Full coverage of preventive, diagnostic and treatment services for vector borne diseases
- Full coverage for minor injuries / illness (all problems manageable as part of standard outpatient care upto CHC level)
- Full coverage of services inpatient treatment of childhood diseases / health conditions
- Full coverage of services inpatient treatment of maternal diseases / health conditions including safe abortion care (free for 50% user charges from APL)
- Full coverage of services for Blindness, life style diseases, hypertension etc.
- Full coverage for providing secondary care services at Sub-district and District Hospital.
- Full coverage for meeting unmet needs and spacing and permanent family planning services.
- Full coverage of diagnostic and treatment services for RI/STI and counseling for HIV – AIDS services for adolescents.
- Health education and preventive health measures.

Institution wise service guarantees are placed at Annex – .

**The coverage under NRHM**

*The Mission has the following coverage:*

Population coverage - 740 million

Households	-	148 million (approx.)
Birth Rate in Rural Areas	-	26.6, nearly 20 million births
Sub Health Centres	-	1,75,000 ( on population, distance and work load norm)
P H Cs	-	27,000 (single MO, 2 MO, 1 AYUSH)
C H Cs	-	7,000 (every Block)
Sub Divisional/Taluk Hospitals	-	1,800
District Hospital	-	600
ANMs at SHC	-	3.50 lakhs
Staff Nurses at PHC	-	81,000
Staff Nurses at CHC	-	63,000
MOs in PHCs	-	40,500
Specialists in CHCs	-	49,000
ASHAs	-	4 - 5 lakhs, in all distant habitations/villages
Village Health & Sanitation Committees	-	7 lakhs – in all villages/big hamlets

#### TIME LINE FOR NRHM ACTIVITIES

	Activity	Phasing and time line	Outcome Monitoring
1	Fully trained Accredited Social Health Activist (ASHA) for every 1000 population/large isolated habitations.	50% by 2007 100% by 2008	Quarterly Progress Report
2	Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them.	30% by 2007 100% by 2008	Quarterly Progress Report



3	2 ANM Sub Health Centres strengthened/established to provide service guarantees as per IPHS, in 1,75000 places.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
4	30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 60% by 2009 100% by 2010	Annual Facility Surveys External assessments
5	6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS.	30% by 2007 50% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
6	1800 Taluka/ Sub Divisional Hospitals strengthened to provide quality health services.	30% by 2007 50% by 2010 100% by 2012	
7	600 District Hospitals strengthened to provide quality health services.	30% by 2007 60% by 2009 100% by 2012	Annual Facility Surveys. External assessments.
8	Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals.	50% by 2007 100% by 2009	Annual Facility Surveys. External assessments.
9	District Health Action Plan 2005-2012 prepared by each district of the country.	50% by 2007 100% by 2008	Appraisal process. External assessment.
10	Untied grants provided to each Village Health and Sanitation Committee, Sub Centre, PHC, CHC to promote local health action.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress reports.
11	Annual maintenance grant provided to every Sub Centre, PHC, CHC and one time support to RKSs at Sub Divisional/ District Hospitals.	50% by 2007 100% by 2008	Independent assessments. Quarterly Progress Reports.
12	State and District Health Society established and fully functional with requisite management skills.	50% by 2007 100% by 2008	Independent assessment.
13	Systems of community monitoring put in place.	50% by 2007 100% by 2008.	Independent assessment.
14	Procurement and logistics streamlined to	50% by 2007	External

	ensure availability of drugs and medicines at Sub Centres/PHCs/ CHCs.	100% by 2008.	assessment.
15	SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HOV/AIDS, etc.	30% by 2007 50% by 2008 70% by 2009 100% by 2012.	Annual Facility Surveys. Independent assessments.
16	District Health Plan reflects the convergence with wider determinants of health like drinking water, sanitation, women's empowerment, child development, adolescents, school education, female literacy, etc.	30% by 2007 60% by 2008 100% by 2009	Appraisal process. Independent assessment.
17	Facility and household surveys carried out in each and every district of the country.	50% by 2007 100% by 2008	Independent assessment.
18	Annual State and District specific Public Report on Health published	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
19	Institution-wise assessment of performance against assured service guarantees carried out.	30% by 2008 60% by 2009 100% by 2010.	Independent assessment.
20	Mobile Medical Units provided to each district of the country.	30% by 2007 60% by 2008 100% by 2009.	Quarterly Progress Report.

## **ANNEXES**

**Existing Schemes to come under the National Rural Health Mission (NRHM) from the XI Plan**

Rs. In crores

Sl. No	Name of Scheme	Total Allocation		Description of Scheme	Modalities of merger
		Plan	Non-Plan		
<b>I</b>	<b>National Disease Control Programmes</b>				
1	National Vector Borne Disease Control Programme	313.45	5.50		
2	National TB Control Programme	166.39		Tuberculosis continues to be a major public health problem. The National TB Control Programme (NTCP) has been operational since 1962 and is carried out through the general health services, the nodal agencies being District TB Centres (DTC). So far, 446 DTCs are functioning in the country. The NTCP aimed at detecting large number of TB cases and instituting treatment. This strategy did not yield the desired results. The programme was reviewed in 1992 and consequently a revised strategy was formulated. The Revised Strategy lays emphasis on increasing the cure rate of infectious patients to above 85%. The revised programme promotes sputum examination for diagnosis rather than radiology.	
3	National Leprosy Control Programme	38.57		The programme has shown tremendous success. Leprosy case load in the country has come down from 4.0 million cases in 1981 to 0.26 million cases at the end of March, 2004. MDT services has been sanctioned for all the Districts of the country. The Programme is run through 590 district Leprosy Societies. Out of the total allocation of Rs.41.75 crores, funds to the extent of Rs.8.00 crores are being provided under Externally Aided Component for the year 2005-06.	
4	National Trachoma & Blindness Control Programme	86.00		The National Programme for Control of Blindness was launched throughout the country in 1976. The Programme provides immediate relief to the needy by camp approach and by establishing permanent eye care facilities coupled with health education measures. Under this programme, the concept of District Blindness Control Societies has been implemented to decentralize management of eye care service in the district and evolve a partnership among Government, Non Government and Private Sector. So far 520 DBCs have been formed and functioning. A project under World Bank Assistance has been launched and is effective to boost up eye care activity in 7 major states namely, Andhra Pradesh, M.P., Maharashtra, Tamilnadu, Orissa, UP and Rajasthan from April 1994. In these 7 states major input of the project are upgrading eye care service, expanding the coverage to rural remote and tribal areas, establishment and functioning of DBCs, training of ophthalmic manpower, improving the management information system and creating awareness about programme in the masses. Co-operation of non-government and private sector is also envisaged in the project.	

5	National Iodine Deficiency Disorders Control Programme	11.00		Nearly 71 million persons are estimated to be suffering from Iodine Deficiency Disorders in the country. The Primary thrust of this programme would be iodization of the entire edible salt in a phased manner.	
6	National Integrated Disease Surveillance Programme	80.00			
	<b>Total National Disease Control Programme</b>	<b>695.41</b>	<b>5.50</b>		
7	Direction and Administration	256.58		Technical wing of Department of Family Welfare provides administrative and policy guideline on technical aspects connected with Family Welfare Programme and is responsible for planning, monitoring, coordination and administration at the Headquarters.	
8	Rural FW Services (Sub-Centres)	1869.20		In order to provide comprehensive Primary Health Care Services at the grass root level, Sub-centres are established for every 5000 rural population (3000 population in the tribal and hilly areas). These sub-centres provide basic health and family welfare services to the rural population. All the sub-centres (1,45,980) are being funded by Department of Family Welfare w.e.f. 1.4.2002.	
9	Urban FW Services	133.08		For providing Family Welfare and MCH services in the urban areas, Urban Family Welfare Centres have been sanctioned in the country. In order to improve out-reach service delivery system in urban slums, Urban Revamping scheme has been introduced. The scheme of revamping of urban family welfare service envisages reorganization of existing Urban Family Welfare Centres. 1083 Urban Family Welfare Centres and 871 Health Posts are currently in operation.	
<b>II</b>	<b><u>Supply of Contraceptives</u></b>				
10	Free Distribution of Contraceptives	169.97		Recognizing the fact that younger couples are entering the reproductive age group, terminal methods of Family Planning, namely sterilization cannot be advocated for them. To respond to the needs of younger couples, various contraceptives under spacing methods of Family Planning such as oral pills, condoms, Cu-Ts etc. are offered under the Programme.	
11	Social Marketing of Contraceptives	238.16			
	<b>Total Supply of Contraceptives</b>	<b>408.13</b>			

<b>III Reproductive and Child Health Programme</b>					
12	RCH Flexible Pool for State PIPs	614.48		This Programme, apart from strengthening and expanding the activities undertaken in the CSSM Programme, has the objective of strengthening and reorienting the services provided under the Family Welfare Programme. The package of services has been expanded to cover Diagnosis and Management of Reproductive Tract Infections/Sexually Transmitted Infections. The first phase of RCH has ended and Phase-II will start from 2005-06.	
13	Training	28.75			
14	Expenditure at HQ	3.50			
15	Procurement of Supplies & Materials	235.00			
	<b>Total RCH</b>	<b>881.73</b>			
16	Routine Immunisation & Injection Safety	472.60			
17	Pulse Polio Immunisation	832.00		This programme is meant for strengthening the immunization coverage of the children and pregnant women. Moreover, all out efforts are being made to eradicate all the strains of the Polio virus from the country.	
18	Information, Education & Communication	119.30	2.53	Information, Education and Communication activities are carried out to achieve wider publicity of RCH and Population Control programme by respective Mass Education and Media set-ups created in the States and Media units of the Ministry of Information and Broadcasting.	
<b>IV Training Institutions under States and Centre</b>					
19	NIHFW, New Delhi	7.35	8.60	The success of FW Programme depends, to a large extent, upon the availability of qualified, trained and dedicated workers. Training is, therefore, given due weightage under the programme. Training at various levels is imparted through the network of Training Centres & Schools. Besides, a number of well reputed instituted viz., ICMR, NIHFW, IIPS, Central Drug Research Institute etc. are involved in carrying out training and research activities.	
20	IIPS, Mumbai	1.65	4.25		
21	FWTRC, Mumbai	1.00	0.88		
22	RHTC, Najafgarh	3.98	3.98		
23	Gandhigram Institute	0.58			
24	UTs without Legislature	0.38			
25	Basic Training for ANM/LHV	70.86			
26	Maintenance & Strengthening of HFWTC	15.12			
27	Basic Training for MPWs (Male)	9.57			
28	Strengthening of Basic Training Schools	1.72			
	<b>Total – Training Institutions under State &amp; Centre</b>	<b>112.21</b>	<b>17.71</b>		

<b>IV</b>	<b><u>Research Institutions</u></b>				
29	CDRI, Lucknow	2.75		As above	
30	Population Research Centres	7.00			
31	Testing Facilities	0.45			
	<b>Total</b>	<b>10.20</b>			
<b>V</b>	<b><u>Other Services</u></b>				
	<b>Area Projects</b>				
32	India Population Projects	50.26		To improve health and family welfare delivery system in certain identified backward districts of the country, so as to hasten their development at par with the nation's average, Area Projects have been taken up with partial assistance from external agencies. Under the scheme, additional inputs in terms of buildings, vehicles, training etc. are provided.	
33	EC assisted SIP Projects	401.00			
34	USAID assisted SIFPSA Project	50.00			
35	UNFPA assisted CP-6				
	<b>Total</b>	<b>501.26</b>			
36	Sterilization Beds	2.00		Under this scheme, grant is released to various States for payment of maintenance of beds reserved under the scheme on the basis of performance as per approved norms.	

*Rs. In crores*

<b>VI</b>	<b><u>Other Schemes</u></b>				
37	Mission Flexible Fund				
38	FW Linked Health Insurance Plan	30.00			
39	Janani Surkasha Yojana (JSY)				
40	NGOs (Public-Private Partnership)	90.52			
41	Management Information System	7.43			
42	National Commission on Population	10.00			
43	Social Marketing Area Projects	9.50			
44	Travel of Experts/Conf./Meetings etc.	3.20			
45	Assistance to IMA	0.30			
46	CHTO		0.17		
	<b><i>Total – Other Schemes</i></b>	<b>150.95</b>	<b>0.17</b>		
	<b>Total NRHM</b>	<b>6444.65</b>	<b>25.91</b>		



**SERVICE GUARANTEES FOR HEALTH CARE**

Sub Health Centre	Primary Health Centre	Community Health Centre
<p><b>(a) Maternal and Child Health:</b></p> <p>(i) Antenatal care</p> <ul style="list-style-type: none"> <li>• Early registration of all pregnancies, ideally within first trimester (before 12<sup>th</sup> week of Pregnancy). However even if a woman comes late in her pregnancy for registration, she should be registered and care given to her according to gestational age.</li> <li>• Minimum four antenatal check-ups: First visit to the antenatal clinic as soon as pregnancy is suspected, 2<sup>nd</sup> between 4<sup>th</sup> and 6<sup>th</sup> month (around 26 weeks), 3<sup>rd</sup> at 8<sup>th</sup> month (around 32 weeks) and 4<sup>th</sup> at 9<sup>th</sup> month (around 36 weeks)</li> <li>• Associated services like general examination such as weight, BP, anaemia, abdominal examination, height and breast examination, Folic acid supplementation in the first trimester, Iron and Folic Acid supplementation from twelve weeks, Injection Tetanus Toxoid, treatment of anaemia, etc. (as per the Guidelines for Antenatal care and Skilled Attendance at Birth by ANMs and LHVs)</li> <li>• Minimum laboratory investigations like haemoglobin, urine albumen and sugar.</li> <li>• Identification of high-risk pregnancies and appropriate and prompt referral</li> <li>• Counselling.</li> </ul> <p>(ii) Intranatal care:</p> <ul style="list-style-type: none"> <li>• Promotion of institutional deliveries</li> </ul>	<p>(a) Medical care:</p> <ul style="list-style-type: none"> <li>▪ OPD services: 4 hours in the morning and 2 hours in the afternoon/evening. Time schedule will vary from state to state.</li> <li>▪ 24 hours emergency services: appropriate management of injuries and accident, First Aid, Stabilisation of the condition of the patient before referral, Dog bite/snake bite/scorpion bite cases, and other emergency conditions</li> <li>▪ Referral services</li> <li>▪ In-patient services (6 beds)</li> </ul> <p><b>3. Maternal and child health care including family planning</b></p> <p><u>Maternal care</u></p> <p>a) Antenatal care:</p> <p>i) Early registration of all pregnancies ideally in the first trimester (before 12<sup>th</sup> week of pregnancy). However, even if a woman comes late in her pregnancy for registration she should be registered and care given to her according to gestational age.</p> <p>ii) Minimum 4 antenatal checkups and provision of complete package of services. First visit as soon as pregnancy is suspected, 2<sup>nd</sup> between 4<sup>th</sup> and 6<sup>th</sup> month (around 26 weeks), 3<sup>rd</sup> visit at 8<sup>th</sup> month(around 32 weeks) and 4<sup>th</sup></p>	<ul style="list-style-type: none"> <li>• Care of routine and emergency cases in surgery: <ul style="list-style-type: none"> <li>• This includes incision and drainage, and surgery for Hernia, Hydrocele, Appendicitis, Haemorrhoids, Fistula, etc.</li> <li>• Handling of emergencies like Intestinal Obstruction, Haemorrhage, etc.</li> </ul> </li> <li>• Care of routine and emergency cases in medicine: <p style="margin-left: 20px;">Specific mention is being made of handling of all emergencies in relation to the National Health Programmes as per guidelines like Dengue, Haemorrhagic Fever, Cerebral Malaria, etc. Appropriate guidelines are already available under each programme, which should be compiled in a single manual.</p> <ul style="list-style-type: none"> <li>• 24-hour delivery services including normal and assisted deliveries.</li> <li>• Essential and Emergency Obstetric Care including surgical interventions like Caesarean Sections and other medical interventions.</li> <li>• Full range of family planning services including Laproscopic Services.</li> <li>• Safe Abortion Services.</li> <li>• Newborn Care.</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>• Skilled attendance at home deliveries as and when called for</li> <li>• Appropriate and prompt referral</li> </ul> <p>(iii) Postnatal care:</p> <ul style="list-style-type: none"> <li>• A minimum of 2 postpartum home visits, first within 48 hours of delivery, 2<sup>nd</sup> within 7-10 days.</li> <li>• Initiation of early breast-feeding within half-hour of birth</li> <li>• Counselling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding.</li> </ul> <p>(As per Guidelines of GOI on Essential new-born care ) and STI/RTI and HIV/AIDS</p> <p><b>(ii) Child Health:</b></p> <ul style="list-style-type: none"> <li>• Essential Newborn Care</li> <li>• Promotion of exclusive breast-feeding for 6 months.</li> <li>• Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI (Current Immunization Schedule at <b>Annexure – I</b>).</li> <li>• Vitamin A prophylaxis to the children as per guidelines.</li> <li>• Prevention and control of childhood diseases like malnutrition, infections, etc.</li> </ul> <p><b>(iii) Family Planning and contraception:</b></p> <ul style="list-style-type: none"> <li>• Education, Motivation and counseling to adopt appropriate Family planning methods,</li> <li>• Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions (Wherever the ANM is trained on IUD insertion)</li> <li>• Follow up services to the Eligible couples adopting permanent methods(Tubectomy/ Vasectomy)</li> </ul>	<p>visit at 9<sup>th</sup> month(around 36 weeks). Associated services like providing iron and folic acid tablets, injection Tetanus Toxoid etc( as per the “guidelines for ante-natal care and skilled attendance at birth by ANMs and LHVs)</p> <ul style="list-style-type: none"> <li>iii) Minimum laboratory investigations like haemoglobin, urine albumin, and sugar, RPR test for syphilis</li> <li>iv) Nutrition and health counselling</li> <li>v) Identification of high-risk pregnancies/ appropriate management</li> <li>vi) Chemoprophylaxis for Malaria in high malaria endemic areas as per NVBDCP guidelines.</li> <li>vii) Referral of high risk pregnancy beyond the capability of PHC MO to manage to FRU</li> </ul> <p>b) Intranatal care: (24-hour delivery services both normal and assisted)</p> <ul style="list-style-type: none"> <li>i) Promotion of institutional deliveries</li> <li>ii) Conducting of normal deliveries</li> <li>iii) Assisted vaginal deliveries including forceps/ vacuum delivery whenever required</li> <li>iv) Manual removal of placenta</li> <li>v) Appropriate and prompt referral for cases needing specialist care.</li> <li>vi) Management of Pregnancy Induced hypertension including referral</li> <li>vii) Pre-referral management (Obstetric first-aid) in Obstetric emergencies that need expert assistance (Training of staff for emergency management to be ensured)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine and Emergency Care of sick children.</li> <li>• Other management including nasal packing, tracheostomy, foreign body removal etc.</li> <li>• All the National Health Programmes (NHP) should be delivered through the CHCs. Integration with the existing programmes like blindness control, Integrated Disease Surveillance Project, is vital to provide comprehensive services. The requirements for the important NHPs are being annexed as separate guidelines with the document.</li> <li>• RNTCP: CHCs are expected to provide diagnostic services through the microscopy centres which are already established in the CHCs and treatment services as per the Technical Guidelines and Operational guidelines for Tuberculosis Control (Annexure 1)</li> <li>• HIV/AIDS Control Programme : The expected services at the CHC level are being provided with this document which may be suitably implemented. (Annexure 2)</li> <li>• National Vector Borne Disease Control Programme : The CHCs are to provide diagnostic and treatment facilities for routine and complicated cases of malaria, Filaria, Dengue, Japanese Encephalitis and Kala-azar in the respective endemic zones. (annexure 3)</li> <li>• National Leprosy Eradication Programme : The minimum services that are to be available at the CHCs</li> </ul>
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<ul style="list-style-type: none"> <li>• Counselling and appropriate referral for safe abortion services (MTP) for those in need.</li> </ul> <p><b>(iv) Adolescent health care:</b> Education, counselling and referral</p> <p><b>Assistance to school health services</b> <b>Control of local endemic diseases</b> Malaria, Kala azar, Japanese Encephalitis, Filariasis, Dengue etc and control of Epidemics</p> <p><b>Disease surveillance</b> <b>(v) Water Quality Monitoring:</b></p> <ul style="list-style-type: none"> <li>• Disinfection of water sources</li> <li>• Testing of water quality using H<sub>2</sub>S- Strip Test (Bacteriological) developed by NICD</li> <li>• Promotion of sanitation including use of toilets and appropriate garbage disposal.</li> </ul> <p><b>Field visits and home care</b></p> <p><b>Community needs assessment</b> <b>(vi) Curative Services:</b></p> <ul style="list-style-type: none"> <li>• Provide treatment for minor ailments including fever, diarrhoea, ARI, worm infestation and First Aid in accidents and emergencies</li> <li>• Appropriate and prompt referral</li> <li>• Organizing Health Day at Anganwadi centres at least once in a month with the help of Medical Officer of PHC, ASHA, AWW, PRI, self help groups etc.</li> </ul> <p><b>(vii) Training, Monitoring and Supervision:</b></p> <ul style="list-style-type: none"> <li>• Training of Traditional Birth Attendants and ASHA</li> <li>• Monitoring of water quality in the villages</li> <li>• Keeping watch over unusual health events</li> <li>• Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRI</li> <li>• Coordination and supervision of activities of ASHA</li> </ul>	<p>c) Postnatal Care:</p> <ol style="list-style-type: none"> <li>a) A minimum of 2 postpartum home visits, first within 48 hours of delivery, 2<sup>nd</sup> within 7 days through subcentre staff.</li> <li>b) Initiation of early breast-feeding within half-hour of birth</li> <li>c) Education on nutrition, hygiene, contraception, <b>essential new born care</b> (As per Guidelines of GOI on Essential new-born care )</li> </ol> <p>Apart from the above PHC would also provide facilities under <b>Janani Suraksha Yojana (JSY)</b></p> <p><u>Child care</u></p> <ol style="list-style-type: none"> <li>a) New Born care:       <ol style="list-style-type: none"> <li>i) Facilities and expertise for neonatal resuscitation</li> <li>ii) Management of neonatal hypothermia/ jaundice</li> </ol> </li> <li>b) Care of the child:       <ol style="list-style-type: none"> <li>i) Emergency care of sick children including Integrated Management of Neonatal and Childhood Illness (IMNCI)</li> <li>ii) Care of routine childhood illness</li> <li>iii) Essential Newborn Care</li> <li>iv) Promotion of exclusive breast-feeding for 6 months.</li> <li>v) Full Immunization of all infants and children against vaccine preventable diseases as per guidelines of GOI</li> <li>vi) Vitamin A prophylaxis to the children as per guidelines.</li> <li>vii) Prevention and control of childhood diseases like malnutrition, infections, etc.</li> </ol> </li> </ol>	<p>are for diagnosis and treatment of cases and reactions of Leprosy along with advice to patient on Prevention of Deformity. (annexure 4)</p> <ul style="list-style-type: none"> <li>• National Programme for Control of Blindness: The eye care services that should be available at the CHC are diagnosis and treatment of common eye diseases, refraction services and surgical services including cataract by IOL implantation at selected CHCs optionally. 1 eye surgeon is being envisaged for every 5 lakh population. (annexure 5)</li> <li>• Under Integrated disease Surveillance Project, the related services include services for diagnosis for Malaria, Tuberculosis, Typhoid and tests for detection of faecal contamination of water and chlorination level. CHC will function as peripheral surveillance unit and collate, analyse and report information to district Surveillance Unit. In outbreak situations, appropriate action will be initiated. (Annexure 6)</li> <li>• Others:       <ul style="list-style-type: none"> <li>Blood Storage Facility</li> <li>Essential Laboratory Services</li> <li>Referral (Transport) Services : (details given in Annexure 7)</li> </ul> </li> </ul>
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<p><b>National Health Programmes</b></p> <p><b>(viii) Record of Vital events:</b></p> <ul style="list-style-type: none"> <li>Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants.</li> <li>Maintenance of all the relevant records concerning mother, child and eligible couples in the area.</li> </ul> <p>Untied grants of Rs. 10,000 per year to every SHC for local health action.</p>	<p><u>Family Planning:</u></p> <ol style="list-style-type: none"> <li>Education, Motivation and counseling to adopt appropriate Family planning methods,</li> <li>Provision of contraceptives such as condoms, oral pills, emergency contraceptives, IUD insertions</li> <li>Permanent methods like Tubal ligation and vasectomy / NSV</li> <li>Follow up services to the Eligible couples adopting permanent methods(Tubectomy/ Vasectomy)</li> <li>Counselling and appropriate referral for safe abortion services (MTP) for those in need.</li> <li>Medical Termination of Pregnancies using Manual Vacuum Aspiration technique for which appropriate training would be provided. (wherever trained personnel and facility exists)</li> </ol> <p><u>Management of Reproductive Tract Infections/ Sexually Transmitted Infections:</u></p> <ol style="list-style-type: none"> <li>Health education for prevention of RTI/ STIs</li> <li>Treatment of RTI/ STIs</li> </ol> <p><u>Nutrition services (coordinated with ICDS)</u></p> <ul style="list-style-type: none"> <li>✓ School health: Regular check ups, appropriate treatment, referral and follow-ups</li> <li>✓ Adolescent health care: Life style education, counselling, appropriate treatment.</li> <li>✓ Promotion of Safe water supply and basic sanitation</li> <li>✓ Prevention and control of locally endemic diseases like malaria, Kala-azar, Japanese Encephalitis, etc.</li> </ul>	
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Disease surveillance and control of epidemics:

- a) Alertness to detect unusual health events and take appropriate remedial measures
- b) Disinfection of water sources
- c) Testing of water quality using H<sub>2</sub>S-Strip Test (Bacteriological) developed by NICD
- d) Promotion of sanitation including use of toilets and appropriate garbage disposal.
- e) Collection and reporting of vital statistics
- f) Education about health/Behaviour change communication(BCC)
- g) National Health Programmes including HIV/AIDS control programme-as relevant

Referral services:

Appropriate and prompt referral of cases needing specialist care including:

- a) Stabilisation of patient
- b) Appropriate support for patient during transport
- c) Providing transport facilities either by PHC vehicle or hired vehicle for which funds will be made available with the medical officer.
- d) Routine and emergency treatment of:
  - i. Cases approaching the PHC directly
  - ii. Cases reaching the PHC on referral from subcentres or elsewhere.  
This will include:
    - i) Providing treatment or referral for all cases reaching the PHC
    - ii) In-patient care for patients needing admission.

	<p><u>Training:</u></p> <ul style="list-style-type: none"> <li>(i) Health workers and trained birth attendants</li> <li>ii) Initial and periodic Training of paramedics in treatment of minor ailments</li> <li>iii) Training of ASHAs</li> <li>iv) Periodic training of Doctors through Continuing Medical Education, conferences, skill development training, etc. on emergency obstetric care</li> <li>v) Training of Health workers in antenatal care and skilled birth attendance</li> </ul> <p><u>Basic laboratory services:</u></p> <p>Essential Laboratory services including:</p> <ul style="list-style-type: none"> <li>i. Routine urine, stool and blood tests</li> <li>ii. Blood grouping,</li> <li>iii. Bleeding time, clotting time,</li> <li>iv. Diagnosis of RTI/ STDs with wet mounting, Grams stain, etc.</li> <li>v. Sputum testing for tuberculosis</li> <li>vi. Blood smear examination for malarial parasite.</li> <li>vii. Rapid tests for pregnancy/ malaria</li> <li>viii. RPR test for Syphilis/YAWS surveillance</li> </ul> <p><u>Monitoring and Supervision:</u></p> <ul style="list-style-type: none"> <li>(i) Monitoring and supervision of activities of sub-centre through regular meetings/ periodic visits, etc.</li> <li>(ii) Monitoring of all National Health Programmes</li> <li>(iii) Monitoring activities of ASHAs</li> <li>(iv) MO should visit all subcentres at least once in a month</li> <li>(v) Health Assistants Male and LHV should visit subcentres once a week.</li> </ul>	
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	<p>AYUSH services as per local people's preference(Mainstreaming of AYUSH)</p> <p><b>Record of Vital events and Reporting:</b></p> <ol style="list-style-type: none"> <li>a) Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants.</li> <li>b) Maintenance of all the relevant records concerning services provided in PHC</li> </ol> <p><b>Concrete Service Guarantees that NRHM will provide:</b></p> <ul style="list-style-type: none"> <li>• Skilled attendance at all Births</li> <li>• Full coverage of childhood diseases / health conditions</li> <li>• Full coverage of maternal diseases / health conditions</li> <li>• Full coverage for blindness due to refractive errors and low vision</li> <li>• Full coverage for leprosy</li> <li>• Full coverage for tuberculosis</li> <li>• Full coverage for vector borne diseases</li> <li>• Full coverage for minor injuries / illness</li> <li>• Full coverage for inpatient treatment of childhood diseases / health conditions</li> <li>• Full coverage for inpatient treatment of maternal diseases / health conditions (free for 50% user charges from APL)</li> <li>• Full coverage of Blindness, vector borne diseases, life style diseases, hypertension etc.</li> <li>• Full coverage for providing secondary care services at District Hospital.</li> <li>• Full coverage for meeting unmet needs and spacing and permanent family planning services.</li> <li>• Full coverage for RI/STI and counseling for HIV – AIDS services for adolescents.</li> <li>• Health education and preventive health measures.</li> </ul>	
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**Annual Fund requirement for Sub-centres**

Sl. No.	Item	As per existing norms		As per revised norms		Difference between current & suggested norms (Rs.) for one SC
		Norms	Cost (Rs.)	Norms	Costs (Rs)	
<b>A.</b>	<b>Capital /Non-recurring</b>					
1.	SC building*		5,13,000	400 sft. @ Rs.400/sft.	1,60,000	
2.	Staff Quarters*	None	0	375 sft. @ Rs.400/sft for 2 ANMs	3,00,000	
3	Equipment ( As per IPHS standards)		22,100	Rs.25,680	25,680	
4	Furniture ( As per IPHS Standards)	None	0	5% of building cost	8,000	
	Sub-total		5,35,100		4,93,680	(41,420)
<b>B.</b>	<b>Recurring</b>					
1	Staff					
	Health Worker (F)/ANM	1	1,36,260	2	2,72,520	
	Health Worker (M)#	1	1,18,800	0	0	
	Voluntary Worker	1	1200	1	1200	



2	Drugs* (at govt. prices) ( As per IPHS list and standards)	Kits A&B 2/ year	5,650		18,135	
3	Travel allowance	Rs.75/ per day		Rs.100/visit X 10 visits	36,000	
4	Other expenses	Contingency	2,000	Rs. 500/ mth	6,000	
	Sub-total		2,63,910		3,33,855	69,945

Source: National Commission on Macro Economics and Health 2005

**The actual resource need for a SHC will take into account the likely utilization of resources. The details regarding equipment, drugs, furniture, etc shall be provided as per the IPH Standards. The Indian Public Health Standards, read with the recommendations of the National Commission on Macro Economics and Health, and the actual Facility Survey, will determine the actual intervention and resource provision. NRHM will not undertake routine allocation of resources. Every SHC will have to develop a baseline and an annual plan of activities. Resources will be released only after outcomes are guaranteed by the additional funds. Every SHCs need will be specifically asked for in the Annual Work Plan and Budget of the district.**

## Financing pattern of PHCs

The broad financing pattern of PHCs at present and as per revised norms would be as follows:

### Annual funds requirement for Primary Health Centers (for outpatient care and public health)

Sl. No.	Item	As per existing norms		As per revised norms		Difference between current & suggested norms (Rs.) for one SC
		Norms	Cost (Rs.)	Norms	Costs (Rs.)	
<b>A</b>	<b>Capital/Non-recurring</b>					
1	PHC building	4000 sft @ Rs.600/sft.	24,00,000	1500 sft @ Rs.600/sft.	9,00,000	
2	Staff Quarters	1 for MO @ 1200 sft	7,20,000	<b>1200 sft X 4 @ Rs.600/sft (1 for MO &amp; 3 for Staff Nurses)</b>	28,80,000	
3	Equipment ( As per IPHS Standards)	1 kit each per district	41,500		1,11,500	
4	Furniture ( As per IPHS Standards)			5% of building cost.	45,000	
	Sub-total		31,61,500		39,36,500	
<b>B</b>	<b>Recurring</b>					
1	Staff					
	Medical Officer	1	3,15,225	1(AYUSH) 1	2,52,660	
	Pharmacist	1	1,53,720	(on contract) 1	1,53,720	
	Staff Nurse	1	1,53,720	3	4,61,160	
	Health Worker (F)/ANM	1	1,36,260	0	-	
	Health Educator	1	1,53,720	0	-	

	Health Assistant (Male)	1	1,71,180	0		
	Health Assistant (F)/LHV	1	1,71,180	0	-	
	Public Health Nurse practitioner	0	-	(on contract)	-	
	UDC/Computer clerk	1	1,18,800	1	-	
	LDC	1	91,330	1	91,330	
	Laboratory Technician	1	1,18,800	1	1,18,800	
	Driver	1	79,806	0	-	
	Class IV	4	2,77,320	(on contract)	-	
	Sub-total for salaries	15	19,41,061	8	10,77,670	(8,63,391)
2	Drugs ( As per IPHS norms and standards)	Under RCH	9,025		3,00,000	
3	Travel Allowance	Rs.75/visit		12 visits/mth X 2 persons	28,800	
4	For contractual Class IV.	None	-	Rs.3500 +	60,000	
	Pharmacist			Rs.1500/mth.		
5	Telephone	None	-	Rs.1000/ mth	12,000	
6	For hiring transport in emergency.	None	-	Rs.300/case X 80 cases	24,000	
7	Other expenses	no norms	-	Rs.2000/mth	24,000	
	Sub-total		19,50,086		15,26,470	(4,23,616)

Source: National Commission on Macroeconomics and Health 2005

At present there are 22842 PHCs but according to 2001 census population 26,150 PHCs are being recommended.

Figures in parenthesis reflect savings.

The actual resource need for a PHC will take into account the likely utilization of resources. The details regarding equipment, drugs, furniture, etc shall be

provided as per the IPH Standards. The Indian Public Health Standards, read with the recommendations of the National Commission on Macro Economics and Health, and the actual Facility Survey, will determine the actual intervention and resource provision. NRHM will not undertake routine allocation of resources. Every PHC will have to develop a baseline and an annual plan of activities. Resources will be released only after outcomes are guaranteed by the additional funds. Every PHCs need will be specifically asked for in the Annual Work Plan and Budget of the district.

Annual funds requirement for Community Health Centres

Sl. No.	Item	<i>As per existing norms</i>		<i>As per revised norms</i>		Difference between current & suggested norms (Rs.) for one SC
		Norms	Cost (Rs.)	Norms	Costs (Rs)	
<b>A</b>	<b>Capital/Non-recurring</b>					
1	CHC building	OT&LR	10,00,000	4000 sft @ Rs.600/sft.	24,00,000	
2	Staff Quarters	No Norms	-			
	For MOs	1 MO	14,40,000	1200 sft @ Rs.600/ sft. X 4 MOs	28,80,000	
	For Staff Nurses	No Norms	12,00,000	1000 sft @ Rs.600/ sft. X 4 SNs	24,00,000	
	For Chowkidar	No Norms	2,40,000	400 sft @ Rs.600/ sft X 1	2,40,000	
3	Equipment	1 kit each type per distt.	6,01,000		22,19,000	
4	Furniture	No norm	-	5% of CHC bldg. Cost	1,20,000	
	Sub-total		44,81,000		1,02,59,000	
<b>B</b>	<b>Recurring</b>					
1	Staff					

	Specialists/Medical Officers	4	14,76,240	7	22,06,575	
	Staff Nurses	7	10,76,040	10	15,37,200	
	Public Health Nurse	0	-	1	1,71,180	
	Computer Clerk	0	-	1	91,330	
	Dresser	1	69,330	1	69,330	
	Pharmacist/Compounder	1	1,53,720	1	1,53,720	
	Laboratory Technician	1	1,18,800	1	1,18,800	
	Block Extension Educator	1	1,53,720	1	1,53,720	
	Radiographer	1	1,18,800	1	1,18,800	
	Ward Boy	2	1,38,660	(on contract)	-	
	Dhobi	1	69,330	(on contract)	-	
	Sweepers	3	2,07,990	(on contract)	-	
	Chowkidar	1	69,330			
	Aya	1	69,330	(on contract)	-	
	Peon	1	69,330	(on contract)	-	
	Mali	1	69,330	0	-	
	UDC	0	0	2	1,93,368	
	LDC	0	0	1	79,806	
	Epidemiologist (Medical Doctor)	0	0	1	2,75,822	
	Driver	0	0	Vehicle on contract	-	
	Sub-total of salaries	26	38,59,950	28	51,69,650	13,09,700
2	Drugs	1 kit each type/Distt.	1,10,713/-		10,00,000	
3	Travel Allowance	No norm	-	Rs.75/ day X 24 visits/mth.	21,600	
4	For contractual dhobi, mali, ward boys, aya, peon	None	-	Rs.1000/ person X 8 persons	96,000	

5	For vehicle on contract	None	-	Rs.400/ case X 150 cases	60,000	
6	Telephone	None	-	Rs.2000/ mth.	24,000	
7	Mobility support to MOs for holding clinics in PHCs.	No norm		2 clinics per week in each PHC ; Rs.86,940/CHC	86,940	
8	Other expenses	No norm	-	Rs.4000/ mth.	48,000	
	Sub-total		39,70,663		65,06,190	25,35,527
	TOTAL		84,51,663		1,67,65,190	83,13,527

Source: National Commission on Macro Economics and health 2005.

At present there are 3043 CHC but as per 2001 population and as per norms, 7951 CHCs are being recommended.

The actual resource need for a CHC will take into account the likely utilization of resources. The details regarding equipment, drugs, furniture, etc shall be provided as per the IPH Standards. The Indian Public Health Standards, read with the recommendations of the National Commission on Macro Economics and Health, and the actual Facility Survey, will determine the actual intervention and resource provision. NRHM will not undertake routine allocation of resources. Every CHC will have to develop a baseline and an annual plan of activities. Resources will be released only after outcomes are guaranteed by the additional funds. Every CHC's need will be specifically asked for in the Annual Work Plan and Budget of the district.

**Assessment made by the National Commission on Macro Economics and Health  
2005**

**Core package of Essential Health interventions for universal Free services as outpatients**

<b>Core package</b>	<b>Approx. number of cases for 2005 population</b>	<b>Unit cost of treatment ( Rs.)</b>	<b>Total cost for treatment (Rs. In crores)</b>
1. Childhood diseases/health conditions			
a. Immunization	26,315,925	84.51	222.39
b. Acute respiratory infections: Pneumonia	34,184,386	141.49	483.68
c. Diarrhoea: with some dehydration	34,184,386	269.82	922.37
d. Diarrhoea: with severe dehydration	3,418,439	742.99	253.99
e. Dysentery	3,418,439	77.47	26.48
2. Maternal diseases/health conditions			
a. Antenatal care	26,315,925	278.46	732.80
b. Abortions	4,726,882	886.99	419.27
c. Female sterilization	4,726,882	886.99	419.27
d. Vasectomy	236,344	200.27	4.73
e. IUD insertion	6,202,399	86.89	53.89
f. Oral contraceptives	8,619,508	79.96	68.92
g. Condoms	17,476,568	79.96	139.74
h. Postnatal care	26,315,925	236.88	623.37
3. Blindness			
a. Blindness due to refractive errors and Low vision	2,884,777	165.97	47.88
4. Leprosy			
a. Paucibacillary	404,957	393.01	15.92
b. Multibacillary	213,036	1,167.53	24.87
5. Tuberculosis			
a. New sputum positive	3,900,000	840.98	327.98
b. New Sputum negative	3,800,000	780.02	296.41
c. Treatment after default/Retreatment/Failure	397,922	1,240.36	49.36
d. Extrapulmonary	800,000	780.02	62.40
6. Vector borne diseases			
a. Malaria: P. falciparum	814,800	150.60	12.27
b. Malaria: P.vivax and P. ovale	1,222,200	148.81	18.19
c. Kalaazar	17321	1677.09	2.90
7. RTIs/STIs	4,929,763	956.90	471.73

8. Preventive and promotive activities @ Rs. 20 per capita to be spent by Gram Panchayats/Village Health Committees	1,061,126,000		2122.25
9. Minor injuries including falls	23,746,056	225.85	536.31
10. Other minor ailments	265,281,500	57.54	1526.50
11. Snake bite	3,957,676	462.65	183.10
Grand Total			9,700
Total Cost Per capita			90

**Basic Health Care Services to be provided at 30- bed Community Health Facility located at 1,00,000 Population**

**(including all inpatient treatment required at CHC for core package)**

List of diseases/Health conditions	Unit cost of treatment ( Rs.)	Approx. number of cases for 1 lakh population	Total cost for treating ( Rs. In lakhs)
A. In patient treatment required at CHC for Core package			
1. Childhood diseases/health conditions			
a. Birth asphyxia	1,621.14	25	0.40
b. Neonatal sepsis	7,086.53	25	1.76
c. Low birth weight (btw. 1500-1800g)	1,604.73	99	1.59
d. Low birth weight(btw. 1800-2500g)	1,460.20	570	8.33
e. Acute respiratory infections: Severe pneumonia	4,435.18	322	14.29
2. Maternal diseases' health conditions ( to be provided free to 50% and user charges collected for cases from APL families)			
a. Normal delivery	509.89	2,108	10.75
b. Puerperal sepsis	1,102.66	18	0.20



c. Septic abortion	1,102.66	5	0.06
d. Antepartum haemorrhage	4,657.31	12	0.56
e. Postpartum haemorrhage	3,568.40	21	0.75
f. Eclampsia	8,115.83	25	2.03
g. Obstructed labour	2,192.23	32	0.70
h. Remaining Caesarean Sections	2,192.23	92	2.02
i. Severe anaemia	2,333.79	248	5.79
3. Blindness			
a. Cataract blindness ( to be provided free to 50% and user charges collected for cases from APL families)	1,737.01	452	7.85
4. Vector borne diseases			
Malaria Complicated :	914.78	40	0.36
Additional services to be performed at CHC for basic package			
1. Chronic otitis media	163.88	3,000	4.92
2. Diabetes mellitus			
Without insulin	1,139.43	2,065	23.53
With insulin	5,109.46	885	45.23
3. Hypertension			
With diet and exercise	424.84	857	3.64
With one drug	456.12	1,714	7.82
With two drugs	740.82	857	6.35
4. Chronic obstructive pulmonary disease	1,008.91	1,461	14.74
5. Asthma	673.32	2,330	15.69
6. Major surgeries	7997.0	438	35.03
7. Accidents/major injuries	8,777.77	438	38.45
8. Counselling for Psychiatric care	318.87	6993	22.30
Per capita cost @ 70%			310
Total Cost for 7951 CHCs in rural areas			Rs. 24,650 crores

### Cost of providing Secondary Care Services at District Hospital

	List of diseases/health conditions	Unit Cost of treatment (Rs.)	Number of cases per lakh population	Total cost (Rs. in lakhs)
	Secondary Care Package			
1	Cardio vascular diseases			
a.	Coronary artery disease			
	Incident cases	12,324.28	283	34.84
	Prevalent cases	5,069.10	3,353	169.97
b.	Rheumatic Heart Disease	1,406.43	72	1.01
2	Acute Hypertensive stroke	10,028.87	118	11.79
3	Cancers			
a.	Breast cancer	4,289.44	11	0.46
b.	Cancer of cervix	10,016.04	10	1.00
c.	Lung cancer	3,854.44	2	0.08
d.	Stomach cancer	7,106.55	3	0.21
4	Mental diseases/health conditions			
a.	Schizophrenia			
	Without Hospitalization	1,844.40	289	5.33
	With Hospitalization of 10 days in 5%	5,093.80	15	0.78
b.	Mood / Bipolar disorders			
	Without Hospitalization	2,982.34	1,543	46.01
	With Hospitalization of 10 days in 5%	6,053.76	81	4.92
c.	Common Mental disorders	1,987.25	2,030	40.34
d.	Child and adolescent psychiatric disorders	2,023.10	2,517	50.92
e.	Geriatric Problems including Dementia	6,273.69	406	25.47

f.	Epilepsy	2,461.63	913	22.48
5	Major injuries & emergencies (50%)	8,777.77	438	38.45
6	Other major surgeries (50%)	7,997.00	438	35.03
	Total cost (Rs.in lakhs)			489
	Premium per capita @ 70%			699
	Total cost for a district of 18 lakhs population (Rs. in crores)			126
	Total cost @ 70% (Rs. in crores) for 500 districts			62,882

## NRHM ACTIVITIES AND NORMS

Activity	Possible processes and illustrative norms
1. Visioning workshops for National, State, District and Block level Mission Teams	Need for setting up teams at each level comprising existing government functionaries and a few contractual personnel with new skills at all levels, as per need. Orientation on the details of the plan of action is critical for the system owning the challenge of NRHM. Involvement of NGOs/non governmental institutions as a team of resource persons under the framework of NIHFWS/SIHFWS. It should not be a routine orientation. <b>Costs as per approved workshop and training norms.</b>
2. Constitution and orientation of all community leaders on village, SHC, PHC, CHC Committees	Effective institutionalization of community ownership requires concerted efforts for appropriate selection and training of community representatives on committees. Broadly, the effort should be to have at least 50 percent women on every committee with at least 30 percent from non governmental sectors. Reservation for SC/ST/OBCs may be considered at various levels as per State norms. The effort has to be for a functional system. Orientation should involve NGOs and resource persons from outside the government system as well. Thrust on surveys, management of accounts, functionality of facilities, etc. <b>Cost as per approved workshop and training norms.</b>
3. Untied grants to Village Health and Sanitation Committees	<b>Every village with a population of upto 1500 to get an annual untied grant of up to Rs. 10,000, after constitution and orientation of Village Health and Sanitation Committees.</b> The untied grant to be used for household surveys, health camps, sanitation drives, revolving fund etc.
4. Selection and training of Community Health Workers (ASHAs, AWWs) etc.	<b>Total support of up to Rs. 10,000 per ASHA for initial training, monthly orientation, drug kit, support materials, travel expenses, etc.</b>
5. Performance related incentives for ASHAs, AWWs.	While performance related incentives would come under various programmes, the total resources should be kept aside at the Gram Panchayat Committee at SHC level for disbursement to ASHAs. Every Gram Panchayat Committee can seek replenishment of performance based funds after disbursement to ASHAs. <b>Rs. 5000 permanent advance may be made available to every Gram Panchayat as a permanent advance for this purpose. Disbursement as per performance norms.</b>

<p>6. Selection and training of non-governmental providers of health care RMPs/TBAs</p>	<p>Based on a survey of non-governmental providers (RMPs/TBAs) and their likely potential to become as qualified as a government provider, <b>special training programmes to enlarge the pool of skilled health workers in rural areas should be made. This will help in promoting common treatment protocols and in promoting current practices and priorities. NGOs ought to be involved in such efforts. Cost as per standard training norms.</b></p>
<p>7. Physical infrastructure for village level health activity.</p>	<p>ASHA to work from the Aanganwadi Centre. Since Aanganwadis have the responsibility for under 6 children, pregnant women and adolescent girls, there is a need for additional space for the ICDS centre that may be used as a health care room. Resources can come from existing rural development programmes under which ICDS centres are being constructed and provided for.</p>
<p>8. Selection, remuneration and training of ANMs.</p>	<p>More than 2 lakh ANMs will be required to be added to the system. Currently only 13,000 ANMs are completing their training each year. Innovative systems involving NGOs to introduce vocational training at High School and Ashramshalas in tribal areas to work with the educated local girls to develop them into ANMs, ought to be undertaken. In service training to develop existing ANMs into skilled attendants at birth is required. Duration to be worked out as per need. Involvement of distance education systems with large local contact hours in hospitals, needs to be explored in partnership with NGOs. Blocks need to develop their plans for filling up ANM vacancies, identification of selection teams, training packages, remuneration, etc. Improvement of mobility of ANMs with a provision for interest free loans for two wheelers could be explored. <b>Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.</b></p>
<p>9. Selection, training and remuneration of PHNs at PHC level</p>	<p>There is a need to strengthen the monitoring and supervision role of the Lady Health Visitor, who may be called the Public health Nurse. She should be equipped to improve skills of ANMs, supervise their work, assign specific tasks to them, etc. <b>Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.</b></p>

<p>10. Selection, training and remuneration of Staff Nurses at PHC/CHC level.</p>	<p>The Nursing Schools put together are not producing as many qualified nurses as needed. Given the huge demand for good Nurses overseas, there is also a large drain of such services to overseas demands. A thorough review of Nursing Schools, ways of augmenting capacities as per needs, has to be worked out in each State. Innovative training and orientation system with the help of NGOs has to be developed to provide for effective monitoring, etc. Existing norms to apply. <b>Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.</b></p>
<p>11. Selection, training and remuneration of Medical Officers at PHCs</p>	<p>Medical Officers at PHCs have to be multi skilled and special programmes for their orientation has to be developed in State specific contexts. The issue of absenteeism has to be tackled by carefully looking at the system of incentives and career progression. Opportunities for need based orientation have to be evolved. <b>Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.</b></p>
<p>12. Selection, training and remuneration of Specialists at CHC level.</p>	<p>It is a problem to get the services of Specialists at CHC level. Flexible systems of recruitment have to be developed along side improvement of facilities and opportunities for hospital like services at these institutions. <b>Cost norms to be developed in consultation with States as per standard cost norms for training, remuneration and orientation. All appointments will be contractual and based on local selection criteria.</b></p>
<p>13. Construction and maintenance of physical infrastructure of SHCs</p>	<p>The Gram Panchayat SHC Committee has the mandate to undertake construction and maintenance of the facilities. <b>An annual maintenance grant of Rupees 10,000 will be available to every SHC. Specific proposal for major repairs will have be developed if such works are required. Provision for water, toilets, their use and their maintenance, etc, has to be priorities.</b></p>

<p>14. Construction and maintenance of physical infrastructure of PHCs</p>	<p>PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure. <b>Annual maintenance grant of Rs. 50,000 to be available to each PHC. Provision for water, toilets, their use and their maintenance, etc, has to be priorities.</b></p>
<p>15. Construction and maintenance of physical infrastructure of CHCs.</p>	<p>CHC level Rogi Kalyan Samiti/ Block Panchayat Samiti to undertake construction and maintenance of CHCs. <b>Annual maintenance grant of Rs. 1 lakh to every CHC, to ensure quality services through functional physical infrastructure.</b></p>
<p>16. Procurement and distribution of quality equipments and drugs in the health system.</p>	<p><b>Develop capacities in States like the Tamil Nadu Health Systems Corporation to procure quality drugs and develop logistic arrangements for their timely utilization. Central government procurements as an interim measure till capacities are developed at State/district/Block levels for quality and timely procurement. Emphasis on timeliness, transparency, and quality of procurements.</b></p>
<p>17. Support to BPL families for institutional deliveries under the Janani Suraksha Yojana.</p>	<p><b>Accreditation of government and non governmental institutions for institutional deliveries with systems for timely availability of financial resources to the BPL families. States may propose enhancement of norms in line with NCMH unit costs.</b></p>
<p>18. Untied grants to SHCs, PHCs and CHCs</p>	<p><b>Every SHC to get Rs.10,000/-, every PHC to get Rs. 25,000 and every CHC Rupees 50,000 as untied grants for local health action. The resources could be used for any local health activity for which there is a demand.</b></p>
<p>19. Support to Mobile Medical Units/ Health Camps</p>	<p>With the objective to take health care to the door step of the public in the rural areas, especially in under-served areas, Mobile Medical Units are proposed to be provided, one per district under NRHM. The states are, however, expected to address the diversity and ensure the adoption of most suitable and sustainable model for the MMU to suit their local requirements. They are also required to plan for long term sustainability of the intervention.</p> <p>Two kinds of MMUs are envisaged, one with diagnostic</p>

	<p>facilities for the states other than North-Eastern States, Himachal Pradesh and J&amp;K. In addition, for the North-East, Himachal Pradesh and J&amp;K, specialized facilities and services such as X-ray, ECG and ultra-sound are proposed to be provided due to their difficult hilly terrain, non-approachability by public transport, long distances to be covered etc.</p> <p>The states are needed to involve District Health Society / Rogi Kalyan Samiti / NGOs in deciding the appropriate modality for Operationalization of the MMU. The provision of staff will be considered only for the states who will run the vehicles with support of NGOs/RKS and in case of states outsourcing the vehicles.</p> <p>The unit cost for mobile van for staff is Rs.7.00 lakhs, mobile unit with essential accessories costs Rs.18.25 lakhs per district and a mobile unit with diagnostic facilities has a unit cost of Rs.23.75 lakhs per district. The total capital expenditure for 595 districts in the country is estimated to be Rs.175 crores. The recurring expenditure for North-Eastern states, J&amp;K and Himachal Pradesh with provision of a radiologist and an additional driver for diagnostic van is Rs.23.71 lakhs per district per annum. For other states, the unit recurring cost is Rs.19.87 lakhs per district per annum. The total recurring expenditure for 595 districts in the country is Rs.122.21 crores.</p> <p>The total capital expenditure is estimated to be Rs.175 crores with total recurring expenditure of Rs.122.21 crores for the whole country.</p> <p>States to work out need and numbers for mobile dispensaries. Health Camps as a means of mobilizing local communities for health action and for creating demand. Unit costs to be developed in consultation with States. Mobile Medical Unit for each State.</p>
20. Support for School Health Programmes	Innovative School Health Programmes could be taken up for a range of issues in public health. Funding as per specific proposals from schools/ Blocks/ districts.
21. Support for IEC activities	A variety of activities involving communities and also the media. <b>Allocations at national, state and district levels. Up to Rupees ten per capita which should be equally spent at the three levels (1/3, 1/3, 1/3).</b>



22. Nutrition and Health Education Programmes for women's groups.	As a means to strengthen ICDS activities and to improve cultural practices with regard to child care. As per local proposals for strengthening the component.
23. Resources for surveys, camps, public hearings.	As per local needs and as articulated in the Block, District and State level Annual and Perspective Plans.
24. Grants in aid to NGOs at district, state and national levels.	Up to 5 percent of the total NRHM Budget could be used as Grants in aid to NGOs at various levels. This will improve outreach of services and efficiency of delivery.
25. Innovation funds at all levels.	For local action that emerge as priorities in the Block/District Action Plans. States to appraise need for innovation and suggest costs as per need and existing State norms.
26. Monitoring and Evaluation Costs.	Up to Rs. 5 per capita will generate an annual corpus of Rs. 150 crores. Of this resource 25 % may be used at the national level, 25% at the State level and the rest at district level and below.
27. Management Costs/Contingencies.	Up to 6 % of the total Annual Work Plan for that year, calculated on the basis of the total State level NRHM Plan (including the District Plans). Resources for contractual engagement of personnel with new skills, travel costs, etc. to be met from this.
28. State level Resource Centre	To be set up with an annual corpus of Rs. One crore in large States and Rupees Fifty lakhs in smaller States/UTs. To be used for operationalizing new ideas and for strengthening service delivery. Resources to be used for hiring resource persons and for field based operational activities.
29. National level Resource Centre	To be set up with an annual corpus of Rupees 15 crores. To be used for raising new ideas and for operationalizing them to improve effectiveness of service delivery and efficiency of resources.
30. Support to district and Block level Resource Groups.	For development of capacities and for field based supervision of services.
31. Research Studies	Up to Rs. 5 per capita will generate an annual corpus of

	Rs. 150 crores. Of this resource 25 % may be used at the national level, 25% at the State level and the rest at district level and below.
32. Support for Planning activities.	As per specific need expressed by Districts/Blocks.
33. Capacity building needs at all levels	To be a priority at all levels. To be designed as per local needs. Non-negotiability of quality and standards. NGOs to be involved as resource teams and institutions at all levels for capacity building.
34. Costs of core, basic and secondary health care	As per National Commission on Macro Economics and Health assessment. The cost in the non-governmental sector is likely to be 30-50 percent higher. State Health Missions to assess costs based on detailed district specific exercise. Mission Steering Group at State level can approve costs up to 25 percent more than provided by NCMH. Any further increase has to be formally approved by the National Level Mission Steering Group.
35. Resources for risk pooling.	To be used as per specific state/region/district models that may evolve, to support premium for Below Poverty Line Families. Ceiling on premium as per UHIS – Rs. 300 for a family of five.
36. Strengthening Nursing Schools.	As per need and specific proposals.
37. Improving physical infrastructure of SHC/PHC/CHC/Taluk/District Hospital	Upto 1/3 <sup>rd</sup> of total annual allocation under NRHM in special focus states and upto 1/4 <sup>th</sup> in low focus states.
38. Ambulances for all PHCs/CHCs/District Hospitals.	As per case load and need. To be under the supervision of the RKS/ User group.
39. Telephones for SHCs/PHCs/CHCs/District Hospitals.	As per need.

<p>40. Rogi Kalyan Samitis / Hospital Management Committees</p>	<p>NRHM strategies to upgrade the CHCs to Indian Public Health Standards (IPHS) with a purpose to provide sustainable quality care with accountability and people's participation along with total transparency. To ensure a degree of permanency and sustainability, a management structure called Rogi Kalyan Samity (RKS) (Patient Welfare Committee)/Hospital Management Committee (HMC) has been evolved. RKSs are proposed to be established in 585 rural hospitals, 3222 Community Health Centres, and 23109 Primary Health Centres in the country. The initiative would bring in the community ownership in running of rural hospitals and health centres, which will in turn make them accountable and responsible.</p> <p>To motivate the states to set up RKSs, a support of Rs.5.0 lakhs per rural hospital, Rs.1.00 lakh per CHC and Rs.1.00 per PHC per annum would be given to these societies through states. The societies would be eligible for these grants only where they are authorized by the States to retain the user charges at the institution level.</p> <p>An amount of Rs.29.25 crore as a seed money for Operationalization of RKSs in rural hospitals, Rs.32.22 crores for CHCs and Rs.231.09 crores for RKS in PHCs has been estimated.</p>
<p>41. Ceiling on Civil works</p>	<p>Up to a maximum of 33% of Annual Plan in Special Focus States and 25% of Annual Plan in other States.</p>
<p>42. Preparation of District Health Action Plans</p>	<p>Up to Rupees twenty lakhs per district for surveys, workshops, studies, consultations, orientation in the process of preparation of District Health Action Plans.</p>
<p>43. Preparation of District and State level public reports on health annually by independent agencies.</p>	<p>Up to Rupees Fifty Thousand per year for the preparation of District Public Reports and up to Rupees two lakhs per year for the preparation of State Public report on Health, based on analysis of published reports, studies, surveys, etc.</p>
<p>44. Special needs of North Eastern States</p>	<p>As mentioned at para 109, North Eastern States may require relaxation of norms. It shall be taken in the appraisal process.</p>

**National Rural Health Mission**

Draft Memorandum of Understanding (MoU) Between Ministry of Health & Family Welfare,  
Government of India And The Government of the State of .....

**[NOTE: Explanatory Footnotes and Sample Annexes are for purposes of clarification and illustration only.]**

**1. Preamble**

- 1.1 *WHEREAS* the National Rural Health Mission, hereinafter referred to as NRHM, has been launched for nation-wide implementation with effect from April, 2005<sup>1</sup>;
- 1.2 *WHEREAS* the NRHM aims at providing accessible, affordable, effective, accountable and reliable health care to all citizens and in particular to the poorer and vulnerable sections of the population; consistent with the outcomes envisioned in the Millennium Development Goals and general principles laid down in the National and State policies, including the National Health Policy, 2002 and National Population Policy, 2000;
- 1.3 *AND WHEREAS* the ‘architectural correction’ of the health sector is a key objective for the NRHM, to be carried out through integration of vertical programs and structures; delegation and decentralization of authority; involvement of Panchayati Raj Institutions and other supportive policy reform measures in the areas of medical education, public health management, incorporation of Indian Systems of Medicine, regulation of health care providers and new health financing mechanisms;
- 1.4 *NOW THEREFORE* the signatories to this Memorandum of Understanding (hereinafter referred to as MoU) have agreed as set out herein below.

**2. Duration of the MoU**

- 2.1 This MoU will be operative with effect from April, 2005 or the date of its signing by the parties concerned whichever is later and will remain in force till March, 2012 or till its renewal through mutual agreement whichever is earlier.

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<sup>1</sup> The NRHM MoUs are to be executed by September, 2005 on the basis of a State NRHM Action Plan.

### **3. State Sector PIP and its financing**

- 3.1 The MoHFW will provide a resource envelope to support the implementation of an agreed State NRHM Sector Programme Implementation Plan (PIP), hereinafter referred to as Sector PIP, reflecting (a) all sources of funding for the health sector, including State's own contribution<sup>2</sup>, (b) a convergence plan for NRHM related sectors<sup>3</sup> and (c) proposals and time frame for institutional reforms referred to in para 1.3 hereinabove<sup>4</sup>.
- 3.2 The agreed outlay for the Sector PIP for financial year 2005-06 and 2006-07 and the sources for the funding of the same will be as given at **Appendix-I**<sup>5</sup> hereto.
- 3.3 Each State will prepare a Programme Implementation Programme (PIP) and a Log Frame based upon the quantum of funds provided to it. The PIP will be consistent with the general principles laid down in the National and State policies relevant to the Sector and other agreed action plans. The Log Frame will, in particular, reflect the core indicators agreed to be adopted by the programme.
- 3.4 Based upon its PIP and Log Frame, each State will set its own annual level of achievement for the programme core indicators in consultation with GoI and subsequently, States will have similar arrangements with the Districts.
- 3.5 The Government of India may issue mandatory core financial and programme indicators as well as institutional process as well as output indicators, which would need to be adhered to by the States.
- 3.6 The implementation of the action plan as set out in the PIP shall be reviewed at the State level once every month at the level of all States and UTs.

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<sup>2</sup> The Sector Action Plan is to be evolved from the agreed RCH-II PIPs to include National Disease Control Programmes, AYUSH and State's share (including the resources sought to be accessed from the funds directly flowing under the State Health Systems Projects of the World Bank 12<sup>th</sup> Finance Commission, and State Partnership Programmes of other Development Partners).

<sup>3</sup> At least water, sanitation and nutrition sectors. The convergence plan has to list out specific action points and the time schedule for their implementation.

<sup>4</sup> Institutional reforms would relate to the 'architectural correction' referred to in the NRHM documents such as restructuring and decentralization of cadres, delegation of financial and administrative authority to the PRIs, streamlining and strengthening of support systems (logistics, MIS, IEC etc.) etc.

<sup>5</sup> The financing plan shall be drawn on the basis of the agreed State PIP.

- 3.7 A review would be held every (quarter/six months) by the MoHFW (for the EAG States, NE States and the State of Jammu & Kashmir)/(every six months/annually) (for other States/UTs). Corresponding State level reviews of Districts would need to be carried out by the States/UTs.
- 3.8 The Sector PIP will be jointly reviewed to arrive at an agreed Sector PIP for the subsequent year.
- 3.9 The NRHM contribution to support the Sector PIP will cover, among others, implementation of RCH phase II, National Vector Borne Disease Control Program, National Leprosy Eradication Program, National Iodine Deficiency Disorder Program, Revised National Tuberculosis Program, National Blindness Control Program, AYUSH scheme on hospitals and dispensaries, Integrated Disease Surveillance Program and the thrust areas identified under the NRHM.
- 3.10 The NRHM would operate as an omnibus broadband programme by integrating all vertical programmes of the Departments of Health and Family Welfare. However, independent sub-budget lines may be retained to provide independent 'financial' identity till the expiry of existing bilateral agreements.
- 3.11 Although the AIDS control program and the National Cancer Control Program shall not be merged into the NRHM budget head, the planning and monitoring functions for these shall remain a specific task for the institutional arrangements agreed through this MoU.

#### **4. Funds Flow arrangements**

- 4.1. The first installment of grant-in-aid under this MoU shall be made during the second half year of financial year 2005-06<sup>6</sup> and will be contingent upon execution of this MoU<sup>7</sup>.

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<sup>6</sup> The MoHFW will switch over to a six-monthly funds release system with effect from April, 2005. The first six-monthly installment will be released on the basis of the agreed RCH-II PIP and the agreed outlays for the other on-going programmes after submission of a Letter of Undertaking by the State (As per Annexure B1 of RCHII National PIP).

<sup>7</sup> Second installment of FY 2005-06 shall be made after submission of the following:

- Draft State Sector PIP, and
- A written report reflecting the progress of implementation of RCH-II and national disease control programmes.
- Fulfillment of Benchmark activities under NRHM.

4.2 Subsequent six-monthly releases shall be regulated on the basis of a written report to be submitted by the State indicating the progress of the agreed State Sector PIP including the following:

- Documentary evidence indicating achievement of targets / milestones for the agreed performance indicators referred to in para 5 hereinbelow,
- Statement of Expenditure confirming utilization of at least 50% of the previous release(s),
- Utilization Certificate(s) and Audit reports wherever they have become due as per agreed procedures under General Financial Rules (GFR).

## **5. Performance Indicators**

5.1. Release of grants-in-aid will be subject to satisfactory progress of agreed Performance Indicators relating to implementation of agreed State PIP including institutional reforms.

5.2 The agreed Performance Indicators are as given at **Appendix-II<sup>8</sup>** hereto.

## **6. Performance Awards**

6.1 The State shall be eligible to receive an Annual 'performance award' to the tune of 10% of its *actual utilization* of cash assistance in the previous financial year provided that the State has successfully achieved the criteria set out in para 5.2 above.

6.2 The releases under the performance award mechanism will be over and above the agreed allocations for supporting the agreed State Sector PIP and will become an untied pool which may be used for such purposes as may be agreed by the State Mission Steering Group referred to in para 8.1 hereinbelow.

## **7. Institutional Arrangements : National Level**

7.1 At the National level, Mission implementation will be steered by a Mission Steering Group (MSG) headed by the Union Minister for Health & Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health & Family Welfare.

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<sup>8</sup> Every State has to propose a set of performance indicators while submitting its State Sector PIP. An illustrative list is given at the draft Appendix-II which is arranged under two categories: mandatory performance indicators and voluntary. It be noted that many of the actions on the mandatory indicators may be completed well within FY 2005-06 itself, even before the NRHM MoU is executed. These have been listed in the mandatory list to remind the States of their importance.

- 7.2 The State Sector PIPs shall be appraised for approval and sanctioned by duly authorized Committee.
- 7.4 The representatives of the concerned State Government(s) shall also be invited to the meeting of the Committee whenever their proposal are listed for consideration / approval.
- 7.5 The Committee may also seek written feedback on the State Plan(s) from the representatives of the Development Partners providing financial and technical assistance to the Mission in the concerned State(s).

**8. Institutional Arrangements : State, District and Hospital Levels**

- 8.1. The State Government has set up the State Health Mission headed by the Chief Minister for providing guidance to State Health Mission activities. The constitution and terms of reference of the State Health Mission are as given at **Appendix-III** hereto.
- 8.2 The State has merged existing State level vertical societies in the health sector and has created an integrated Society, called ..... The said society shall receive the funds from the MoH&FW and other sources. The Society shall also perform the functions of a flexible mechanism for sourcing program management support for the State Directorate and district health administration in the State<sup>9</sup>. The Rules and bye-laws of the State Society as filed with relevant registration authorities are as given at **Appendix-IV** hereto.
- 8.3. *The State has completed the merger of the Departments in the Health and Family Welfare sector and has issued necessary orders for appointing the State Mission Director.*<sup>10</sup>
- 8.4 The State has ordered merger of all District level vertical societies into an integrated District Health and Family Welfare Society called..... The District Health Mission shall guide the Integrated District Health Society in policy and operations.

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<sup>9</sup> The Governing Body of the State Health Society is to be headed by the Chief Secretary/Development Commissioner. The Rules / bye-laws of State Health Society provide for a permanent secretariat headed by the Mission Director and having a multi-disciplinary team of experts and consultants to provide management support to mainstream implementing agencies / line Departments. The secretariat of the State Health Society shall also perform the functions of the secretariat of the State Health Mission.

<sup>10</sup> The MoHFW recommends that the various Departments under the Health and Family Welfare sector may be brought under a single Secretary / Principal Secretary.



The (model) Rules / bye-laws of the district Society as notified through Resolution / Notification are as given at **Appendix-V** hereto.

8.5. The State has also ordered creation of a Hospital Management Society called .....The model Rules / bye-laws of the hospital level society to be registered / filed with relevant registration authorities are as given at **Appendix-VI** hereto<sup>11</sup>.

## **9 Performance Review**

9.1. The Department of Health & Family Welfare shall convene national level meetings to review progress of implementation of the agreed State Sector PIP.

9.2 The department of Health and Family Welfare may also organize a State level review<sup>12</sup>.

9.3 The review meetings may lead to proposals for adding to or modifying one or more Appendices of this MoU. These will always be in writing and will form part of the minutes of meetings referred to hereinabove.

## **10 Government of India Commitments**

10.1 The funds committed through this MoU may be enhanced or reduced, depending on the pace of implementation of the agreed State PIP and achievement of the milestones relating to the agreed *Performance Indicators*.

10.2 The MoH&FW also commits itself to:

- (a) Ensuring that the resources available under the State Partnership Programs outside the MoH&FW budgets are directed towards complementing and supplementing the resources made available through the MoH&FW budget and are not used to replace the recurring expenses hitherto provided for under the Centrally Sponsored Schemes under the health and family welfare sector.

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<sup>11</sup> Specific State level arrangements will have to be specified in the draft State Sector PIP and certified copies of the rules / bye-laws appended to the MoU.

<sup>12</sup> Especially in the 18 high focus States.

- (b) Ensuring that multilateral and bilateral development partners co-ordinate their assistance, monitoring and evaluation arrangements, data requirements and procurement rules etc. within the framework of an integrated State Health Plan.
- (c) Facilitating establishment of District Health Missions and development of District Action Plans through such means as may be mutually agreed.
- (d) Assisting the States in mobilizing technical assistance inputs to the State Government including in the matter of recruitment of staff for the State and district societies.
- (e) Developing social / equity audit capacity of the States through joint development of protocols for assessing access levels for the most disadvantaged groups.
- (f) Developing and disseminating protocols, standards, training modules and other such materials for improving implementation of the program.
- (g) Consultation with States, at least once a year, on the reform agenda and review of progress.
- (h) Prompt consideration and response to requests from states for policy, procedural and programmatic changes.
- (i) Release of funds on attainment of agreed performance indicators, within an agreed time.
- (j) Holding joint annual reviews with the State, other interested Central Departments and participating Development Partners; and prompt corrective action consequent on such reviews.
- (k) Dissemination of and discussion on any evaluations, reports etc., that have a bearing on policy and/or have the potential to cause a change of policy.

**11. State Government Commitments:**

11.1 The State Government commits to ensure that the funds made available to support the agreed State Sector PIP under this MoU are:

(a) used for financing the agreed State Sector PIP in accordance with agreed financing schedule and not used to substitute routine expenditures which is the responsibility of the State Government.

(b) kept intact and not diverted for meeting ways and means crises.

11.2 The State Government also commits to ensure that:

(a) The share of public spending on Health from state's own budgetary sources will be enhanced at least at the rate of 10% every year<sup>13</sup>.

(b) Its own resources and the resources provided through this MoU flow to the districts on an even basis so as to ensure regular availability of budget at the district and lower levels. Of these, at least .....% of funds will be devolved to the Districts with provision for flexible programming.

(c) Structures for the program management are fully staffed and the key staff related to the design and implementation of the agreed State Sector PIP, and other related activities at the State (including Directorate) and district level are retained in their present positions at least for three years<sup>14</sup>.

(d) Representative of the MoH&FW and/or development partners providing financial assistance under the MoU mechanism as may be duly authorized by the MoH&FW from time to time, are allowed to undertake field visits in any part of the State and have access to such information as may be necessary to make an assessment of the progress of the health sector in general and the activities related to the activities included under this MoU, subject to such arrangements as may be mutually agreed.

(e) The utilization certificates (duly audited) are sent to the Ministry of Health & after close of the financial year, within the period stipulated in the General Financial Rules.

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<sup>13</sup> Mandatory performance indicator.

- (f) The State shall take steps for decentralization and promotion of District level planning and implementation of various activities, under the leadership of Panchayati Raj Institutions.
- (g) The State shall endeavour to implement models of 'Community Health Insurance'.

11.3 The State Govt. agrees to abide by all the existing manuals, guidelines, instructions and circulars issued in connection with implementation of the NRHM, which are not contrary to the provisions of this MOU.

11.4 The State Government also commits to take prompt corrective action in the event of any discrepancies or deficiencies being pointed out in the audit. Every audit report and the report of action taken thereon shall be tabled in the next ensuing meeting of the Governing Body of the State Society.

## 12. Bank Accounts of the Societies and their Audit:

12.1 State and district society funds will be kept in interest bearing accounts in any designated nationalized bank or such bank as may be specified by the MoHFW<sup>15</sup>.

12.2 The State will organize the audit of the State and district societies within six-months of the close of every financial year. The State Government will prepare and provide to the MoH&FW, a consolidated statement of expenditure, including the interest that may have accrued.

12.3 The funds routed through the MoU mechanism will also be liable to statutory audit by the Comptroller and Auditor General of India.

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<sup>15</sup> The MoHFW are introducing an electronic funds transfer system in a phased manner, which may be through other than a nationalized bank.

13. Suspension

13.1 Non compliance of the commitments and obligations set hereunder and/or upon failure to make satisfactory progress may require Ministry of Health & Family Welfare to review the assistance committed through this MOU leading to suspension, reduction or cancellation thereof. The MoH&FW commits to issue sufficient alert to the State Government before contemplating any such action.

Signed this day, the ..... of ..... 200 .

For and on behalf of the Government of .....	For and on behalf of the Government of India, Ministry of Health & Family Welfare,
Principal Secretary (HFW) Government of .....	Secretary, Ministry of Health & Family Welfare, Government of India
Date: _____	Date: _____

Appendices which form part of this MoU:

Appendix-I: Agreed outlays and financing plan for the agreed State Sector PIP

Appendix-II: Agreed Performance Indicators

Appendix-III: Constitution and Terms of Reference of the State Health Mission

Appendix-IV: Certified copies of the Rules / bye-laws of the State Society

Appendix-V: State Government Resolution / Notification ordering registration of  
integrated  
District Society

Appendix-VI: State Government Resolution / Notification ordering registration of Hospital  
Management Society.

## Appendix-I

### Agreed Financing Plan for the Agreed State Sector PIP for FY 2005-06 and 2006-07 (Year-wise, separately,)

#	Item / purpose	Agreed outlays and source of funding (Rs lakh)			
		Grant-in-aid from MoHFW	State share	Other sources (*)	Total
<b>A: RCH-II Resource Envelope</b>					
<b>B: NRHM related activities</b>					
<b>C: Immunization</b>					
<b>D: Implementation of (on-going) National Disease Control Programmes</b>					
<b>E: Intersectoral Convergence</b>					

#	Item / purpose	Agreed outlays and source of funding (Rs lakh)			
F: Activities not included in A, B or C above					

(\*): Includes State Health Systems projects, State Partnership Projects, Finance Commission awards, projects / schemes funded through Global Funds and/or Global Partnerships in the health sector and projects / schemes being (or proposed to be) funded outside the State budget.

## Performance Indicators

**Institutional process performance targets whereby release of [2006/7] flexible pool resources will be decided**

	Indicator	Source	Target level of achievement set by the state*	Date on which the indicator is to be measured
1.	% of ANM positions filled	State reports and quarterly management reviews		
2.	% of ASHAs selected	State reports and quarterly management reviews		
3.	% of ASHAs trained	State reports and quarterly management reviews		
4.	% of Sub-centres submitted UC for Untied Fund	State reports and quarterly management reviews		
5.	% of State and districts having full time program officers including Programme Manager for RCH with financial and administrative powers delegated	Same as above		
6.	% of sample State and District Program Managers received training as prescribed under the programme	Management review		
7.	% of sampled state and district program managers whose performance was reviewed during the past six months	Management review		
8.	% of Districts not having at least one month stocks of essential drugs supplied by various programmes, e.g. (a) Anti-TB drugs (b) Measles vaccine (c) Oral Contraceptive pills (d) Gloves	MIS		
9.	% of Districts with integrated societies	MIS		
10.	% of Districts with Quality Assurance Committees	MIS		
11.	% of District Action Plans ready	MIS		
12.	% of facilities with Hospital Management Society	MIS		
13.	% of districts reporting quarterly financial performance in time	FMR		
14.	% of district plans with specific activities to reach vulnerable communities	Management reviews		
15.	% of sampled districts that were able to implement M&E triangulation involving communities	Management reviews		
16.	% of sampled outreach sessions where guidelines for AD syringe use and safe disposal are followed	Quality reviews		



17 .	% of sampled FRUs following agreed infection control and healthcare waste disposal procedures	Quality reviews		
18 .	% of 24 hrs PHCs conducting minimum of 10 deliveries/month	MIS and quality reviews		
19 .	% of upgraded FRUs offering 24 hr. emergency obstetric care services	MIS and quality reviews		
20 .	% of CHCs upgraded to IPHS	MIS		

## APPENDIX II

### Agreed Performance Indicators

#### A: Mandatory Performance Indicators

A-1: Share of State Budget for health sector [ Benchmark: minimum 10% (nominal) increase every year]

Item /category	Last Financial Year	Current Financial Year	%age Increase over previous year
State Budget-Total			
Outlay for health sector			

A-2: Vacancies of management posts [benchmark: maximum 10%]

Level /category	Number Sanctioned	In position as on 1 <sup>st</sup> April	In position as on 31 <sup>st</sup> December	Average in-position	Posts vacant	Vacancy rate
State level – Directorate						
Technical (Assistant Director or equivalent and above)						
Finance and accounts (all)						
State level – SPMSU (Society secretariat)						
Technical (all)						
Finance and accounts (all)						
District level						
District Programme managers						
DPMSU (society secretariat)						

A-3: Vacancies of critical field staff [ benchmark: maximum 10%]

Level /category	Number Sanctioned	In position as on 1 <sup>st</sup> April	In position as on 31 <sup>st</sup> December	Average in-position	Posts vacant	Vacancy rate
Specialists for below district level health facilities– regular						
Specialists for below district level health facilities– contractual						
Medical Officers for below district level health facilities – regular						
Staff Nurses for below district level health facilities– regular						
Staff Nurses for below district level health facilities– contractual						
Paramedical Supervisors -female (LHV)						
Paramedical Supervisors –male						
Multi-purpose worker-female (ANM)-regular						
Multi-purpose worker-female (ANM)-contractual						
Multi-purpose worker (male) – regular and contractual						
Lab-technicians for below district level facilities –regular and contractual						

A-4: Vacancies in training institutions [ benchmark: maximum 10%]

Level /category	Number Sanctioned	In position as on 1 <sup>st</sup> April	In position as on 31 <sup>st</sup> December	Average in-position	Posts vacant	Vacancy rate
State level Institute						
Senior faculty (Assistant Director or equivalent and above) – regular or contractual						
Other than senior faculty – regular or contractual						
ANM Training Schools						
Teaching staff– regular or contractual						
Non-teaching staff – regular or contractual						
Paramedical Supervisors- female (LHV)						

**B Performance / Process Indicators for service delivery [ benchmark: maximum 10% shortfall from agreed targets]**

Indicator	Agreed target	Agreed method for measuring achievement	Actual achievement	Short-fall	% age shortfall
<b>A: RCH and Family Planning services</b>					
No. of facilities providing emergency obstetric service on 24/7 basis		Independent assessment report			
No. of facilities conducting at least 10 deliveries per month		Independent assessment report			

Indicator	Agreed target	Agreed method for measuring achievement	Actual achievement	Short-fall	% age shortfall
No. of facilities providing full range of family planning services including vasectomy		Independent assessment report			
<b>B: Tuberculosis Control Programme</b>					
<b>C: Vector borne disease control programme</b>					
% of PHCs having facility for management of severe and complicated malaria					
<b>D: Leprosy Control Programme</b>					
<b>E: Blindness control Programme</b>					
Cataract surgery rate (No. of cataract surgeries done divided by number of cases (requiring cataract) detected)					
No. of children with refractive errors provided with glasses					
% utilization of donated eyes					
No. of teachers trained in vision screening					

Indicator	Agreed target	Agreed method for measuring achievement	Actual achievement	Short-fall	% age shortfall
<b>F: Implementation of ASHA (or equivalent)</b>					
No. of Gram Sabhas who have selected their ASHA (or equivalent)					
No. of ASHA (or equivalent) who have completed the first round of training					
<b>G: Disease surveillance</b>					
<b>H: Implementation of Janani Suraksha Yojana</b>					

**C Indicators to assess progress of institutional reforms**

Domain	Milestones to be achieved	Agreed month for achievement	Agreed source for verifying achievement
Empowerment and involvement of PRIs			
OD Review of the Directorate			
Strengthening and capacity building of district societies			
Streamlining / strengthening of MIS(including disease surveillance)			

Streamlining, strengthening and re-structuring of logistics			
Strengthening and capacity building of hospital societies			
Decentralization of administrative and financial authority			
Re-structuring and decentralization of medical and paramedical cadres			
Integration of AYUSH			

NOTE: More than one verifiable actions (e.g. a Government Notification announcing policy change, patient satisfaction survey, prescription audit etc.) will be necessary to assess progress.

**D Performance Indicators to assess improved access for vulnerable groups**

Indicator	Total achievement	Share of SC/ST	Share last year (*)	Source of verification
Deliveries reported by below district level public health facilities				
Number of pregnant women covered under Janani Suraksha Yojana				
Cataract operations in public health facilities				
Cataract operations through outreach (special camps)				
Number of habitations				

covered under Total Sanitation Campaign				
Number of children benefiting from mid-day meal scheme				

(\* ) Comparison to be started after one year from separate data being maintained