

**Report of the Working
Group on National Rural
Health Mission (NRHM) for
the Twelfth Five Year Plan
(2012-2017)**

*WG-1 :
Progress and
Performance of
National Rural
Health Mission
(NRHM) and
suggestions*

No. 2(6)2010-H&FW
Government of India
Planning Commission

Yojana Bhavan, Sansad Marg
New Delhi – 110001

Dated 9th May 2011

OFFICE MEMORANDUM

Subject: Constitution of working group on Progress and Performance of National Rural Health Mission (NRHM) and suggestions for the Twelfth Five Year Plan (2012-2017)

With a view to formulate the Twelfth Five Year Plan (2012-2017) for the Health Sector, it has been decided to constitute a Working Group on Progress and Performance of National Rural Health Mission (NRHM) and suggestions for the Plan under the Chairmanship of **Shri K. Chandramouli, Secretary, Department of Health & Family Welfare, Government of India.**

The composition and the terms of reference of the Working group would be as follows:

1	Shri K. Chandramouli, Secretary, Department of Health & Family Welfare, Government of India	Chairperson
2	Mission Director (MD) NRHM, Department of Health & Family Welfare, Government of India	Member
3	Secretary, Department of AYUSH, Ministry of Health & Family Welfare, Government of India	Member
4	Ms Anita Das, Former Secretary, AYUSH , GOI	Member
4	Dr. N.K. Sethi, Former Sr. Adviser (Health), Planning Commission ,GOI	Member
5	Joint Secretary (RCH) Ministry of Health & Family Welfare., GOI	Member
6	Joint Secretary (PH) Ministry of Health & Family Welfare, GOI	Member
7	Representative, Ministry of Women and Child Development, GOI	Member
8	Principal Secretary (H&FW), Uttar Pradesh	Member
9	Principal Secretary (H&FW), Bihar	Member

10	Principal Secretary (H&FW), Rajasthan	Member
11	Dr. Manohar Agnani, Mission Director, NRHM, Madhya Pradesh	Member
12	Mission Director, National Rural Health Mission (NRHM), Tamil Nadu	Member
13	Mission Director, NRHM, Assam	Member
14	Director, ,National Institute of Health and Family Welfare(NIHFW) New Delhi	Member
15	Director, International Institute for Population Sciences (IIPS), Mumbai	Member
16	Executive Director, Population Foundation of India), (PFI) New Delhi	Member
17	Dr. H. Sudarshan, Karuna Trust, Bangalore	Member
18	Dr. Sunil Kaul, Action Northeast Trust, (ANT) Bongaigaon, Assam	Member
19	President, Federation of Obstetric and Gynecological Societies of India, (FOGSI) Mumbai	Member
20	Ms. Renu Khanna, Society for Health Alternatives, (SAHAJ) Vadodara, Gujarat	Member
21	Dr. M. Prakasamma, Director, Academy of Nursing Studies, Hyderabad	Member
22	Dr. N.K.Arora, Director, International Clinical Epidemiology Network (INCLEN), New Delhi	Member
23	Dr. Shalini Bharat, Professor, School of Health System Studies, Tata Institute of Social Sciences, Mumbai	Member
24	Dr. Nerges Mistry, Foundation for Research in Community Health, Pune	Member
25	Dr. P.Nirmala Nair, Ekjut, Jharkhand	Member
26	Ms. Madhavi Kukreja, Uttar Pradesh	Member
27	Dr. Pankaj Shah, Self-Employed Women's Association (SEWA) Rural Gujarat	Member
28	Dr. Shakeel, Patna, Bihar	Member
29	Dr. Dhruv Mankad, Lead Consultant, Project Evaluation Team at Sir Dorabjee Tata Trust, Nasik	Member
30	Dr. Joe Verghese, Senior Programme Coordinator, Christian Medical Association of India, New Delhi	Member
31	Dr. Mohan Rao, Professor, Centre of Social Medicine and Community Health, JNU, New Delhi	Member

32	Sh. S.M.Mahajan, Adviser (Health), Planning Commission	Member
33	JS (Policy), MOHFW	Member Secretary

Terms of Reference

1. Critical review of progress and performance of NRHM against its goals, objectives and expected outcomes; documentation of its strategies and assessment of its strengths and weaknesses; commenting on regional and socio-economic imbalances in its health coverage.
2. Review the trends in public sector expenditure in health over the last 5 years of NRHM and the absorptive capacity of the States and Districts.
3. Review the healthcare infrastructure, human resources and provision of health services, specifically to women, children and the rural population of the country.
4. Review the programme management capabilities consequent to setting up of the State, District, Block and Facility level Programme Management Units and involvement of professionals under NRHM.
5. Review the community processes and community ownership of public health services and the change in the system since 2005 due to flexible funding.
6. Review the strategies for Reproductive and Child Health and Nutrition undertaken under NRHM and the progress so far.
7. Review the involvement of private sector and the existing Public Private Partnerships under NRHM for their effectiveness, strengths and weaknesses.
8. Review status of integration of all vertical programmes under one umbrella and strengthening of State Health Systems to deliver the health services.
9. Review the performance of the disease control programmes under the umbrella of NRHM and the way forward.
10. Review availability of and access to drugs, including promotion of generic drugs and indigenous diagnostic facilities and suggest reforms to make distribution more equitable.
11. Review the strategy of Population Stabilization and suggest effective measures to meet the 12th Five Year Plan targets.
12. Explore the possibility of an overarching National Health Mission that subsumes NRHM and the NUHM.
13. Deliberate and give recommendations on any other matter relevant to the topic.

14. The Chairman may constitute various Specialist Groups/ Sub-groups/ task forces etc. as considered necessary and co-opt other members to the Working Group for specific inputs.
15. Working Group will keep in focus the Approach paper to the 12th Five Year Plan and monitorable goals, while making recommendations.
16. Efforts must be made to co-opt members from weaker sections especially Scheduled Castes, Scheduled Tribes and minorities working at the field level.
17. The expenditure towards TA/DA in connection with the meetings of the Working group in respect of the official members will be borne by their respective Ministry / Department. The expenditure towards TA/DA of the non-official Working group members would be met by the Planning Commission as admissible to the class 1 officers of the Government of India.
18. The Working group would submit its draft report by 31st July, 2011 and final report by 31st August, 2011.

(Shashi Kiran Baijal)
Director (Health)

Copy to:

1. Chairman, all Members, Member Secretary of the Working Group
2. PS to Deputy Chairman, Planning Commission
3. PS to Minister of State (Planning)
4. PS to all Members, Planning Commission
5. PS to Member Secretary, Planning Commission
6. All Principal Advisers / Sr. Advisers / Advisers / HODs, Planning Commission
7. Director (PC), Planning Commission
8. Administration (General I) and (General II), Planning Commission
10. Accounts I Branch, Planning Commission
11. Information Officer, Planning Commission
12. Library, Planning Commission

(Shashi Kiran Baijal)
Director (Health)

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List of abbreviations

ANM	Auxiliary Nurse Midwife
ANMTC	ANM training Centre
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda Yoga Unani Siddha and Homeopathy
BMI	Body Mass Index
BRMS	Bachelor of Rural Medicine and Surgery
CRM	Common Review Mission
DDO	Drawing and Disbursement Officer
DLHS	District Level Household Survey
EAG	Empowered Action Group
IMR	Infant Mortality Rate
JSSK	Janani Shishu Suraksha Karyakram
MIS	Management Information System
MCTS	Mother and Child Tracking System
MIS	Management Information System
MMR	Maternal Mortality Ratio
NFHS	National Family Health Survey
NHA	National Health Accounts
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
NUHM	National Urban Health Mission
OOP	Out Of Pocket
PCPNDDT	Pre Conception, Prenatal Diagnostic Test
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti
RSBY	Rashtriya Swasthya Bima Yojana
SBA	Skilled Birth Attendant
SIHFW	State Institute of Health and Family Welfare
SRS	Sample Registration System
TFR	Total Fertility Rate
TOR	Terms of Reference
U5 MR	Under 5 Mortality Rate
VHSNC	Village Health, Sanitation and Nutrition Committee

1. Review of NRHM: Goals and Objectives – TOR I

- 1.1. The National Rural Health Mission (NRHM) of the Eleventh Plan was “conceptualized in response to what were perceived as systemic flaws in the health system namely, the lack of a holistic approach, absence of linkages with collateral health determinants, gross shortage of infrastructure and human resources, lack of community ownership and accountability, non-integration of vertical disease control programs, inadequate responsiveness to community needs and lack of financial resources” (background paper issued by Planning commission to Twelfth five year plan process for health sector).
- 1.2. **Measurable Objectives of the Eleventh Five Year Plan:** The Eleventh Five Year Plan had set time bound measurable goals and some process objectives. The Measurable Outcomes specified were:
 - Reducing MMR to 1 per 1000 live births (100 per 100,000 live births).
 - Reducing IMR to 30 per 1000 live births.
 - Reducing TFR to 2.1
 - Providing clean drinking water for all by 2009.
 - Reducing malnutrition among children of age group 0 to 3 to half of its present level.
 - Reducing anaemia among women and girls by 50%.
 - Raising the sex ratio for age group 0 to 6 to 935 by 2011-12 and 950 by 2016-17.
- 1.3. **Outcomes in Maternal Mortality:**
 - 1.3.1. MMR has reduced from 254/100000 live births in 2004-06 to 212/100000 live births in 2007-09 (SRS), a reduction of 42 points over a three year period or 14 points per year. At this rate of improvement MMR of 156/ 100000 live births could be achieved by year 2012, which would be short of the target of 100/ 100000 live births set by the eleventh plan.
 - 1.3.2. In the four southern states, Kerala and Tamil Nadu have already achieved the goal of a MMR of 100/100000 live births but, within the group, Karnataka lags significantly behind with a MMR of 178/100000 live births and at current rate of decline would only reach about 130/100000 live births in the year 2012. In the non EAG large states the MMR is 149/100000 live births. Though potentially these states should also achieve the goal by 2012, some caution is needed- as all these states except perhaps Maharashtra have faced a slow down. At the current rate of decline of only 8 points per year, the group average would reach near the MMR target of 100 /100000 live births by 2012.
 - 1.3.3. In the sub-group of EAG states including Assam, there has been a sharp fall and at this rate of 22 points decline per year for the group the 2012 figure should be around 220/100000 live births. Many of these states have shown acceleration in

improvements in the latest three year period notably Assam, Madhya Pradesh and Rajasthan. Assam where MMR declined at only 3 per 100,000 in the previous three years now recorded a decline of 30 points per year- but still at a MMR of 390/100000 live births, Assam remains India's most maternal death prone state. The caution is that it is difficult to sustain this rate at the lower levels of the curve.

- 1.3.4. Another important feature is the comparisons between MMR as maternal mortality ratio and the maternal mortality rate. West Bengal and Gujarat for example have the same ratio- 148 and 145, but the Gujarat maternal mortality rate at 12.8 is 30% higher than the west Bengal rate at 9.2. At the other end Assam has a MMR of 390 versus Uttar Pradesh – 359, Rajasthan- 318 or Bihar- 261- but the maternal mortality rates of the Assam is 27.5 against 40.0, 35.9 and 30.1 for the latter. Clearly the life time risk is much higher in the latter states due to the much higher fertility rates for these states – which points out to the tremendous reduction in total number of maternal deaths, lower fertility rates by themselves bring about.

1.4. *Outcomes in Infant and Under 5 mortality (U5 MR):*

- 1.4.1. The national infant mortality rate has declined from 57 /1000 live births in year 2006 to 50 /1000 live births in the year 2009. Of this the decline in rural areas was more (from 62 /1000 live births to 55/1000 live births). In urban areas, the decline in IMR was from 39/1000 live births to 34/1000 live births. The rate of decline across the sexes, in both urban and rural areas was the same. At the all India level, by 2012 at the current rate of decline, we would have reached an IMR of 44/1000 live births, well short of the goal.
- 1.4.2. The decline in under 5 mortality was similar. The current levels have reached a total of 64/1000 live births with a rural of 71/1000 live births and urban of 41/1000 live births - a larger difference than for IMR. Gender differentials are also higher- much more in rural areas. Female U5 MR 76/1000 live births in rural areas compared to 66/1000 live births in males- a difference of 10 points. In urban areas also there is a difference – of 5 points.
- 1.4.3. Comparing between IMR and under 5 mortality rates, one notes that the greatest contribution of the 1 to 4 deaths is amongst the rural girl child- the difference between rural female IMR and rural female under 5 mortality rate being 20 as compared to only 12 in rural males and only 11 in urban females and 7 in urban females. Gender acting through neglect of the girl child more than through nutrition, has a disproportionately higher role to play in 1 to 4 mortality.
- 1.4.4. Ten states and union territories have reached the NRHM goals of IMR of 30. At the current rate of decline a total of 15 states would have crossed the goal-post by 2012.

1.4.5. Of the remaining states, the poorest performing nine states account for 68% of total infant deaths in the country. These nine states however have all shown higher rate of improvements as compared to the national average except for Meghalaya which unfortunately has seen an increase in IMR.

1.5. *Progress on Population Stabilization:*

1.5.1. The national TFR is 2.6 in the year 2008. By 2012 it could reach 2.4 and this would be short of the target of 2.1 which the eleventh five year plan had set.

1.5.2. Nineteen states and five union territories have reached population stabilization goals of a TFR below 2.1(2008) and/or a crude birth rate below 21 per 1000 population (2009). Three states are on way to achieving it- Haryana, Gujarat, Assam.

1.5.3. Six large states have a TFR above 3.0, which is matter of concern, but even these six states have shown steady improvements. Four of these states had a 0.4 point TFR decline in these five years and the other two declined by 0.3 points, as compared to an all India decline in TFR of 0.3. TFRs are not available for small States and UTs.

1.5.4. The Census 2011 report states that the report “marks a milestone in the demographic history of the country, as it is perhaps for the first time, there is a significant fall in growth rate of population in the EAG states after years of stagnation.” The rate of fall of the five most populous states of these 8 states was even faster. That it fell, when IMR was also falling in these states, shows the potential for early achievement of population stabilization even in states where the challenges are the most. Census 2011 shows growth rate for the nation as a whole as 17.4; and this is a significant decline from the previous decade.

1.6. *Progress on Clean drinking water for all:*

1.6.1. The coverage statistics on habitations according to National Rural drinking water programme data for July 2011 show that out of 1,661,058 habitations about 1,180,684 habitations have 100 percent drinking water coverage, 43,963 habitations have 0 to 25 % drinking water coverage, 97,119 habitations have 25- 50% drinking water coverage, 153,256 habitations have 50- 75% drinking water coverage, 116,320 habitations have 50- 75 % drinking water coverage and 69,716 habitations have no drinking water coverage. The mid- term review of the eleventh plan highlights that slip- backs continue to happen on an ongoing basis.

1.7. *Progress on Reducing malnutrition among children of age group 0 to 3 to half its present level and reducing anemia by 50%*

- 1.7.1. The most recent figures available on these are from NFHS- III which formed a base line for the plan. No further figures have since been generated.
- 1.7.2. The proportion of children under weight below the age of three is 40.4% (NFHS III). The proportion of severely underweight is 15.8% (NFHS III). 52% of underweight children were among Underweight mothers (BMI <18.5). Malnutrition is highest in Madhya Pradesh, where 60% of the children were underweight and 27% severely underweight; followed by Bihar & Jharkhand (56%), Meghalaya (48%) and Orissa (40%). Stunting was at 44.9% with severe stunting at 22%. The state of Uttar Pradesh has shown the highest proportion of children stunted (56.8%), followed by Bihar (55.6), Chhattisgarh (55.9%) and Gujarat (51.7%). The proportion of children under wasting is 22.9% (NFHS III), and severe wasting is 7.9% (NFHS III). Malnutrition is consistently much higher in SC and ST families.
- 1.8. ***Raising the sex ratio for age group 0 to 6 to 935 by 2011-12 and 950 by 2016-17.***
- 1.8.1. The child sex ratio in India has dropped to 914 females against 1,000 males - the lowest since Independence. According to 2011 Census, the child sex ratio has declined from 927 females against 1,000 males in 2001 to 914 in 2011.
- 1.8.2. Disaggregating by states, an increasing trend in the child sex ratio (0-6 years) has been seen in Punjab, Haryana, Himachal Pradesh, Gujarat, Tamil Nadu, Mizoram and Andaman and Nicobar Islands. Some of these states had faced major declines in the past and the reversal of the trend in the northern three states and in Gujarat is a welcome development.
- 1.8.3. In all remaining 27 states and Union Territories, the child sex ratio shows decline from census 2001 to census 2011. The major decline in child sex ratio is recorded in state of Jammu and Kashmir by 82 points from 941 in 2001 to 859 in 2011.
- 1.8.4. Much of the decline is due to declining sex ratio at birth, and the most common reason for this is sex selective abortion, which despite the PCPNDT, has not been adequately curbed. Another significant contributor to the declining sex ratio is the differential mortality with much lower child survival rates in the girl child of the 0 to 5 age group.
- 1.9. Other than the above measurable goals, the Eleventh Five Year Plan also specified a number of important process or health sector development goals on disease control and a number of process/public health infrastructure goals. These are:
- Increase in public health expenditure

- Increase in healthcare infrastructure, human resources and provision of health services, specifically to women, children and the rural population of the country
- Improvements in programme management capabilities
- Strengthening community processes and community ownership of public health services: and changes in flexible funding.
- Improved delivery of Reproductive and Child Health and Nutrition services.
- Involvement of private sector and strengthening Public Private Partnerships.
- Improved performance of the disease control programmes and their integration with the rest of the health sector.
- Improved access to drugs and diagnostics.
- Achievement of Population Stabilization with gender balance.

We shall consider these in subsequent sections.

2. Trends in public sector expenditure in health and the absorptive capacity of the States and Districts – TOR II

- 2.1. Over the last six years, the central government has made a total of Rs. 52,832 crores release under NRHM for the explicit purpose of financing their state plans to strengthen public health services with a focus on primary health care. (Source: Public Accounts Committee 32 Report, 2010-11). The total *expenditure* by the central government in the period 2005-06 to 2009-10 was Rs 73,606 crores of which the total NRHM component was Rs 38,420 crores, that is 52.2%.
- 2.2. The central government budgetary expenditure for health increased by 21.45 per cent per year (compounded annually) in the post NRHM phase (2005-06 to 2009-10) as compared to 10.85 per cent per year in the pre-NRHM period (2001-02 to 2004-05). The increase was from 9650 crores in 2005-06 to 20,996 crores in 2009-10 and this includes the NRHM. In 2009-10 the NRHM release was Rs. 11,225 crores and this comes to 53.46 % of the central government health budget.
- 2.3. The state governments combined budgetary expenditure increased by 19.87% (compounded annually) from 22,031 crores in 2005-06 to 45,493 crores in 2009-10
- 2.4. The utilisation rate of the funds in the first years was slow, but subsequently it picked up and compensated for the low initial releases. The utilisation rate of RCH Flexi pool increased from 27.77 per cent in 2005-06 to 104.32 per cent in 2010-11, whereas NRHM flexi pool utilisation increased gradually from 4.24 per cent in 2005-06 to 141.74 per cent in 2010-11. Overall during the six years (2005-06 to 2010-11) the utilisation rate of NRHM Flexi Pool was 97.87 per cent and RCH Flexi Pool was 92.63 per cent (Source: NRHM MIS State Wide Progress as on 31.03.2011)
- 2.5. The trend is not confined to the Society route of funds only. A similar encouraging trend is also seen in the utilization of treasury route of funds for health. The RBI budget figures show that utilization of capital expenditure for all states, increased from 63.36 per cent in 2003-04 to 89.31 per cent in 2008-09 (expenditure as percentage of budget allocated) while the revenue expenditure of state health budget for all states remained steady at 90.87 per cent in 2003-04 to 95.11 per cent in 2008-09.
- 2.6. We note that as the expenditure cycle of procurement and civil works (constructions/renovations) is around 2-3 years, especially in the EAG and North-Eastern states, the low level of expenditure upto 2008 needs to be understood in that context. Booking of expenditures, implying absorption of funds would be increased in the subsequent years as funds related to civil works and procurement undertaken after 2007-08 start getting booked by the close of 2009-10.

- 2.7. Another major reason for the initial problems in absorption of funds and subsequent decrease in this is due to better understanding of the programmes and procedures and due to increased institutional capacities - functional Societies and RKS, training and orientation of staff, addition of management and accounting technical staff. The increased deployment of skilled human resources also led to improvement in fund absorption in the later years.
- 2.8. Another reason for improved absorption, is that in funds flow through the society mode, the power of authorizing and actually undertaking the expenditure moved down to health facility and village level, whereas under the treasury route the Drawing & Disbursing Officers (DDO) are limited only to the block level, and does not go below that. The society mode of operations is not aimed at replacing the treasury system, but targets those specific areas of decision making and expenditure which is immediate and localized in nature. Addressing such needs through the treasury system might not be very efficient with respect to the timeliness and appropriateness of the response. However in the first two years, since procedures and mechanisms had not been established absorption of funds remained low.
- 2.9. The NRHM funds have been released to states through the state health societies as four components- RCH flexi-pool, Mission flexi-pool, Immunization (including Pulse Polio) and the National Disease Control Programmes. Under RCH flexi-pool the total amount released to states in these six years was Rs 14,488 crores and under Mission flexi-pool the total amounts released was Rs 16,265 crores. For Immunisation and Pulse Polio, a sum of Rs 2728 crores has been released. In these six years, for disease control, the amount released was Rs. 4667 crores. In addition through the treasury route, Rs 14,250 crores was released for infrastructure maintenance. (Table :)
- 2.10. Most of NRHM funds released (31%) went to finance the health system strengthening taken up under Mission flexi-pool. This is followed by funding the maternal and child health interventions under RCH-II (28%), immunization and disease control programmes (14%) and on Sub Health Centre expenses (27% under the head “infrastructure maintenance – which flows through the treasury route and not under society route) (The Per Capita expenditure on National Rural Health Mission was Rs. 80.44 in 2005-06, which increased to Rs. 129.77 in 2007-08 and then to Rs. 163.62 in 2009-10 (Source: Public Accounts Committee 32 Report, 2010-11)
- 2.11. The proportion of releases between primary, secondary and tertiary for the health sector is one area of concern. If all of NRHM is considered as primary and secondary- this accounts for approximately 70% of the health budget. The rest has gone to medical research, medical and nursing education and to tertiary care hospitals. The NHA 2004-05 data shows that at the state level, 38% of health expenditure is spend on primary health care, 18.67 % on secondary health care ,21.84 % on tertiary health

care and rest on direction and administration and other services. This has not been changed substantially by 2008-09 as per the NHSRC budget tracking report.¹

- 2.12. Rate of expansion of financing did not keep pace with expectations. The annual expenditure in 2010-11 was to reach 55,000 crores. The NRHM Framework for Implementation estimated an expenditure of Rs 175,000 crores over seven years. But in fact we have reached only Rs 50,000 crores or less than one thirds of this projected amount. Even including the 2011- 12 expenditures we would achieve about 75,000 crores only.
- 2.13. This period of the NRHM has also seen a considerable increase in state health sector expenditure also. Most of this is in the non plan aspects. States were committed to increasing their expenditures by 10% annually and most states have adhered to it. Increase in states own health budget has gone up by more than 10 % in most of the states (including EAG states) post NRHM period.²
- 2.14. They were expected to pay 15% of the cost of the NRHM state budgets and most states have made some contribution in this regard. In 2007-08 only 4 States/UT's made the desired contribution of 15 percent of State PIP from their own budget .By the year 2008-09, 25 out of 35 states had contributed 68.75 % of the total state share requirements. And in 2009-10 34 out of 35 states had contributed 79.28 % share of funds due towards state contribution. (Source: Public Accounts Committee 32 Report,2010-11)
- 2.15. Most states spend around 4 to 5 % of the state budgetary outlay on health and less than 1% of the GSDP on health- which is insufficient to meet the NRHM goals. . The total public expenditure on health in the country as a percent of GDP stands at around 1.1 percent in 2009-10. The state share of public expenditure on health was 0.67 percent of GSDP in 2005-06 and this increased gradually to 0.70 percent of GSDP in 2009-10, whereas the central share increased from 0.29 percent of GDP to 0.39 percent during the same period. However, if we take into consideration the health related inputs which includes the expenditure on water supply, sanitation, nutrition and estimated expenditure on national insurance programme (RSBY) this is around 1.96 percent of the GDP. (Source: Mid Term Review of the Eleventh Five Year Plan)
- 2.16. There has also been some concern that the money provided to states under NRHM substituted instead of supplementing state health expenditures. Though there are sectoral instances of this in some states, especially as regards contractual appointment

¹ In Bihar the share of state expenditure on primary health care services in 2008-09 was 55%, secondary health care 14% and tertiary health care 26%, in Jharkhand it was 52%, 12% and 20 % ,in Tamil Nadu it was 38%, 39% and 8%.

² As per the budget tracking study done by NHSRC in 2007-08, the increase in states own share of health budget over the previous year for Bihar was 10%, Chhattisgarh 36%, Himachal Pradesh 13%, Karnataka 40%, Maharashtra 25%, Rajasthan 16% ,West Bengal 16% and Tamil Nadu 5%

and maintenance funds, on the whole, there is no such trend and if anything it has spurred states to spend more. The state expenditures increased by about 20% per year and in parallel to the central government increase. However much of this increase could be non plan and consequent on increase in salaries and does not necessarily reflect greater investment in health.

- 2.17. Though absorption is much less a problem it is likely to recur as fund flows increase. One important reason is that one has to estimate and provide for considerable funds to remain in the pipeline and not expect utilization too prematurely.
- 2.18. Yet another major constraint to absorption at the current higher level of fund flows- is that funds flow within the districts was on a per facility normative basis and not responsive to utilization patterns leading to scarcity in some facilities and stagnant funds in others. JSY has brought over a crore pregnant women into public health facilities but the delivery load is unevenly distributed across facilities. The fund flows however are evenly spread across all the facilities. Since funds to the districts are provided through the State Health Society, the State Governments need to plan their allocations according to the felt needs and the District Health Action Plans.
- 2.19. The expansion of management structures and institutions, has not kept pace with requirements and this begins to slow down the pace of the programme. The third and fourth CRMs both pointed out that states that invest in a state level infrastructure development management unit absorb infrastructure funds better; states that have a good procurement and logistics system spend far more on drugs and get much more value for the money spent. Even programmes like ASHA, training of skilled workers, quality improvements in public facilities etc utilize their full funds only if corresponding management structures at the state level are created.
- 2.20. Non inclusiveness in “expanding capacity to spend” the amounts and implement the activities is also a major constraint to expanding expenditure. Weak development of partnerships with non governmental agencies and private sector, even for purposes of strengthening public service delivery through auxiliary services and management contracts and a trend to try to get all work done with only the staff and set ups that are already existing.
- 2.21. Though there has been a major expansion of human resources efforts in this direction need to be continued and rationalization of deployment and reforms in recruitment process must be taken up with greater vigour.
- 2.22. The Twelfth Five Year Plans needs to address these constraints creatively – especially the central problem of efficiency in resource allocation to districts and within districts. Having said that it needs to provide a much larger resource envelope to all states for them to be able to achieve their goals. The current public spending is roughly 1% of the GDP and the urgency of it rising to 2-3% of the GDP should not be minimized.

India ranks very low in terms of financial protection as more than 70% of the financing is through OOP payments by individual households at the time of utilization of health services. As per the NHA (2004-05), Of the total health expenditure, the share of private sector was the highest with 78.05%, public sector at 19.67% and the external flows contributed 2.28%. Out-of pocket spending accounts for over 95% of total private health spending and 71.13 % percent of total health spending in India, which is one of the highest, even amongst low-income countries. The high OOP expenditure on health care forms a barrier to accessing care and can cause households to incur catastrophic expenditures, which in turn can push them into indebtedness and poverty. According to a recent article published in lancet, health expenditures account for more than half of Indian households falling into poverty, with about 39 million Indian people (30.6 million in rural areas and 8.4 million in urban areas) being pushed into poverty every year due to health costs. The NSSO morbidity and health care utilization surveys show that between 1995–96 and 2004, the absolute expenditures per outpatient visit and inpatient visit in rural and urban areas increased, particularly affecting the ability of the poorest individuals to access services. The average expenditure for inpatient care in public facilities increased from Rs .2080 in 1995-96 to Rs .3238 in rural areas and from Rs .2195 to Rs.3877 in urban areas. In the private sector the average expenditure increased from Rs .4300 to Rs. 7408 in rural areas to Rs. 11553 in urban areas. Expenditures on drugs represent 70 to 80% of these out of pocket payments and this has been rising at twice as fast as the general price increase. The rise in the private sector was much higher than in the public sector.

- 2.23. One of the functions of the public sector is to provide protection against the rising costs of care. However, out of pocket expenditures even in the public sector are high, and for hospitalization they can be as high as Rs. 3288 per episode in rural areas and Rs. 3877 in urban areas. Paradoxically, the out of pocket expenditure in the public sector is much higher in the high focus states and in the northern states of Haryana and Punjab and Himachal. The average total medical expenditure for inpatient care in public hospitals for rural areas is Rs. 4998 in Bihar, Rs .3096 in Orissa, Rs. 5464 in Rajasthan, Rs. 7648 in Uttar Pradesh, Rs. 6035 in Himachal Pradesh and Rs. 11, 665 in Haryana. But in these states the bottom 20 % of the population incurred very high out-of-pocket expenditure with Rs. 3443 in Bihar, Rs. 3096 in Orissa, Rs. 3453 in Rajasthan in public hospitals. Compared to these states in Tamil Nadu, the bottom 20% spend Rs. 152 as OOP in government hospitals. The 60th round of NSSO survey showed that in both in rural and urban areas the financial burden of the medical treatment as an inpatient is very heavy. It is also seen that the number of untreated ailments are on the increase gradually due to financial reasons. In 1986-87 the financial reason was reported by 15% and 10% in rural and urban areas respectively. The same has increased to 28% in rural and 20% in urban areas in 2004. In rural India, about 47% of the hospitalization cases were financed by loans, sale of assets etc. In urban India, about 31% of the hospitalization cases were financed by loans, sale of assets etc.

- 2.24. Social protection through insurance programmes has been launched in a number of states. In Andhra Pradesh and Tamil Nadu and Karnataka, such publicly financed insurance is for the BPL and covers tertiary care. Sustainability of these schemes needs to be examined. In most other states, the RSBY is the main insurance mechanism made available to the poor. Though intended for social protection, the actual degree of social protection it offered is not quite known especially for RSBY, where the information on the cases handled and category of persons who benefitted is not in the public domain. It is understood that in many states the RSBY has a poor claims ratio despite widespread moral hazards of overcharging, except in Kerala where the claims ratio is over 130%. It also has the propensity to convert primary and secondary care- into tertiary care and outpatient care into in-patient care. Mechanisms of gate-keeping or monitoring are weak and critical data needed for its evaluation is difficult to access. While recognizing the great hope and potential that lies behind this scheme, prudence calls for evaluation before this is scaled up even further- much less projected as the general solution. Publicly financed insurance programmes, when much better structured, monitored and regulated could play an important supplementary function, rather than become the main vehicle of health care financing.
- 2.25. The Twelfth Plan recommendations therefore need to address the following aspects- a. increase in total public expenditure as % of GDP, b. principles of allocation to state, c. principles of resource allocation to districts, d. the problem of making resource allocation responsive to local needs as expressed by communities and as assessed by public health studies, e. the mechanisms for improved absorption of funds, f. the monitoring and achievement of substantial reductions in out of pocket expenditure in both public and private sector, e. g. the fulfillment of the social protection obligations of the public health sector. These are all suggested in the last section on proposals for the 12th Five Year Plan.

Table- 1 NRHM Releases by Components from 2005-06 to 2010-11:Rs. in Crores

Year	NRHM Flexi Pool	RCH Flexi Pool	NDCP	Pulse Polio	Infrastructure Maintenance	Total NRHM
2005-06	962	1050	564	313	1546	4434
2006-07	2054	1426	648	452	1195	5774
2007-08	3133	1843	795	422	2317	8509
2008-09	2597	3070	812	618	2527	9625
2009-10	3366	3478	888	593	2900	11225
2010-11	4154	3622	961	370	3765	12871
	16265	14488	4667	2768	14250	52438

Source: NRHM MIS State Wide Progress as on 31.03.2011

Table 2- Central and State Government Health Budget: Rs. in Crores

	Central Government	Percent increase over previous year	State Government	Percent increase over previous year
2001-02	5937		16627	
2002-03	6504	9.5%	17094	2.8%
2003-04	7249	11.5%	18235	6.7%
2004-05	8087	11.6%	19617	7.6%
2005-06	9650	19.3%	22031	12.3%
2006-07	10948	13.4%	25375	15.2%
2007-08	14410	31.6%	28908	13.9%
2008-09	17661	22.6%	34353	18.8%
2009-10	20996	18.9%	45493	32.4%
2010-11	25055	19.3%	50297	10.6%

Source: Government of India Budget Documents
State Finances: A Study of Budgets of 2009-10 (RBI)

Note: The budget figures for central government for the year 2010-11 corresponds to budget estimates and that for state government for 2009-10 are revised estimates and 2010-11 are budget estimates.

3. Infrastructure Development and Provision of Services under NRHM – TOR III

- 3.1. One of the stated purposes of the NRHM was to close health infrastructure gaps. The Eleventh Five year plan document identified a requirement of 158792 sub-centers with a short fall of 13.36% , 26022 PHCs with a short fall of 18.46% and a requirement of 6491 CHCs with a short fall of 40.87%- the last of these being identified as the most critical short fall. The NRHM envisaged all these gaps as being closed and the necessary manpower as required to make these fully functional as per IPHS guidelines as being put in place. The emphasis was on making the existing 145,000 sub-centers, the 22669 PHCs fully functional rather than creating new facilities at this level. At the CHC level it envisaged 6500 facilities becoming functional. In the penultimate year of the Eleventh Five year plan (2010) we find that there are 147,046 sub-centers functioning and 22834 PHCs and 4745 CHCs which have been established.

- 3.2. One of the aims of the NRHM was that every government facility should have its own, adequate building. Of the sanctioned facilities 38% of sub-centers are not in a government building, and 13% of PHCs and 3% of CHCs are not in their own building. There are a number of health facilities in which construction is ongoing. 34% of the new work would be getting completed in high-focus states by 31st December 2011 with another 51% in progress, while 49 % of new construction would be completed in non-high focus states with 39% of new construction work is under progress in non-high focus states. NRHM supported renovations of Public Health Facilities have made good progress with 72% work getting completed in high-focus states, while 49 % of sanctioned work has been completed in non-high focus states. Under NRHM, it is proposed that all Community Health Centres would be upgraded to level of a 30 bed hospital with functional Operation Theatre and all basic specialties. Construction of 70 new buildings for Community Health Centre was sanctioned in high focus Non-NE States and 96 new CHC buildings were sanctioned in NE States till 31st December 2010 and 157 CHCs in other states- a total of 323. Of these 142 are completed, the pace of construction being slowest in the NE. The Fourth CRM concluded that where states had a dedicated institutional arrangement for infrastructure development, the performance was better. But in many states largely due to the lack of such management capacity, progress has been slow.

- 3.3. The other major issue is in prioritization. The Eleventh Plan had stated that population based norms would be modified by flexible norms comprising habitation based needs, community based needs and disease pattern based needs. This policy should be continued more effectively in the next plan. Facilities which have higher volume of cases and which are more utilized because of central location or better quality service providers need to be prioritized for better infrastructure. Similarly

mapping areas of lack of access and using such gap identification to locate new facilities must also be done. Though facility surveys were done to identify gaps- the prioritizing of facilities based on – infrastructure, human resources, skills, equipments and supplies would be closed in a synergized fashion was not done adequately.

- 3.4. There is also a question of the impracticality of achieving the same level of package delivery and the same range of services in all facilities of a certain type. The provision of healthcare should move closer to people to enable easy and timely access to quality care. Ideally one must be able to access the health services in their village itself. For which, we require a long term goal of setting-up of one sub-centre in each village. A simpler clinic, adequate for holding an outpatient clinic for ante-natal care would have helped achieve the goal of universal access easier. In states like Kerala and Tamil Nadu, Punjab etc, the sub-center has officially or by convention been withdrawn from the task of providing delivery services and even much of the outreach services have migrated to the PHC and CHC and the female MPW plays a much more active role in school health, adolescent health and other newer priorities.
- 3.5. The major learning from this pattern should be to base prioritization of facilities and outreach centers for development on “access mapping”. Access to a functional health team is seen as preferable to a lone provider in an isolated clinic- be it a sub-center of a PHC. A smaller number of facilities well located with better assured referral transport system would then in a large number of districts be adequate to achieve the goal of universal access. In some highly dispersed districts however we may need a much higher number of facilities than the current population norms. The increase in population within a village should be met with more staff in existing PHC. Infrastructure development must be prioritised accordingly by taking into consideration both population served and standards of access.
- 3.6. The number of primary and secondary care beds required in the district should be based on population and epidemiological norms with the option for the district plan to distribute these beds between the various facilities- PHCs, CHCs and SDH and DH. Thus for a 10 lakh population we could start with a minimum of 500 beds and increase beds in facilities depending on bed occupancy rates. Maximum size of a district hospital could also be fixed. We however would have a base line of 30 beds in a CHC and 200 for a district hospital in a population of 10 lakhs. WHO norms are 1500 beds for 10 lakhs- but given both private sector presence and also limited public sector capacity- a 500 bed per 10 lakhs starting point as a baseline for all districts is being proposed. The 4 to 6 beds in the PHC are largely day care beds and for institutional delivery and stabilization care and are not counted either for reaching norms of bed creation or later in bed occupancy calculations.
- 3.7. The other finding we have from various studies is that a) the district hospitals are now managing a huge part of the case load and b) they provide the major part of all specialist care for obstetrics and infectious disease and c) they are the only place

where we can expect specialist care for chronic disease of at least secondary level to be established within a district in the plan period. The district hospital is also the site of nurse training, ANM training, SBA training, IMNCI training and so on. However the investment in district hospitals in this eleventh plan period has been very limited and grossly insufficient to meet even the increased load due to JSY.. The Twelfth Plan would therefore need to plan for much larger district hospitals with at least 200 beds (for a ten lakh population) with an additional 100 beds for every further 10 lakhs population and the ability to support and complete set of district level services as envisaged in the IPHS.

- 3.8. The approach paper to the 12th Plan mentions that the aim should be to locate a Sub Centre in every Panchayat. The current establishment of Sub Centre is on a population norm of 5000 for the plains and of 3000 for the hilly/tribal/desert areas. Aligning it with the Gram Panchayats may result in the reduction of the number of Sub Centres in some States, as the average population covered by a Gram Panchayat is much more than 5000 in these States. Hence, there would be provision for at least one health Sub Centre in every Panchayat. An additional ANM may be added for upto 10% of Sub Centres which have high delivery loads. In hilly/tribal/desert areas the existing norm may be further relaxed to ensure that the people do not have to travel long distances or for long durations to reach the health Sub Centres.
- 3.9. With these caveats and conditions in place, the Twelfth five year plan could aim to achieve universal access to a health care facility- with adequate infrastructure in this five year period. Funds release to states would be conditional on their showing that they have put in place a management capacity to not only absorb the funds but also ensure quality construction.

States	Type of Health Facility	Number	New Construction		Renovation	
			Sanctioned	Completed	Sanctioned	Completed
High-focus Non-NE States (EAG)	DH	312	24	18	326	119
	CHC	2053	271	23	1262	500
	PHC	11602	367	168	2065	1505
	SC	71738	9737	5105	5463	3365
NE States	DH	77	6	3	56	53
	CHC	242	101	01	201	151
	PHC	1421	318	108	706	483
	SC	7255	2943	1194	1985	1765
Non-high Focus States & UT	DH	216	25	12	110	42
	CHC	2240	262	211	1014	712
	PHC	10650	844	401	4148	2832
	SC	68076	2467	1204	4640	3455

3.10 The Provision of Services:

- 3.10.1. **Range of Services:** The promise of NRHM was to move towards comprehensive health care services- which meant not only RCH services but also infectious diseases and emergency services and for chronic diseases. We know that institutional delivery services increased in all states, and that emergency obstetric care and the management of obstetric complications and the provision of other dimensions of RCH expanded, but at a slower rate. This had spin off effects in reviving these facilities leading to general increases in outpatient and in-patient care at the PHC and CHC level- but systematic increase in care for infectious diseases and chronic diseases was not adequately prioritized.
- 3.10.2. **Mainstreaming of AYUSH:** One of the core strategies of NRHM was to promote co-location of AYUSH services with other mainstream health facilities, so that people have a better access to AYUSH, a choice between systems and so that the human resource and infrastructure can be shared and synergized for better reaching NRHM goals. Under this scheme 11575 AYUSH doctors and 4616 paramedical staff have been appointed- over 60% of these doctors being in high focus states. In a total of 18222 health care facilities AYUSH services have been collocated- and this includes 416 district hospitals, 2942 CHCs and 1246 other sub-district hospitals, 9559 PHCs and 4059 equivalent primary care facilities. Apart from the above services there is an almost equal or more number of AYUSH standalone facilities at the Primary and Secondary Level AYUSH Hospitals (3360) and Dispensaries (21769) as well as 7 National Institutes which offer tertiary level care. These health facilities deliver the services of their own system. However, collection of information about their services through collocation - either through HMIS, or in surveys is currently not being done.
- 3.10.3. **Building on AYUSH systems:** Measures to utilize and build upon our AYUSH strengths are: inclusion of information on AYUSH and Local Health Traditions services and their utilization in surveys and HMIS, continuing education programmes for AYUSH providers on AYUSH services, training to AYUSH providers for provision of essential services of public health importance-a form of multi-skilling or mid-level provider creation, and resource centers at state level, linked to research institutions in AYUSH so as to develop better knowledge management in this area, leading to better resource inputs for programme implementation and better research questions for knowledge generation. Meanwhile both the co-located facilities and the stand-alone facilities should continue to be strengthened.
- 3.10.4. The representative of the Department of AYUSH during discussions in the Working Group, and subsequently followed up through a written communication, pointed out that with the present system of release of funds under NRHM, the objective of mainstreaming of AYUSH as set out in the National Policy on ISM&H, 2002 and as

included as part of NRHM mandate, was not having the desired impact at the State level, since health is a State subject and States are free to set their own priorities from the funds received by them. The Deptt of AYUSH further pointed out that in the light of this position, the States when faced with shortage of resources to the extent sought by them, quite often tend to restrict the outlay in the AYUSH sector. The Department of AYUSH therefore suggested that since mainstreaming of AYUSH is the core strategy of NRHM, Rs. 10160 Cr may be earmarked out of NRHM funds at the disposal of Department of AYUSH. If the Planning Commission finds it difficult to earmark and place the funds of Department of Health and Family Welfare under the Department of AYUSH, then mainstreaming of AYUSH may be separated from NRHM Flexipool and an amount of 10,160 Cr may be placed with the Department of AYUSH for effective implementation and monitoring during Twelfth Plan.

- 3.10.5. However, under NRHM, annual Resource Envelope is indicated to the State and they are given flexibility to prepare their own annual Programme Implementation Plan. Earmarking of funds is not done for any activity except funds for annual maintenance grants, Rogi Kalyan Samiti grants and untied funds for healthcare facilities. This is to ensure that funds actually flow to the facilities where they are needed and they are not retained at the State level. These non-negotiable items of NRHM are not earmarked for any particular activity and are done in order to promote the objective of Decentralisation.
- 3.10.6. Earmarking of funds under NRHM for AYUSH activities, as suggested by Department of AYUSH is not possible since it runs against the basic tenet of NRHM. States decide what activities are to be taken up during the financial year. As proposed by Department of AYUSH as an alternative, the Steering Group may take a view to allocate the funds separately to Department of AYUSH. In that case it would become necessary to rework the strategy for mainstreaming of AYUSH under NRHM mandate.
- 3.10.7. **Quality of Services- Overview:** The provision of quality services requires in addition to infrastructure and human resources, proper equipment, drugs and supplies, an efficient organization of work and a high level of motivation and a consciousness about quality. It is also important to observe how affordable the services were –in the public sector. And finally there is the issue of how women friendly and child friendly the hospital is, with affirmative action to ensure that there are no social barriers or processes of exclusion that are keeping out the poor and marginalized. While the States should be allowed flexibility, quality assurance should be standardized across all the States.
- 3.10.8. **Quality of care- the availability of medicines:** In this period expenditure on drugs and supplies increased and availability of drugs also increased but high out of pocket expenditure continues. Only Tamil Nadu and to some extent Kerala have

curbed out of pocket expenditure on drugs in the public hospital significantly. Part of this is due to the procurement and logistics systems in place- organized by the TNMSC. Kerala now has a similar model in place. Maharashtra, Karnataka, Andhra Pradesh, Punjab, Delhi and West Bengal have similar systems of drug procurement in place, and this is welcome for it leads to better quality and costs of drugs purchased. But it still does not lead to reduced OOPs on drugs in the public hospital and uninterrupted supplies of drugs in the facilities- because the entire procurement system is not automatically responsive to the actual consumption of drugs. Tamil Nadu's system is logistics driven- with facilities indenting from district warehouses in response to their needs such that at all times they have a buffer stock and district warehouses maintaining a three month stock of every drug on the essential drug list, with orders placed as and when a district warehouse stock falls below the threshold level. The Eleventh Plan period has been a period of increasing advocacy for a TNMSC like system- not only of procurement but also of drug logistics. The Twelfth Plan must aim to ensure that this is now implemented in all states.

- 3.10.9. **Quality of care- Diagnostics:** User fees need to be rationalized in both inpatient care and diagnostics. Exemption for the BPL, senior citizens, pregnant women and newborn should be provided both in registration fee and at the diagnostic laboratory. The range of diagnostics available need to be significantly expanded.
- 3.10.10. The Twelfth five year plan – must move towards reduction of out of pocket expenditure on account of drugs and diagnostics and make available a wide range of supplies in these areas.
- 3.10.11. **Quality Improvement Approaches:** In the eleventh five year plan period a number of measures was tried to improve quality of care. This was based on an understanding that even with available inputs, at the level of the hospital there were many management steps that could improve quality of care. Patient satisfaction often related to the dignity with which they were treated and to basic amenities in the hospitals which the untied funds were to be used for. The most widespread approach to quality in this plan period was the creation of quality assurance committees which would use a check list to monitor for quality gaps. With few exceptions, this approach did not sustain or gain the necessary importance it needed nor have measurable impacts. They were indistinguishable from routine monitoring. The major reason for this was lack of adequate professional set up of quality assurance cells at State and district level. For sustainability of quality in the service provision it is essential that States should have their own quality assurance mechanism. The quality assurance cells at State and district level needs to be strengthened in 12th Five Year plan The other was a number of hospitals taken up for NABH in a number of states- Kerala, Gujarat, Madhya Pradesh- to name a few. However except for two or three hospitals across the country, most never got accredited and the high degree of inputs needed to get NABH and to sustain such an accreditation was prohibitive. Another approach which was piloted by NHSRC

approach built on the ISO system adding 24 state government- NHSRC specified mandatory processes which were to be audited. Currently over a 100 facilities are certified and another 500 are in the pipeline.

- 3.10.12. **Quality Certification:** The Twelfth Plan should encourage quality certification of public hospitals. One type of certification involves certification of quality of care in terms of the input standards – infrastructure, human resources, drugs and equipment and the outputs in terms of package of services available. This is certification for the achievement of IPHS. Another form of certification relates to the organization of work and processes central to providing ethical, efficient and effective quality care, and such certification is relatively independent of the level of inputs. It only certifies that there is a quality management system in place which ensures the best quality of outputs for the level of inputs currently available. Quality certification should not remain limited to standards of infrastructure but it should have thrust on comprehensive in-house quality assurance for both infrastructural and service delivery. A good quality service delivery should be first certified by district and State quality assurance cells/committees before any third party certification.
- 3.10.13. **Women-friendly hospitals:** There has been a greater awareness of the need to make hospitals more women friendly and baby friendly, and CRMs show modest improvements in this dimension. Where they are put in place, ASHA help desks provide valuable services to the patient in guiding them through the hospital. These initiatives needs to be further strengthened. There is a role for non-governmental partnerships with activists groups and ASHAs and their support structure to provide such a facilitator service in all public hospitals.
- 3.10.14. **Assured services- building a district road map:** The Twelfth Plan thus envisages that every district would announce as part of its five year strategic district plan, the package of services each facility would guarantee such that taken together the district health system would ensure universal access to a good quality of comprehensive RCH services, emergency care and trauma related services, infectious diseases management and chronic disease management. Such a district plan would become the instrument to be used for programme audit by the government and for social audit and community monitoring purposes.
- 3.10.15. **Assured services- balance between preventive, primary and secondary care:** In each of the four health service areas- RCH, emergency services, infectious disease and chronic disease the emphasis and major expenditure of the plan should be on primary prevention and then on primary health care and secondary prevention. This would be the most cost effective approach in a situation where the district health system has to pay for the primary, secondary and tertiary care costs. For example in emergency care , prevention of road traffic accidents or burns is the priority- but were it to happen, quick transport to facilities where trauma care is well-publicized and known to be available, through an emergency response system is essential.

4. Increasing Human Resources for Health – TOR III

- 4.1 The eleventh five year plan period has seen positive changes in four major dimensions of human resources for health. These include
- a. Increasing availability of skilled professional through the expansion of professional and technical education.
 - b. Recruitment and deployment of additional human resource as contractual staff financed by NRHM
 - c. Skill development of existing staff.
 - d. Measures for attracting and retention of staff in rural and remote areas.

Increasing Medical and Nursing Education:

- 4.2 In the last six years of NRHM, 82 medical colleges have been added, and 9751 seats have been increased. Of 595 ANM schools, 1227 GNM schools, 1026 B.Sc nursing courses, 405 post basic B.Sc nursing courses, and 327 M.Sc nursing courses have also been added. . The ANMTCs and Nursing Schools in most states had shut down and the faculty dispersed. Reviving these schools took a few years and the first batches of ANMs and nurses needed to close critical gaps are graduating only in the later years of the programme. Further in the poor performing districts, the lack of such schools is much higher and the ability to start them up with human resources available within such regions is very weak. This lack of skilled trainers and teachers was also a problem for the roll out of training programme in the poor performing districts. The design should have revived and built up the training institutions and sites in the first year, with a substantial reform and strengthening of apex institutions of training – like SIHFWs to lead this effort. This remains a weak link even at the final year of the NRHM.
- 4.3 There have also been substantial increase in paramedical education in this period- but the gaps here are some of the largest especially in disciplines like Optometrists, Physiotherapists, Dental Hygienists and Multi Purpose Workers (Male)

Increased Recruitment and Deployment in public service delivery

- 4.4 One of the major contributions of the NRHM has been the addition of 148361 contractual skilled service providers (as on 31/3/2011) to the public health services in the space of these six years. Of these 60268 are ANMs, 33667 are

staff nurses, 21740 are paramedics, 11575 are AYUSH doctors, 4616 AYUSH paramedics, 9432 are medical officers, and 7063 are specialists.

- 4.5 This does not include the substantial increases in workforce that has resulted by filling up of regular vacancies under state government financing. Some of these like in the male worker post were directly under insistence from the NRHM, while the rest was responsive to the increased attention given to revitalization of primary health care. These measures have led to a substantial decline in the number of Sub Centres without ANMs and in PHCs without doctors.
- 4.6 In addition to the increase in service providers, NRHM also takes credit for the induction of a number of non clinical personnel-, 583 district programme managers, 565 district data managers, 575 district accounts managers, 3771 block managers, 4143 block accountants and 5458 PHC accountants. Over 500 management and public health consultants have been inducted at state management roles. This staff has played an important role in improving the quality of programme management.
- 4.7 The Indian Public Health standards have also contributed by giving State planners a direction in how many staff they need to recruit. One caution is the need for rationalization of recruitment even when based on IPHS norms. Firstly there is a tendency to go in for normative recruitment based on a mechanical understanding of the IPHS. Thus many facilities would have more staff than their case loads merit and other facilities would have less.
- 4.8 Over reliance on contractual appointments as the main mode of increasing service providers and managerial staff has limitations. There is a high turn-over and reluctance to invest in training them. In some states, contractual staff, instead of being additional and supplementary became substitutes for regular staff. There is significant difference in pay between the contractual and the regular employees. The salaries of contractual employees should be higher than regular staff.
- 4.9 Skill development of Existing staff.

One of the major activities under NRHM was training of different categories of service providers and programme managers. Such training aimed to increase the skill sets of existing service providers so that they are more effective in saving lives, and provide a better quality of services. The major training packages were as follows:

4.9.1 ANMs and staff nurses

- 4.9.1.1 SBA (21 days) – 42530 trained- for providing skilled birth assistance in every PHC and potentially in every sub-center as well.

- 4.9.1.2 IMNCI (8 days)- 47843 trained – (UNICEF data base)- This training is meant not only for ANMs and nurses, but also for every Anganwadi worker and ASHA. Including all these categories of staff 329546 have been trained.
- 4.9.1.3 IUCD (5 days)- 27522 trained
- 4.9.2 Medical Officers-
- 4.9.2.1 Short term training programmes for life saving anesthetic skills (18 weeks) and an Emergency Obstetric Care training (16 weeks) has been initiated to overcome the shortage of skilled manpower at district and sub-district level. Over 100 medical colleges and 180 district training sites have been developed with about 280 Master Trainers available for the LSAS training. About 13000 MBBS Doctors have been trained in Life Saving Anesthetic Skills gynecological Societies (FOGSI). About 168 Master Trainers at medical college and 231 district hospital practical trainers are available for the EmOC training. About 830 MBBS doctors have been trained in EmOC including C-Section. However, we have not been able to achieve the targets of the training since could not depute enough number of doctors for the training due to shortage of workforce at the health facilities in the State.
- 4.9.2.2 In addition there are short training programmes on Basic emergency obstetric care (3892) and on medical termination of pregnancy (15 days- 9037 trained), female sterilization, (12 days- 9723 trained) and male sterilization (5 days- 2286 trained)and F-IMNCI- (4017 trained), Newborn care(2days), blood storage unit training(3), RTI/STIs(2 days), Immunization (2 days) These trainings are meant to ensure every 24*7 facility provides these services.
- 4.9.2.3 One day training programmes on malaria, tuberculosis, leprosy, blindness control, and IDSP programmes – about 500 to 1200 trained in each of these programmes
- 4.9.2.4 There are also programmes to train trainers for SBA and IMNCI training.
- 4.9.3 In addition to the above, over one lakh have been given orientation programmes on NRHM, 1785 programme officers have undergone three month public health management training(professional development course) and 2861 contractual programme managers have

undergone 5 to 10 days of training for NRHM programme management. All these data are from the training data base maintained by NIHFV.

- 4.10 This is a great amount of inputs which need to be duly noted. However this pace of training is far from adequate. There is a need for every skill based service provider to undergo full refresher training at least once in three years. Even for SBA training and IMNCI training only about one thirds of the training requirements have been addressed. Quality of training and post training follow up was a major problem. Selection of trainees is another concern as those providing the greatest volume of services are generally taken up for training last, and those unlikely to start up with services are generally taken up early. The other major problem as well as reason for the poor progress in training was the lack of professionally managed training institutions and training teams.
- 4.11 The Twelfth five year plan should give priority to developing institutional capacity in training. The Outcome/impact of all training programs needs to be monitored to bring about improvement in training modes and quality.

Strategies of attraction and retention of skilled professionals in rural areas

- 4.12 One of the central issues of human resource planning is the challenge of getting skilled professionals to join in public health systems and agree to stay and work in rural and remote areas. Since most doctors come from urban middle class backgrounds, the economic loss and professional and social isolation of rural service, deters them from public service. NRHM has begun to change this scenario with multiple strategies for attracting and retaining the skilled providers in the rural and remote areas. Initial results have been very encouraging. The various measures tried are listed below:
- 4.13 Incentives- Financial and Non financial. – Difficult area incentive - Introduced in most states for doctors, nurses and midwives working in remote areas. There is a wide diversity between states in categorizing “difficult” areas. Incentives are given as a difficulty allowance or as performance based incentives linked to institutional delivery, C-sections, sterilizations, cataract surgery etc. Non financial incentives include preference for post-graduation and promotion. Chhattisgarh has rural service cadre that packages a large number of financial and non financial incentives. States like West Bengal and Chhattisgarh have introduced group housing for health workers living in remote areas.
- 4.14 Workforce management - Tamil Nadu, Karnataka, Nagaland have shown that a major impact on worker morale by providing rotational posting in difficult areas. Simplification of recruitment process in Haryana, Maharashtra, and West Bengal has yielded positive results in filling up vacancies.

- 4.15 Educational Strategies: Measures to preferentially admit only those students who are likely to serve in under-serviced areas and moulding education to retain this commitment are also most successful. In West Bengal, locality based selection of ANMs by a process involving the community/Panchayats and posting them back to the Panchayats helped find and train 10,000 more ANMs within 4 years. The “Swalamban Yojana (self-reliance plan)”, in Madhya Pradesh provides scholarship against a bond for candidates from remote areas. Chhattisgarh provides a career path for Mitanins (ASHAs) to train for becoming ANMs and nurses in their villages and over 400 Mitanins have opted for this. Chhattisgarh and Assam have introduced 3 year diploma courses with the objective of filling in vacant positions in the remote, far flung and rural areas with skilled providers for primary care services. Government of India has proposed a three and a half year “Bachelor of Rural Medicine and Surgery” (BRMS) course, to be taught in medical schools affiliated to different universities in the country. This cadre would be posted in rural areas to provide primary level health care as ‘Community Health Practitioners’. Training AYUSH graduates to work as medical officers in primary health centers has been used extensively in states like Chhattisgarh, Maharashtra, Orissa, Gujarat.
- 4.16 Regulatory: Compulsory rural bonds for those obtaining medical education from government colleges have been used in Kerala, Tamil Nadu Meghalaya and Nagaland to fill vacancies in rural areas. A number of other states have made rural service mandatory criteria for admission into post graduate programmes.
- 4.17 Strategies for retention were not rolled out in most states- and best practices in some states were not picked up by others for replication. There is a need to provide for a scheme to resolve the problem of retention based on experiences gained. The Approach Paper to the Eleventh five year plan, raised this but the Twelfth Plan should provide for concrete schemes to address this issue.
- 4.18 The Twelfth Plan should allow a maximum of 30 % of the most difficult facilities within high focus states and 15 % in non- high focus States to qualify for a difficulty allowance. Besides this, states may add on non financial incentives, like preferential consideration for post graduation, for workshops and training programmes and for study trips abroad, preferential admission for their children in boarding schools etc. The financial incentives should be substantial to have an impact. The selection of the facilities should be based on objective criteria, by which every single facility is scored and there is complete transparency in its decision.
- 4.19 The Twelfth Plan would also invest in measures implemented specifically to provide support and a positive practice environment for those working in difficult rural and remote areas. The problems of professional isolation should be addressed by special continuing education programmes and telemedicine or even short three week internship opportunities, and by special conferences and

workshops that interest them and builds their skills in public health. Their social isolation should be addressed by more opportunities to interact both with peers and with the community they serve. Special support groups that reach out to them, and keep them in contact and provide assistance to them could be mooted. Very short duration postings with frequent rotation in areas of special difficulty areas and other innovative measures would be useful supplements.

- 4.20 A pool of dedicated trainers at State and district level for supervision, monitoring and hand holding of trainees being trained should be developed. Performance monitoring and organising CME/ refresher courses for updating knowledge and skills of the health personnel should be done.
- 4.21 A nursing division at State level with proper staffing and with distinct responsibilities for both ANM and GNM should be developed. Simultaneously, developing mid-wifery cadre, developing public health midwives and creating management/supervisory cadres of midwives will be focused in the twelfth plan.

5. Programme Management – TOR IV

5.1 The NRHM envisaged improvements and reform in programme management as one of the keys to improved health care. The efforts it made in this regard could be listed below.

5.2 *Creation of new institutions of governance:*

5.2.1 At the national level it was the mission steering group, the empowered financial committee. Set up for policy making as well as implementation will be strengthened at Central as well as State level for better planning, implementation and monitoring.

5.2.2 At the state level it was the state health mission and the state health society.

5.2.3 At the district level it was the district health mission and the district health society. The Panchayati raj institutions would provide leadership to the district health society with participation of the block panchayats.

5.2.4 At the facility level it was the governing body of the hospital development society that would provide leadership with leadership of the block panchayat and participation of gram panchayats at the appropriate levels.

5.2.5 At the village level, the village level health and sanitation committees at the revenue level with leadership from the gram panchayats.

5.3 *Strengthening/creation of appropriate institutions of management*

5.3.1 At the state level- it was 1.strengthening the directorates of health services, 2. Creation of state programme management units under the state health societies, 3. Creation of institutions or divisions for infrastructure development, 4. The creation of institutions or divisions for procurement and logistics, 5. The strengthening of state instituted of health and family welfare for training functions, 6. The creation of State health systems resource centers for technical assistance and innovation or the utilization of equivalent bodies often paid for by development partners and 7. The creation of institutions for managing the community processes.

5.3.2 At the district level it was the creation of a district programme management unit.

5.4 Addition of a large number of management professionals- at district and state level- Programme managers at state and district level; Accounts managers/accountants and data managers/data entry operators at state, district, block and in some states even at the facility level.

- 5.5 Addition of a large number of public health professionals as consultants at the national and state levels. These are either placed in the national level in ministry divisions or in state programme management units or in NHSRC and SHSRCs or in the NIHFWS/ SIHFWS.
- 5.6 Encouragement of qualification in public health or public health management has been an important development during these five years. Other than the one year diploma in public health management run in five institutions, over a 100 public health education courses have come up during this period and a further few courses are available in distance learning format also. A public health cadre has been mooted but not implemented.
- 5.7 Creation of Health Management Information Systems where a national web-portal playing a nodal function.
- 5.8 Institutionalizing monitoring and evaluation mechanisms systematically. Thus the NRHM has in place the annual common review missions and the joint review missions, the concurrent evaluation process led by the IIPS, and the number of studies and evaluations done by the international advisory panel, and various national institutions. The SRS, the NFHS and DLHS and now the annual health surveys also provide important health data.
- 5.9 Creation of improved financial management systems with clarity on flow of accounts and accounting process, and with e-banking and computerized accounting at every level.
- 5.10 All these above initiatives have made important contributions in the direction of reform. However, improvement in design and execution is desirable. The immediate lesson is of course to persist, because even to establish these changes took years and one could easily undermine them, by failing to recognize their existence and gains.
- 5.11 One of the most important areas where persistence and quality is needed is in the state level institutions of management and governance. Governance institutions need to function as good governance and need to have the necessary separation from management functions. The governing boards of the state and District Health Societies and Rogi Kalyan Samitis must perform different functions from the executive committees. The programme management units must function as secretariats of the executive committees.
- 5.12 The synergy of the directorates of health with the new institutions of governance and management should be thought through. At one level this is posed as a problem of “NRHM becoming a parallel structure” and the need for “merging it” with the health department. Such a perception relegates every institution or organization created in this period to being seen as an ad hoc arrangement that

should pass away with directorates (or state programme management units) eventually taking over. The creation of a public health cadre is seen as the critical step needed for directorates to be able to be strengthened and to take over these functions as institutional permanent arrangement. But at another level, the pressures on the ground and the practice are to multiply and strengthen institutions outside the directorates- even whilst calling all of these as ad hoc arrangements. There are many reasons for this contradiction, other than the limitations of existing directorates. Firstly as health management becomes increasingly inter-disciplinary, the conventional structures of government administration do not allow space for their inclusion and bodies outside it become necessary to recruit such skills. Secondly merely adding on technical consultants into existing structures without mechanisms for their workforce issues and capacity development and leadership roles, also dumbs them down into “extra hands” rather than “extra minds” and fails to sustain them. Areas like logistics, or community mobilization, or quality improvement or human resource development or financing have all become disciplines in their own right and merely conceiving of these areas as common-sense based decision making that doctors or general administrators could perform without specialized learning, fails to recognize the needs of knowledge management in the modern health care scenario. For these reasons, the recommendation for multiple institutional arrangements at the state level is unavoidable. There is much experience to be gained from best practices in each domain on how to form and run such institutions. It is within this context that the strengthening and leadership role of directorates of health and the synergy of NRHM structures with directorates has to be resolved.

- 5.13 The creation of a public health cadre must remain a priority. The creation of public health management skills in leadership roles is necessary at all levels. The technical divisions at national level needs strengthening and supports for adequate supervision and guidance to the States. There should be a mix of technical and managerial skills and national level for achieving this.
- 5.14 It is also important to define the direction of development of the health management information systems. The approach should be towards permitting multiple systems which meet well defined and regulated data standards and standards of inter-operability, with each user level or institution able to access the information most useful at that level- rather than one single system to which all data entry and interpretation in the nation must conform. If such an architecture is created the Twelfth five year plan period would see a massive expansion in the integrated use of health informatics for human resource planning and management, GIS applications, mobile transmissions, hospital information systems, disease surveillance systems and nutrition and social determinants monitoring, death reporting, case based follow up systems including what is referred to as pregnancy and child tracking. The current HMIS and tracking systems captures RCH service delivery indicators and needs more inter-operability with existing systems. If the

district plan is to take on management of infectious disease, emergencies and chronic disease in addition to RCH, given the varied development of these programmes across and within districts, there would be an urgent need for decentralized information systems- which the center by creating appropriate policy and standards must provide stewardship for- instead of trying to run all of it, all by itself. Of course the center would have its own information needs for decision making and these would be supplied through electronic bridges by all the other state and even district systems.

- 5.15 The Concurrent Evaluation of the NRHM and the DLHS-III were two main sources of information pertaining to outcome evaluation on the mid-term performance of the Eleventh Five Year plan. For 284 districts covering the main high focus states of the north and Assam from the north east, the Annual Health Survey done in 2009 will serve as a detailed source of information on outcomes and as a baseline for district planning in these states. The DLHS-IV starting up in November 2011 and completing by March would provide an end of the plan outcome report for the Eleventh Plan and a baseline for the Twelfth Plan, but it would be covering only the districts not covered in the Annual Health Survey. There is a need to further strengthen quality of data collection by using health para-professionals in data collection.
- 5.16 District Health Plans - challenges of integration, convergence and decentralization: 540 districts prepared plans in the last year- an increase from 310 in the first year of the NRHM. The plans have helped integration of all department activities- disease control, RCH and AYUSH as part of an integrated health systems development, but have not yet addressed inter-sectoral convergence. Plans and societies as vehicles of decentralized governance remain a challenge due to varying levels of Panchayat involvement and due to problems of matching resource allocations to locally developed plans. The initial enthusiasm has declined as the exercise is time consuming and is not linked to resource allocation, and often not even for review of progress. The challenge before us to build a resource allocation policy that can interface with the participatory nature of planning – being responsive to both public health needs as measured and felt needs as expressed by communities. There is need for adequate techno managerial structure at State and district level. The present focus is more on administrative aspect and technical support is weak. This needs priority strengthening in 12th Five Year plan.

6. Strengthening of Community Processes under NRHM – TOR V

6.1. The NRHM launched a number of initiatives to promote space for community processes and increased public participation. The main programmes that would be considered in this section are :

- i. The ASHA and her support structures
- ii. The Village Health and Sanitation Committee
- iii. Rogi Kalyan Samitis: at the level of the PHC, CHC and District Hospital
- iv. The use of untied funds at all levels
- v. The community monitoring programme
- vi. The district and state health societies.

6.2. The ASHA was designed to facilitate access to health services, mobilize communities to realize health rights and access entitlements and provide community level care for a number of health priorities where such intervention could save lives and improve health. This includes counseling on improved health practices and prevention of illness and complications, and appropriate curative care or referrals in pregnant women, newborn, young children as also for malaria, tuberculosis and other conditions that are location specific. This mix of roles was deliberately proposed and seen as critical to both sustain the programme and to bring around much needed health outcomes. The NRHM also envisaged a support and training structure for the ASHA to enable these roles.

6.3. The ASHA programme is the most visible face of the NRHM, and is likely the world's largest community health volunteer programme, with approximately one ASHA for every 1000 population in rural India. There are presently a total of 849331 ASHAs selected across the country³, of which 492784 ASHAs are in the high focus states, 53619 in the NE states, 298286 in the Non High focus states and 4642 in the union Territories. The proposed total is 8,80,739, of which 93.73% have been selected overall with over 97% of selections completed for the high focus states. Although it was only intended to cover high focus states and tribal areas in the non high focus states, in 2008 the remaining states⁴ opted for the programme.

6.4. The ASHA programme differs from past efforts in distinctive and substantial ways. Its key features are enumerated below:

- i. Comprised solely of women,
- ii. Selected by the community

³ ASHA update, January 2011 (Data as of December 2010)

⁴ Except Himachal Pradesh, Pondicherry, Goa, and Damn and Diu, and the non tribal areas of Tamil Nadu

- iii. Remunerated on a performance based reimbursement,
- iv. Support systems extending from sub block to national levels.
- v. Periodic review meetings and on the job training and support
- vi. A well crafted modular training strategy with a strong element of health rights; consists of seven training modules for initiation. These modules include key skills for provision of appropriate community level care. There is a commitment to sustain training at least 20 days per year-.
- vii. Equipped with a drug kit which includes essential minor equipment.

6.5. Most ASHAs have completed the first four rounds of training and in states that had initiated this, the fifth round of training as well. (94% in the NE states and 85% in the other high focus states). 96% of all ASHA have been provided with a drug kit in the high focus states, with the exception of Bihar, where the drug kit distribution has just been initiated. 97% of ASHA in the NE have received drug kits, and in the non high focus states, 79% of ASHA have received drug kits. Procurement and distribution is underway in Gujarat, Kerala, and Tamil Nadu. Most ASHA earn between Rs. 500 to Rs.1000 per month from this task. Most states have provided identification badges, bicycles for increased mobility, passes for travel, staying arrangements at health facility, rest rooms for ASHAs and help desks for patients referred by ASHAs, and recognition by way of annual ASHA awards. The programme has expended Rs 1098 crores-over five years- which is only one fifth of the expenditure that was envisaged for the programme.

6.6. The ASHA programme is a well studied component of NRHM. The studies have ranged widely in scope, methods and outcome measures. One overriding finding is that the programme is the single most important instrument for community outreach and has significant potential for saving lives. A recent large scale evaluation of the programme in a sample of 16 districts across eight states⁵, offers important evidence on the functionality and effectiveness of the ASHA. The finding that about 74% of women with a child up to 6 months and about 71% of women with a child under two who had an episode of illness in the past month, reported receiving services from ASHA indicates that nearly 30% of the population is still not reached. The second significant finding is that ASHAs were very active and effective in promoting institutional delivery and immunization and to some extent access to sterilisation, because the support system was geared to promoting exclusively these aspects. The ASHAs were therefore less functional and effective in tasks related to community level counselling, care provision and in mobilisational work and the lesser effectiveness is correlated to the inadequate emphasis on skills in the training

⁵ Which way forward?: An Evaluation of the ASHA programme in eight states, National Health Systems Resource Center, 2010

curriculum and lack of support systems for ongoing mentoring, support and supervision. Thus at this stage though we are getting outcomes related to improved institutional delivery and increased attendance at immunisation, the role of the ASHA in child survival has only been strengthened recently with issue of guidelines on Home Based New born Care and introduction of 6th and 7th Module training. These deficiencies have since been corrected and the last year of the plan has brought considerable focus on skills and home based newborn care as envisaged so clearly in the eleventh five year plan. This plan would need to persist for at least three years before an acceleration in child survival can be seen.

- 6.7. The studies indicate that an important corrective needed is greater clarity on the ASHAs functions to mid and senior level programme managers- so that they see how health outcomes relate to ASHAs work. Other findings relate to the need for a full time dedicated set of trainers, the need for special efforts to reach the marginalized and immediate attention to timely payments and drug kit replenishment.
- 6.8. In the eight high focus states and Assam, the focus should be to provide the ASHA with the skills and support to strengthen her ability to provide home based new born care and care for the child. This should be the pattern for the high focus districts in other States as well at least for the period of the Twelfth plan. In the non high focus States, where programmes for non communicable diseases, mental health, palliative care, disability, etc, are beginning to be piloted or scaled up the ASHA should be trained in counseling for behaviour change, basic screening such as for diabetes, hypertension, and selected cancers, referral and home based drug distribution.
- 6.9. As the programme enters the next plan period, we need to evolve a strategy of sustainability of the programme. Firstly this implies planning for as much as a 5% turnover and fresh recruitment every year. Secondly it needs to recognize the different aspirations with which women have volunteered and provide for some of these aspirations. Some states such as Orissa and Chhattisgarh have made provision for reservation of seats and enabling ASHA to complete the required educational level for entry into ANM training schools. Others have given preference to her recruitment as anganwadi workers. The gaps left by such turnover can be easily replaced and the training already invested in her is not lost. Still others who have more interest in the mobilization and leadership role have become elected Panchayat members or active in non-governmental organizations
- 6.10. But while increasing her avenues for progression for those who have such an aspiration, the voluntary nature of the ASHA programme needs to be preserved. Allocating multiple roles is likely to reduce her motivation and the spirit of the programme. Her work should be such that it is done without impinging on her main livelihood and adequate monetary compensation for the time she spends on these tasks- through performance based payments.

- 6.11. Managing this 5% to 15% turn over, retraining ASHAs and facilitators and creating new interventions for implementations by ASHAs need some established training and development centers at the state level. Training cum demonstration and experimentation site for community processes should be encouraged and developed in each State. These would also pilot new models, evolve guidelines, field test material and nurture and support a resource team.
- 6.12. The Village Health Sanitation and Nutrition Committees (VHSNC) were intended to function as a village level organization comprising of key stakeholders including members of PRI, ASHA, AWW and ANM, and include representations from women (including from Self Help Groups) and marginalized communities. The VHSNC was expected to develop village health plans, specific to the local needs, support the ASHA and generally serve as a mechanism to promote community action for health, particularly for social determinants of health. There is a need to bring in NGO participation in a major way so as to expand the systemic capacity to train and support VHSNCs to play a role in addressing social determinants of health in a meaningful way.
- 6.13. The Approach Paper to the 12th Plan suggests that the Anganwadi Centre and the Sub Centre both could be brought under the oversight of Panchayat level Health Nutrition & Sanitation Committee. However, the Health Sanitation & Nutrition Committees under NRHM are set up at the level of village and not the Gram Panchayat. While the number of Gram Panchayats is approximately 2.45 lakhs in the country, the number of Village Health Sanitation & Nutrition Committees (VHSNC) is approximately 5 lakhs at the moment. Hence, the appropriate course would be to ask the States to issue necessary notifications to put the health Sub Centre, Anganwadi Centre and also the Village Health, Sanitation & Nutrition Committees under the oversight of the Gram Panchayat.
- 6.14. The NRHM also created a platform at the village level, the Village Health and Nutrition Day (VHND) where the ANM was expected to provide services for antenatal care, immunization, postpartum care, etc, and the ASHA was expected to mobilize mothers and children, with the Anganwadi center being the venue, with a view of fostering convergence between the ICDS and the health systems. Two related components of the NRHM were expected to strengthen and enable the Community Processes component. The first was to provide financial assistance to NGOs to undertake functions related to training, mentoring and implementation support to various elements of the CP, and the second was a pilot effort for community monitoring.
- 6.15. A total of 483496 VHSNCs have been formed in the country^[1], covering about 76% of the villages. Of these, 9% (42640) are in the NE states, 56 % (269213) are in the non NE High Focus states, and the remainder in the non high focus states. States

such as Bihar, Uttar Pradesh, Haryana, Himachal Pradesh, Kerala and Tamil Nadu have formed the VHSNC within the Gram Panchayat while in the remaining it is at the level of the revenue village. There was a provision of Rs 10,000 untied funds for each VHSC. Under this scheme a total of Rs 1464 crores have been disbursed over four years for expenditure by the VHSC at the village level. Of this 11% went to the north east VHSCs and 50% has gone to the VHSCs of other high focus states.

- 6.16. There is less information available on VHSNCs as compared to other community programmes. VHSNC functionality in six of the eight states, as seen in the ASHA evaluation study showed that functional VHSNCs defined minimally as at least “holding some meetings in the year” was about 83% (mode- across the states- range 58% to 97%). This is based on information collected independently from the ASHA and ANMs and Anganwadi workers of the village. The VHSNCs appear to be active in support to VHND and promotion of immunization in about 63%, in health awareness campaigns in 56%, in promotion of institutional delivery in 53% (excluding Kerala where this was not necessary), and in clearing stagnant pools of water in 45%. On Village Health Planning, there appear to be wide variations, but overall, about 60% of VHSNCs had made such an effort. About 20 to 40% of ASHAs felt supported by the VHSNC, but it was precisely in these villages that the mobilization role of ASHA played out best. VHSNC members helped ANMs in hosting village level meetings and in disseminating key health related information. Although, in terms of percentages the achievements are modest, the absolute numbers of people mobilized by the VHSC and sensitized to health issues are likely to be high.
- 6.17. The Village Health Sanitation and Nutrition Committees remain the key mechanism to address action on social determinants including age at marriage, literacy, water and sanitation, nutrition, substance abuse. This aspect was always part of the design, but there was no management capacity to handle this. There is a need to bring in NGO participation to expand the systemic capacity to train and support VHSNCs to play a role in addressing social determinants of health in a meaningful way. This VHSNC programme with an adequate support structure is also needed to support the ASHA and for the ASHA to play her mobilisational and health education roles.
- 6.18. Rogi Kalyan Samitis- or hospital development societies: 678 district hospitals, 4875 CHCs, and 27596 other facilities have a registered RKS in place. A total of Rs 4373 crores have been released to these facilities, of which Rs 898 crores was in the form of RKS corpus funds and the rest in the form of untied grants, grants for annual maintenance, and grants for up-gradation of CHCs. Though there are exceptions, in most states, meetings of RKS are held regularly. However its functionality and effectiveness need to be assessed more carefully.
- 6.19. There are multiple expectations of the Rogi Kalyan Samiti. The Rogi Kalyan Samitis should be strengthened by having better rules in place for public participation and transparency and by orientation to ensure quality of care and

improved access to care. The NRHM provided space for inclusion of representatives of the public in the hospital development committees (Rogi Kalyan Samitis). It also provided similar space for public participation in the district and state health societies and in various committees like the implementation of PCPNDT Act, quality assurance committees etc. The impact of the RKS on enhancing community participation is highly variable across the states, and findings from successive reviews suggest that in general RKS need strengthening and better oversight. The Twelfth five year plan period must build on the hesitant beginnings with clearer policies of norms for membership in these structures and mechanisms for ensuring their functioning.

- 6.20. The other expectation of RKS and DHS is as a vehicle for inter-sectoral coordination, a function it played well where a senior officer or the district Panchayat played the leadership role effectively. This could become a problem if the senior officer could not find the time. Correction of this problem requires much better monitoring and review of RKS and DHS functioning in the state health society.
- 6.21. Yet another expectation of the RKS was as a vehicle for untied grants and for user fees, providing local facility managers to utilize the funds for local facility level improvements. After initial delays and hesitations, this function has picked up very well across the states. The problem now is that all facilities, irrespective of level of functioning get equal finances – and the money gets locked up in facilities with low levels of functioning and is inadequate for improvements in the facilities handling larger case loads. This problem is sought to be addressed through differentially financing different facilities. The other problem is that RKS becomes the manager of only the user fee and untied grant, or like in Punjab, only the manager of the untied grant- with all other aspects of facility management and access to care and quality of care being placed outside its purview. This was not the purpose of the programme, and the aim should be to see how the RKS is re-vitalized to meet all its expectations and not get reduced to some narrow and limited role. For this too, specific RKS training programmes should be undertaken to provide the additional capacity needed.
- 6.22. The community monitoring programme is intended to collect information about community health needs and how they are met (according to locally developed yardsticks and key indicators) and provide feedback through *Jan Sunwais* or public hearings to improve accountability and responsiveness of the public health facilities. Nine states implemented a pilot phase of this programme in 1620 villages of 324 PHCs spread across 108 blocks and 36 districts. These nine states were Assam, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Orissa, Rajasthan and Tamil Nadu. The design and implementation was through an Advisory Group on Community Action composed of renowned civil society representatives. One NGO, the PFI plays the secretariat function for this group. It

was implemented for a period of about eighteen months covering a total of 1620 villages, 324 PHCs and 108 blocks in 36 districts and facilitated by NGOs. The programme was shown to have resulted in increased utilization of services and greater accountability in the facilities. This programme has recently been scaled up across the entire state in Maharashtra, Karnataka and is planned to be expanded in phases in Bihar and Madhya Pradesh.

- 6.23. Given the importance of NGO participation to retain the mobilisational character and spirit of community processes in NRHM and given the fact that such community works also has its own set of skills and experience requirements; there is a need for the Twelfth plan to address the needs of sustained NGO participation and growth. NGO participation can be effective in training and support to ASHA, VHSC, RKS and community monitoring programmes. It is also valuable for district planning, environmental and occupational health, in PCPNDT implementation, in promotion of rational drug use, and in health communication, and in advocacy for health promoting and safeguarding policies –for example tobacco control. It is also needed for innovation and action research in this area. There should therefore be joint mechanisms developed with states to build leadership capacities in this sector in the states. Such leadership capacity would then be able to build requisite programme implementation capacities in district and sub-district NGOs. There should be national standards set for transparency, financing and appraisal of NGO performance and with conformity to these standards grant in aid committees can be formed in the states. The role of the center is in accrediting this grant – in- aid committees as conforming to the standards. Such state level grants in aid committee going along with capacity building in this sector, would speed up and improve the quality of NGO participation rapidly. The huge task of NGO participation requires such policy initiatives. The NRHM Framework for Implementation provided for spending upto 5% of its funds on NGO participation. This is necessary for quality outcomes in this sector and above all to address many social determinants of health care.

7. Progress in RCH Services – TOR VI

- 7.1 The Eleventh Five year Plan envisaged universal access to quality antenatal care, post natal care & universal access to safe delivery services. It is represented by access to skilled birth attendants in an institution or a trained person at home. It also envisages universal immunization, access to emergency obstetric care through a network of (First Referral Units) FRUs, a functional referral transport system, access to safe and quality abortion services, facility based services for sick neonate and child, care for Reproductive Tract Infections (RTIs), child nutrition and adolescent health.
- 7.2 The provision of these services is discussed below broadly categorized into outreach services and facility based services. Outreach services refer to services provided by ANMs in the sub-centers usually through outreach sessions held in Anganwadi centers in the villages. These include immunization services, antenatal care, post natal care and access to temporary methods of contraception. Facility based services includes institutional delivery, emergency obstetric care both basic and comprehensive, safe abortion services, sterilization services, management of Reproductive Tract Infections / Sexually Transmitted Infections (RTI/STIs) and adolescent health clinics. Outreach services also refer to all the services offered at the anganwadi center for the young child.
- 7.3 Three Antenatal care checkups, a sensitive indicator of access to outreach care in pregnancy has improved in *rural areas* from 36.7% in 2005 to 63.3% in 2009. Quality of care is now part of the monitoring framework. The efforts need to be expedited in the 12th plan period for universal antenatal care checkups.
- 7.4 Full immunization in *rural areas* has improved from 47.4% to 58.5%, an increase of 11.1%, over four years. Measles immunisation in rural areas improved from 61.8% to 72.4% over the same period. In contrast, urban full immunisation stayed unchanged at about 67.5. Urban measles immunisation coverage in this period declined from 79.4% from 78.3%. Thus, rural-urban aggregation underplays the improvement in rural areas.
- 7.5 According to the coverage evaluation survey 2009, institutional delivery rose from 53.3% in 2005 to 72.9 % in 2009. The 11 States which had the weakest performance at the baseline, i.e. States with less than national average of 53% institutional delivery showed substantial increase. Institutional Delivery in *rural areas* improved from 39.7% in 2005 to 68% in 2009 resulting in a jump of 28.3 % (all India increase 19.6%). In urban areas, where access to facilities is much easier and where Janani Suraksha Yojana is also available, the increase was from 78.5% to 85.6%- a mere 7.1% increase. Though Janani Suraksha Yojana is a major contributor to improvements in institutional delivery, other dimensions of NRHM listed below also contributed significantly to the increase in institutional

delivery in rural areas. This trend is also confirmed by District Level Health Survey (DLHS) which shows an all India increase in institutional delivery from 40.5% in 2002-03 to 47% in 2007-08.

- 7.6 Part of this improvement could be attributed to the strengthening of sub-centers under NRHM. Of the total of 145,920 sub-centres, 95% are functional with at least one ANM. In 2005, one fourth of sub-centers did not have a single ANM or were non functional for similar reasons. Further, 35% of current sub-centres (50,728 in number) have a second ANM. In 2005, no sub-center had a second ANM. It is worth noting that under NRHM, a total of 53,552 ANMs have been appointed, most of them as second ANM at the sub-centre, but also to close critical gaps in PHCs and sometimes as a first ANM in the sub-centers. Other than the provision of second ANM, NRHM has contributed to strengthening of the sub-centres through the provision of Rs 20,000 as untied funds and Annual Maintenance Grants.
- 7.7 Another factor that contributed to the improvement in antenatal care, immunization and access to skilled birth attendants is the renewed emphasis given to a fixed monthly Village Health and Nutrition Day (VHND) held in every village. Over 58.7 lakh VHNDs were held in 2009-10 and 69.25 lakh during 2010-11. This works out to about 4.8 lakh VHNDs per month as against 6.38 lakh villages.
- 7.8 Another major factor that led to improved outreach services is the introduction of Accredited Social Health Activists (ASHAs). ASHAs were uniformly active in promotion of the VHND and attendance for immunization. They were less effective in improving health practices or in providing appropriate home based care for common illnesses.
- 7.9 There are Mobile Medical Units (MMUs) in place in 461 districts of which 66% are in high focus States. In 2005, very few districts had mobile medical unit. This has helped at least immunization and antenatal care to reach to a higher population.
- 7.10 Improvements in Referral Transport for pregnant women and the newborn: about 22 States have some sort of emergency response system or referral transport system in place. In 2005, two States had a very preliminary model of emergency response system or referral transport system.
- 7.11 Janani Suraksha Yojana (JSY) benefits are availed by over one crore women each year who avail of cash benefit under this scheme. It has also put pressure on the system to improve the provision of obstetric services.

- 7.12 However significant the improvements, these are still well short of Eleventh Plan targets. Reasons for a lesser performance could be attributed to a number of factors. One major factor, as the above discussion shows is the stagnation in urban areas in immunization, ante-natal care and even in institutional delivery.
- 7.13 Another major constraint was that States that could have benefitted from the second ANM have been slow in deploying second ANMs. Most of them spent the first years in filling the first vacancy, and then in expanding ANM education. Only now these States are approaching deployment. There are also problems of the clarity in working conditions between first ANM and the second contractual ANM. Poor work allocation between the two compounds the problems.
- 7.14 The number of sub-centers, their distribution and the number of outreach sessions, requires expansion and better micro-planning with logistics support. In the critical States of Bihar, Uttar Pradesh and Jharkhand which are lowest performers in immunization, the last Ice Lined Refrigerator (ILR) point of the cold chain stops at the block level which in these States is over 2.0 lakh of population. In other States, the last storage point in the cold chain (referred to as the ILR point) reaches up to the sector. The confusing way in which the block PHC is referred as PHC obscures huge differential in cold chain management which needs to be addressed.
- 7.15 Provision of comprehensive emergency obstetric care: At the onset of the NRHM, there were 1,052 First Referral Units (240 District Hospitals+ 410 Sub District Hospitals+402 Community Health Centres). As of March 2011, this had increased to 2,891 FRUs (574 DH + 826 SDH+1491 CHCs). In High focus States; the increase was of 786 FRUs from 97 FRUs to 883 FRUs. It is 52.5% of the nationwide increase of 2,654 FRUs in these five years. In North East States, the increase was 114% from 56 FRUs to 120 FRUs. In non high focus large States; the increase was 130% from 798 FRUs to 1842 FRUs, which represents 54% of the nationwide increase in FRUs. In one FRU is present for every 5 lakh population equal to the WHO norm and this is excluding the urban private tertiary care facilities which provide these services. despite the dramatic 648% increase in FRUs in high focus States under NRHM, the gaps between targets and achievements still are higher in the high focus States. In the non high focus large States, there is 1.35 FRU per 5 lakh population, and in the NE States as well as in other small States, there is 1.1 FRU per 5 lakh population, in the high focus large States, the number of FRUs is still 0.58 per 5 lakh population- half of the minimum required. NRHM and Eleventh five year plan made a commitment to move towards an FRU in every CHC which means almost one FRU per 1.2 lakhs population. By that standard we are at only one fourth of the distance to the target. Thus much more needs to be done to increase the number of FRUs so that they cater to a higher proportion of the population.

- 7.16 Primary health care facilities are providing Basic emergency obstetric care services on a 24x7 basis. In the year 2005, there were 2,243 facilities functioning as 24x7 facilities (this consisted of 1,263 PHCs and 980 CHCs). Now, there are 18,348 sub-district facilities (9107 PHCs, 3,338 other primary health care facilities, 4531 CHCs and 1,372 other sub-district facilities) functioning on a 24x7 basis. This represents a 718% increase over the base line.
- 7.17 Of the total increase in 24x7 sub-district facilities, 59% is from non high focus large States and 37% is from high focus States(other than NE). 2.7% is from the NE States and 0.75% in the small States and UTs. In terms of regional achievements, there is 774% increase in high focus large States, 755% increase in other large States, an 88% increase in NE States and 446% in small States and UTs.
- 7.18 The major problem with the 24x7 facility concept was that it either became defined or measured by the presence of three nurses or by the availability of services round the clock. While both definitions are applicable, the central definition is the availability of a package of services which includes basic emergency obstetric care, facility based care for sick newborns and children, safe abortion services for less than 12 week fetus, RTI/STI management, VCTC etc. However, these have become the most important sites of institutional delivery-defined in this context to mean access to a skilled birth attendant.
- 7.19 Many 24x7 facilities fail to become functional because there are higher level public facilities almost as easy to access providing a better range and quality and assurance of services. The development of roads, the desirability of health teams as compared to single doctor PHCs or single nurse sub-centers, the changes in health seeking behavior have all made a number of facilities redundant. A large number of partnerships with private sector hospitals have been encouraged to expand the capacity to cater to the increasing load of institutional delivery. As of last year end, a total of 6,043 private sector institutions had been accredited for JSY of which 5,133 are from the non high focus States. In the North east States, there were only 38 private hospitals and in other high focus States, only 836 hospitals could be accredited. It is largely a reflection of low availability of willing private sector hospitals where they are needed most. In addition, a modest number of private sector hospitals in 8 States have become partners to provide free obstetric service to poor women, their charges being reimbursed by the government (similar to the Chiranjeevi model of Gujarat).
- 7.20 Monitoring and supervision, though improved from earlier periods, still remains weak. Supervision which ensures that clinical protocols are followed along with building up of skills is exception rather than rule. Community monitoring helped

in bringing pressure to bear on erring employees at the peripheral facility- but even in this was limited in outreach to what the centrally sponsored initiative could achieve. It did not get picked up and replicated by States in a major way. It was unable to address even issues like district plan implementation, fidelity of data systems, organization of support services, and use of untied funds. Its overall contribution to improved facility functioning remained limited.

- 7.21 Though under JSY, the major increase in institutional deliveries has been managed by the public sector, when it comes to complications a significant number get shifted to the private sector. In the public sector, the district hospital does most of the management. There is no cost protection or support for the second referral, especially when it is to the private sector.
- 7.22 Due to limited amenities and problems of transport, women tend to leave soon after delivery when the risk of complications is still very high. Out of pocket expenditures even in the public hospital are high.
- 7.23 To address these issues, Government has recently announced the Janani Shishu Suraksha Karyakram (JSSK) which promises free treatment with no out of pocket expenditures for both the pregnant woman and the newborn- upto one month. This would include provision of diet and other amenities during her hospital stay and free transport to the hospital and drop back home..
- 7.24 In 12th Five Plan improving quality of care for services being rendered will be a major thrust. All health facilities should have a citizen charter and protocols on technical services being rendered.

8. Engaging the Private Sector TOR VII

- 8.1. National Rural Health Mission aimed at bringing architectural corrections in the health sector. It also adopted strategies to supplement the public healthcare system by partnering with the private (for-profit and non-profit) sector to provide quality healthcare accessible to poor and marginalized sections. Within the ambit of Public Private Partnership (PPP), NRHM tried to consolidate already existing frameworks for engaging the private sector (under RCH-I/II, RNTCP, NPCB, etc.). However it provided flexibility to the States regarding the actual design and financing of PPPs.
- 8.2. Various States had embarked upon various models and frameworks for engaging the private sector. It included contracting for specific services, outsourcing clinical and non-clinical services and outright purchase of care/services from the private parties. However, the proportion of funds spent on PPP was not substantial as most of the funds were actually getting used to strengthen the public system through improving physical infrastructure, hiring human resources, etc. By 2008-09 the all-India level spending on 'Innovations & PPP' were Rs. 61.10 crores under Mission Flexipool and Rs.118.31 crores under both RCH-II and Mission Flexible pools combined (both being less than 2% of the respective flexible pools).
- 8.3. The PPPs adopted by various States under NRHM varied greatly. They covered the entire spectrum of contracts and types of services. The broad types of PPPs implemented under NRHM are listed in the table below. The categorization is ad hoc and there is considerable overlap between categories. This is more of an exercise of mapping some of the major types of PPPs that have taken place in last 5 years.
- 8.4. The approach Paper to the 12th Plan says that the 12th Plan will explore the possibilities of introducing a government funded Health Insurance Plan, which will focus on both preventive and curative aspects. The working group is of the view that it would be prudent to continue strengthening the public health infrastructure, keeping quality in mind and recommends that preventive health care and also primary health care should be delivered through public health infrastructure and should be kept outside the ambit of health insurance and health insurance for secondary and tertiary care should be introduced with caution.

Types of PPP Contracts	Purchase of care/service	<i>Chiranjeevi for obstetric care Cataract surgery Sterilization services from Janani Vouchers for child health- Agra/ Haridwar AND Insurance schemes</i>	<i>Microscopy centers for RNTCP</i>	<i>ANM Training (West Bengal)</i>	<i>Janani Express</i>	
	Contracting In or out (outsource)	<i>PHCs:(Arunachal /Karnataka) Boat clinics MMUs HMRI Fixed-day specialist clinics</i>	<i>Diagnostics (Labs-Bihar) Imaging systems in TN</i>	<i>Cleaning (Sulabh) Diet Laundry</i>	<i>EMRI/108</i>	<i>1. Community monitoring 2. PRI training 3. ASHA support</i>
		Clinical services	Clinical support services	Non-clinical services	Referral transport	Community level
Types of Services						

8.5. As can be seen from the table, there are some examples of all these types of PPPs adopted by the States under NRHM. There are also multiple ways of categorizing and discussing these.

- a. Various evaluations and case studies have been documented by various agencies highlighting the operations and challenges faced in the PPPs. As has been pointed out by the review of EMRI, which is a major PPP, adopted across more than 11 States in India, the financing and monitoring of the PPP had been a major shortcoming in an otherwise very popular and innovative scheme. It has been found that most of the PPPs are actually managed at the district level (day-to-day management, monitoring and to some extent payments), whereas the contracts had been designed and signed at the State level, causing a gap in understanding the deliverables and parameters of the PPP. Hence district and State level capacity building of health officials, managers and administrators is required in terms of contracts management.

- b. A general trend observed is that the private sector had been engaged in those areas where public system found it difficult to provide assured services on a regular basis (PHCs in difficult areas, ambulance service, diagnostic/radiological services in block and PHC levels, etc.). However, engaging the private sector does not absolve the public system of managing the services contracted out. The service might become unregulated and give rise to fissures with the private partner (as happened with diagnostic services in Bihar). This calls for greater capacity of the public system in supervising and managing the services contracted out which was lacking in the first place and which is why it was contracted out. This gives rise to a peculiar dichotomy which also needs to be addressed.
- c. In the Twelfth Plan, Public Private Partnerships would play an important supplementary function to the development and strengthening of the public health function. When constructing such partnerships, care would be taken to ensure the following key principles of engagement. One principle is that PPPs would supplement and not substitute existing public health systems. They would bring in fresh investment. That there would be a government or independent cell or team put in place to ensure that the terms of the MOU especially as regards, cost and quality terms are adhered to and there is no double charging, and to assess the public health benefits as envisaged are obtained. This includes assuring that the governments responsibilities in the MoU are also adhered to despite changes in leadership and payments are made promptly. Priority for not for profit providers of essential services should be built in for example, to recruit mission hospitals providing emergency obstetric care services where even the district hospital is not doing so to ensure cashless services and access to the poor. There would be also preference given to private sector units who are willing to get totally contracted in- thus becoming a public sector equivalent with private management. There would be also an effort in the district plan to indicate which set of essential services currently not available in the district public health system can be immediate purchased in from the private sector that is operational in the district- even if it is from commercial providers. Much higher levels of district programme management capacity would be required than currently available to be able to do such purchasing efficiently.
- d. The potential and need for PPPs in the Twelfth Plan period based on the evidence seems to be
- e. High potential and value in referral transport and emergency response systems,
- f. High potential and value in outsourcing of major support functions of the public hospitals.
- g. Low but important potential for outsourcing PHCs- as something which would add value in niche situations without it being posed as a general solution. Niche

solutions largely refer to a dedicated NGO or even a dedicated specialist wanting to take up such work in a PHC or block as part of a personal and organizational commitment. The system must flex to find place for such individuals and organizations- but these would be interesting exceptions only.

- h. Very high potential in NGO involved in community processes would be mandatory and bring in additional technical capacity and would be another major area of expansion of PPPs.
- i. Modest potential in purchasing care- where the element of care is well defined and easy to package, and where supplementary capacity is needed for the delivery of essential services- eg- cataract surgery, emergency obstetric care, trauma care, etc. Often such private options are either physically unavailable where public sector does not offer this service, or unwilling to be purchased at reasonable rates as they operate in a favorable market and would like to limit their clientele to those who can pay. But the contention is that there are enough providers, especially not for profit hospitals, mines hospitals, other public sector undertaking hospitals etc- who would be available for such purchasing of services and these opportunities would be maximized during this plan period.

9. Integration of Vertical Programmes and Performance of Disease Control Programme – TOR VIII and TOR IX

9.1. Five major National Disease Control Programmes (DCPs) are included under the NRHM umbrella. They include - Revised National Tuberculosis Control Programme (RNTCP), the National Vector Borne Disease Control Programme (NVBDCP), The National Leprosy Elimination Programme (NLEP), the Integrated Disease Surveillance Programme (IDSP) and the National Programme for Control of Blindness (NPCB). The following are the stated goals of the DCPs for the 11th Plan:

- i. Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012.
- ii. Kala-Azar Mortality Reduction Rate - 100% by 2010, sustaining elimination until 2012.
- iii. Filariasis/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012, elimination by 2015.
- iv. Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012.
- v. Cataract operations- increasing to 46 lakhs until 2012.
- vi. Leprosy Prevalence Rate –reduce from 1.8/10,000 in 2005 to < 1/10,000 thereafter.
- vii. RNTCP: Maintain 85% cure rate, also sustain planned case detection rate.

9.2. Integrated Disease Surveillance Programme (IDSP):

This programme now extends to all states and 618 districts. It has provision for gathering disease surveillance reports from every facility, analyzing it and organizing an investigation followed by necessary action whenever a disease outbreak is picked up.

9.3. RNTCP:

This programme reached a nationwide coverage in 2006, the second year of NRHM. The case detection rate which was 66% in the first quarter of 2005 has over the last five years increased to 71% (3rd quarter, 2010). Sputum conversion rates are over 90% and treatment success rate is 87%. Following integration with NRHM, systems response has improved with better laboratory support, more equipment, and an improved human resource situation. At the community level ASHAs are trained for DOTS provision. The ASHA evaluation study showed that about 80% of those ASHAs, who reported a TB case in their village, were DOTS providers, thus decentralizing DOTS providers to the habitation level. Building on this experience ASHAs are further to be trained in identifying the suspected cases

and also in sputum collection. However, with decentralization of DOTs, it is imperative to include infection control measures at all levels for safety of community and health personnel.

9.4. **National Vector Borne Disease Control Programme:**

- 9.6.1. **Malaria:** Malaria cases reported declined from 17.85 lakhs to 14.95 lakhs in 2010- with an adequate annual blood examination rate of 10 crores. The blood smear examination of the suspected cases has remained steady at 10 Cr. in 2006 and 2010. Highest numbers of cases were reported from Orissa, Chhattisgarh, Jharkhand, West Bengal and Maharashtra. Confirmed deaths reported into the system declined from 1707 in the second year of NRHM to 767 in 2010- but actual number of deaths would have been higher. The introduction of long lasting bed-nets in a massive way, a major increase in residual spraying, the training and empowering of ASHAs to diagnose the disease through Rapid Diagnostic Test Kits and provide Artemisinin Combination Therapy for treatment of Pf cases in endemic areas are all major initiatives which are expected to make further dents into this major problem.
- 9.6.2. **Filariasis:** Micro filarial rate declined from 1.24 in 2005 to 0.65 in 2009. The rate continues to range above 1.00 in Jharkhand, Bihar, Dadar and Nagar Haveli. Out of 20 states reporting the disease, 10 States have achieved a rate of less than 0.5 and a national goal of zero is achieved in Goa, Puducherry and Daman & Diu (0.07). As part of the control strategy in 250 endemic districts of 20 states 85.55 % eligible population are covered under Mass Drug Administration in 2010. This MDA campaign owes much of its success to community level sensitization, mobilization and drug dispensation by VHSCs and ASHAs.
- 9.6.3. **Kala Azar:** The disease is currently endemic in 48 districts, mainly in Bihar, but also a few in Jharkhand, Uttar Pradesh and West Bengal. The number of cases have declined from 32, 803 cases at the start of NRHM in 2005 with 157 deaths out of which 90% of deaths reported from Bihar to 28,610 cases reported in 2010 with 98 deaths out of which 90% deaths reported from Bihar. The NRHM has provided funds for prolonged hospital stay, for supervisory support, for community mobilization and for training and involving ASHAs in this process.
- 9.6.4. **Other vector borne diseases :** Japanese Encephalitis Dengue and Chikungunya reports an increase in incidence, but deaths due to these diseases are low and declining- about 667 for Japanese encephalitis, 110 for dengue and none for Chikungunya. Japanese Encephalitis Vaccination Campaign, launched in the second year of NRHM extends to 11 most sensitive districts and 86 endemic districts. In many states the ASHA and VHSC were used for reduction of vector density, and health workers for spraying and source reduction monitoring. Both rapid urbanization and climatic changes are contributors to the rise of these diseases.

- 9.5. **Leprosy:** Leprosy Prevalence rate has declined from 8.37 per 10000 population in 2001 to 0.77 per 10,000 population in 2010. There are still about 70,000 new cases detected, of which about 47% are the more infective multi-bacillary form and 9% are in children. But even this level of disease is decreasing.
- 9.6. **Non- Communicable diseases:** There are a number of new initiatives launched- for cardiovascular disease, stroke and diabetes, for cancers, for mental illness, for deafness, for flourosis, for tobacco control, for iodine deficiency disorders, for oral health and for occupational disease. There are also 243 highway based trauma centers which are established. Most of these except for blindness control are at an early stage of planning and implementation. Their integration into the district health plan needs to be planned. These programs may not be brought under the umbrella of NRHM as the non-communicable diseases require separate focus and attention. Bringing these under the umbrella of NRHM, at this point of time, may dilute the attention towards these programmes.
- 9.7. One concern of NRHM has been the horizontal integration of vertical programmes. The main vehicle of integration has been by bringing their flow of funds and their monitoring and reporting into the purview of the state and district health societies. They are also part of the district plan. This has been a major step forward. There has been a greater sharing of equipment and technical staff and infrastructure across the programmes and with the NRHM structure. The information systems and the vertical supervisory structures are yet to be completely integrated.. This level of integration is operationally convenient – and a greater operational integration may be gradual.
- 9.8. Flexibility needs to be built into the Disease Control Programme framework to align with State requirements and priorities. The reporting and performance evaluation system for the officers of various DCPs should have a clearly defined role for the Mission Director NRHM of the State to facilitate better integration and coordination. The policy and guidelines in different areas like HR, Infrastructure etc. of various DCPs should be synchronized.

10. Access to Drugs and technologies – TOR X

- 10.1. As there is a separate working group on this area, this working group report does not dwell at length on this area. There are broadly four aspects of concern to NRHM which are identified below as
- 10.2. Access to adequate quantity of essential drugs and technologies through the public health service.
- 10.3. Control of cost of drugs and technologies. This will lead to lower out of pocket expenditure in the private and public sector, and lower costs of care in the public system.
- 10.4. Rational use of drugs and diagnostics and health technologies.
- 10.5. Generation of new drugs and technologies that would improve health status.
- 10.6. *In access to essential drugs and technologies the major components are***
- 10.7. An efficient, transparent system of drug procurement and logistics benchmarked to the TNMSC
- 10.8. An improved system of equipment purchase, installation and maintenance.
- 10.9. Expansion of public health facilities and reduction of social barriers and costs barriers to its access.
- 10.10. *In Control of costs of drugs and technology availability the main components are:***
- 10.11. Adequate manufacture of drugs where necessary invoking compulsory licensing. Indigenous manufacturing capacities in health technologies. Development of more cost effective drug and technology solutions.
- 10.12. Drug price control mechanisms.
- 10.13. Bulk purchase by the public system- both for its own use and for distribution through fair price shops.
- 10.14. *Rational drugs and technology use.***
- 10.15. In Rational drugs and technology use the required interventions are
- 10.16. Creation of essential drug lists, drug formularies and standard treatment protocols.
- 10.17. Active promotion and monitoring to ensure adherence to rational drugs use in the public sector and investment in consumer and provider awareness to curb irrational prescription and consumption.

- 10.18. Legislation and administrative action to withdraw irrational drugs and hazardous drugs from the market and to curb sharp practices that misuse and over use technologies for unethical monetary gains.
- 10.19. For generation of new drugs and technologies the main areas of intervention would be mapping the gaps and opportunities- identifying the areas where innovation is needed to either reduce costs, or increase access, or address neglected problems. It also includes creating a favorable climate for generation and absorption of innovation, including the creation of a national technology assessment institution, comparable to National Institute of Clinical Excellence. This would help assess each new drug and technology in a fair, transparent and professionally competent manner, keeping costs and social dimensions included, before they are included in the national health programmes or approved for use. It also includes a policy for building synergy between different sources of innovation and knowledge generation.

11. Population Stabilization - TOR XI

- 11.1 The outcomes as regards the goal of population stabilization have been discussed in an earlier section. The main strategies for population stabilization has been to increase availability of a menu of contraceptives from which people could choose, to promote the small family norm, to push back the age of marriage, delay the first child and increase the spacing between children. It is certain that population stabilization should be an area of focus during the 12th Five Year Plan, All ministries e.g. Agriculture, Rural development, Railways, Road transport, Environment, Infrastructure sector, Women and Child development, Law and order (home) etc. get affected by ever growing population. Thus, population stabilization should not be the concern of Health Ministry alone.
- 11.2. In most States, the percentage of marriages below 18 and the first child below 19 has reduced appreciably largely related to advances in girl child's school education. Contraception promotion and use for delaying the first child is still minimal. The pattern, even in most States where there is a decline in fertility rates is therefore a first child soon after marriage, followed within two to three years by a second child and then option of sterilization- usually female sterilization. To address this pattern, there has been renewed emphasis given to spacing and the promotion of male sterilization – with the introduction of a new IUD with better training and non scalpel vasectomy as the main area in which significant advances were made. However, we are still well short of the limited objective of at least 10% of sterilizations being male sterilization and there is much more work to be done in this front. The Behaviour Change Communication (BCC) inputs have to be intensified for the promotion of spacing and male sterilization and pushing back the age of marriage.
- 11.3 There are however eight States where crude birth rates are above 21 and TFR above 2.5. – Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh Assam and Meghalaya. The situation amongst those accepting and accessing contraception services is the same as in the other States but there is still a large part of the population which is either not accessing or not accepting contraception for limiting family size. There needs to be a differential strategy for two contexts.
- 11.4. In the context of the high fertility States- the aim is for a massive increase in supply side provisioning for contraceptive services by both recruiting many private providers and by an intensive training programme on non laparoscopic based forms of sterilization. With the huge increases in emergency obstetric care loads in the public hospital consequent to JSY, gynecologist services are difficult to withdraw from the district hospital without immediately causing loss of lives. Sterilization camps based on laparoscopic sterilization need gynecologists and surgeons and become more difficult to perform. The common belief that JSY influences health behaviors in favor of larger families has no evidence. Studies indicate that JSY merely covers out of

pocket costs of institutional delivery thus enabling access to institutional services. Family's reasons for opting for institutional delivery or home relates to other factors like their perception of quality of care, the availability of transport etc. Similarly, the decision on family size too has little to do with the availability of this meager amount at the time of delivery and there is no evidence to the contrary.

- 11.5. Behaviour change communication (BCC) for promoting the small family norm is needed. What needs to be focused on is BCC for improved access to contraception- the how, rather than the why. Spacing methods including a greater use of IUD and oral contraceptive pills should be actively promoted, though sterilization services still remain the main strategy. Efforts will also be made to introduce injectable contraceptives.
- 11.6 In the context of all States the focus of population stabilization efforts is on a shift from sterilization methods to a variety of other methods and pushing back the age of the mother at the time of the first child and increasing the spacing between children. Contraception should become part of the routine package of services available at the block hospital, and the focus of public health efforts should be on counseling.
- 11.7 Availability of contraception of temporary methods – both condoms and oral pills – is best done through social marketing, supplemented by easy availability in public facilities. The ASHA as the main vehicle of social marketing is an approach that is being rolled out in a major way in the sale of sanitary pads and in contraceptives.
- 11.8 In addition to all the above strategies we should seriously consider the introduction of a mid-level service provider for conventional tubectomy, mini-lap and vasectomy services- a task shifting- that needs to be considered- only for the States where unmet needs are over 30% and simultaneously TFR is over 3.0. Task shifting too is an option. We note that in Maharashtra, AYUSH providers are legally permitted and they do provide this service and this could be one option. In these same States we should also consider a center- State jointly managed project for accrediting private providers for the provision of these services. This could extend to hiring specialized not for profit agencies that are active in this area.
- 11.9 For States that have already achieved a replacement TFR of 2.1 or less, the Planning Commission may ask all central ministries to set up a Population Stabilization Incentive Fund which will be used to additional allocation to these States/UTs. This fund will also be utilized to incentivize those States with high TFR which are taking positive steps towards controlling population growth. This additional allocation would be a kind of 'untied fund' available with the State governments, with the rider that with this money, works can be taken up in the same sector. This will incentivize the states which have checked their population growth or are taking effective steps to continue to maintain this. This will also encourage other states with high rate of population growth to take necessary steps urgently.

12.National Urban Health Mission– TOR XII

Meeting the public health challenges and the health needs of the urban poor

- 12.1. Conservative estimates show that 38 crore people are living in urban areas at present, which is projected to increase to 54 crore by 2050. This unprecedented urbanization brings with it influx of migrants, rapid growth of populations, expansion of the city boundaries and a concomitant rise in slum populations and urban poverty. As per NSSO estimates, urban poverty has risen from 15% in 1970s to 25% in 2004-05 (NSSO 61st round). The Planning Commission has estimated that 8 crore of the urban population is poor. However, the approximation of slums populations vary and city wise mapping accurate figures are needed for proper planning. The distribution of the urban poor is 41 % in the EAG states, 18% in Maharashtra, 9% in Tamil Nadu, 8% each in Karnataka and Andhra Pradesh with the rest of India contributing to 16% of the urban poor populations. Therefore, for planning and resource allocation prioritization should be done based on the number of urban poor.

- 12.2. As per Census 2001, 4.26 crore people lived in slums spread over 640 towns/ cities (population more than 50,000). There are more than 2 million births annually among the urban poor [Based on CBR 19.1 for urban population and 100 million urban poor] and the health indicators in this group are poor. 56% deliveries among the urban poor take place at home. Under 5 Mortality at 72.7 among urban poor is significantly higher than the urban average of 51.9. In addition, several health indicators among the urban poor are significantly worse than their rural counterparts. 60% urban poor children do not receive complete immunization compared to 58% in rural areas. 47.1 % urban poor children <3 are under-weight as compared to 45% of the children in rural areas and 59% of the woman (15-49 age group) are anemic as compared to 57% in rural India. The invisibility of the urban poor has contributed to their systemic exclusion from the public health care system. Lack of economic resources inhibiting/ restricting their access to private facilities, Illegal status, poor environmental condition, overcrowding and environmental pollution has further contributed to their poor health status.

- 12.3. Further, no systematic investments and efforts have been made to improve health care in urban areas. There has been a history of underinvestment with a project based approach instead of comprehensive strategy. The Public Health Network in urban areas is inadequate and functions sub optimally with a lack of manpower, equipments, drugs; a multiplicity of service providers, weak referral system and a focus on RCH and in-adequate attention to public health. Recognizing the

seriousness of the problem, urban health will be taken up as a thrust area for the 12th Five Year Plan. The National Urban Health Mission (NUHM) will be launched as a separate mission for urban areas with focus on slums and other urban poor. The NUMH core strategies include Decentralized Planning with the flexibility to develop city specific models, strengthening the urban health system and capacity building, communitization and development of partnerships with CBOs, NGOs, charitable organizations and other stakeholders, development of IT and e- governance systems for effective programme monitoring, evaluation and implementation, and focus on intersectoral convergence with other programmes like the JNNURM, RAY, etc.

- 12.4. The NUHM will ensure health services for all urban dwellers targeted on: urban poor population, living in listed, unlisted slums and other parts of the cities, identified by the urban local bodies; All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, and other temporary migrants; Public health thrust on determinants of health like sanitation and clean drinking water; and Correcting structural (infrastructure and human resource) imbalance of public health system in urban areas with a thrust on Urban Local Bodies (ULBs).
- 12.5. The NUHM is designed in a way that accords primacy to public sector for the provision of public health. It will be launched in 779 cities/towns (772 cities/towns + 7 metros), having a population of 50,000 or more including all district headquarters. Towns having less than 50,000 population will be covered under healthcare infrastructure/ system created under NRHM. Seven mega cities (Mumbai, New Delhi, Kolkata, Chennai, Bengaluru, Hyderabad, Ahmedabad) will be treated differently – their municipal corporations will implement NUHM. In other cities, District Health Societies will be responsible for NUHM. Flexibility will be given to states to hand over management of NUHM to cities/towns where sufficient capacity exists with ULBs. In the 12th Plan period NUHM and NRHM will be separate programmes which may be merged in the 13th Plan period or later. The budget allocation for NUHM in the 12th Plan period is envisaged to be approximately Rs 30,000 Crores.
- 12.6. At the Primary Care level, one Urban Primary Health Centre (U-PHC) will be established for every 50-60 thousand population. These U-PHCs will provide services to the entire urban population in their catchment's areas. At the community level, outreach services will be provided to the urban poor in slums and other vulnerable population. An Urban Social Health Activist (USHA) will be posted for every 200-500 households and a Mahila Arogya Samiti (MAS) will be established

for every 50-100 households. The MAS will be provided an annual united grant of Rs 5000 per year.

- 12.7. Creation of Sub Centers has not been proposed. Outreach services will be provided through Female Health Workers (FHWs)/ANMs headquartered at the U-PHCs, utilizing community halls, AWC, etc., as fixed points for these services. Communitization through Mahila Arogya Samiti (MAS), Rogi Kalyan Samiti (RKS) and Urban Social Health Activist (USHA) has been envisaged. Secondary and Tertiary level care and referral services will be provided through public or empanelled private providers. A National Program Management Unit (NPMU) has been envisaged for effective implementation and continued monitoring of the NUHM. The proposed framework provides for active need-based engagement with the private and the non-government sectors.

- 12.8. NUHM also envisages an effective monitoring and evaluation framework - regular monitoring at District/ City and at State level by the respective PMUs, Societies and Mission and feedback. A web based M&E framework effectively integrated and leveraging MIS of other National programmes like IDSP is also proposed along with baseline and end line evaluations, and community monitoring through Rogi Kalyan Samiti/ Mahila Arogya Samiti.

13.A. Gender Concerns in the Health Sector - TOR XIII

The report of the working group on NRHM has addressed gender concerns related to this sector and many places in the report. In this section we do a round-up of all these concerns as gathered from the different sections and some more issues that need to be addressed.

- 13.1 The single greatest concern is the declining sex ratio in the 0 to 6 age group. The Twelfth Plan should give priority to an effective implementation of the laws in place to curb illegal sex determination and sex selective abortion. It would combine this with action taken to raise awareness against son preference attitudes. It would also address the problem of the neglect of the girl child leading to higher child mortality on girls by orienting the ASHA, the VHSC and other community processes for greater efforts to promote appropriate care seeking for the girl child.
- 13.2 The programmes that address the needs of adolescent girls have been sub-critical. The Twelfth plan would make a major effort to improve the range and effectiveness of programmes addressing adolescent girls. This would include adolescent health clinics and would include correcting malnutrition and anemia in adolescent girls through a well focused effort reaching out to both in-school and out of school girls.
- 13.3 Population stabilization programmes should aim to empower women to make their own choices on when they would have a child and also on how many children they would have. This means much more effective counseling and much easier access to contraception. It would also mean a rise in the proportion of male sterilizations and the use of methods that involve greater and more informed male participation. Delaying the age of marriage and pushing back the age of the mother at the time of the first child birth are also very basic requirements for women's health and women's rights. Adequate spacing between children is also essential to safeguard health of women and access to counseling and contraceptives for enabling this is a women's right.
- 13.4 There shall be universal access to safe and quality abortion services. The same criterion of universal access as stated for emergency obstetric care applies.
- 13.5 Making hospitals women friendly, in terms of amenities, ensuring privacy, maintaining dignity would be a mandatory part of every quality assurance system that is put in place.

- 13.6 The Twelfth plan should lead every district to provide universal access to quality reproductive and child health care. This would include the availability of assured referral transport and a site for basic services within 30 minutes to an hour of every habitation and an emergency obstetric care center within one hour of any basic obstetric facility.
- 13.7 Every village health sanitation committee would have at least one thirds, preferably 50% representation of women.
- 13.8 Not only are all ASHA's to be women, their immediate supervisors are also to be all women. ASHAs would have grievance redressal cell that is functional. When they go to a facility, there must be a place where they can stay and rest.
- 13.9 All women employees must be assured of the following as part of their terms of employment: maternity entitlements, privacy, freedom from harassment, a functional grievance redressal mechanisms and ASH committee and equal opportunities for career advancement.
- 13.10 There would be a greater emphasis on rolling out programmes related to the prevention and a health system response to gender –based violence.
- 13.11 A few carefully chosen indicators should be deployed to trace gender disaggregated patterns where it is relevant- e.g. on full immunization rates, on OPD or IPD attendance, on mortality etc. The same or even better quality of information and action is made possible by the correct choice of a few select indicators. It would be important to start using existing gender disaggregated data for action, even without waiting for more- e.g. in differential mortality rates.

13. B. Accountability Framework - TOR XIII

- 13.12 The NRHM aims at providing effective, affordable and equitable health care to the rural population, especially the vulnerable sections including women and children. It creates certain entitlements and service guarantees. The Mission has a robust social accountability mechanism and seeks to actively involve people in the public health system not only as consumers but also as key stakeholders involved in planning, decision making, and monitoring to ensure community ownership.
- 13.13 Further, in the 12th Plan Period, a system of constructive accountability is envisaged with the aim of bringing about improvements in the public health system rather than holding people accountable in order to reprimand them or take other punitive measures. An accountability framework needs to be built with clearly identified responsibilities for all stakeholders at all levels. Involvement of communities should

be strengthened to ensure that the accountability framework is implemented effectively.

- 13.14 The principles of good governance and transparency are to be emphasized and practices such as display of expenditures on the district and State websites as well as at the facility level on a monthly basis could be mandated to ensure transparency in the 12th Plan. The accountability framework should include managerial as well as financial accountability. Physical progress on monitorable targets should be evaluated periodically. Territorial responsibilities of Medical Officers and Programme Managers should be fixed and their performance monitored and appraised. The Logical Framework Approach could be used to identify and quantify inputs, outputs, outcomes and means of verification.
- 13.15 The financial management process and financial monitoring at both State and district level will need further strengthening. It must be ensured that funds are utilized as per the mandate and not diverted or substituted. Capacity building to demand and facilitate accountability would be encouraged. In the 12th Five Year Plan, NRHM should realize a positive connotation of accountability with the aim of bringing about concrete improvements in public health care services.

Key Recommendations and Budget Proposals for the Twelfth Five Year Plan

I. Setting Objectives for the Twelfth Five Year Plan

1. “The Twelfth Plan will build on the successes of the NRHM in treating healthcare as a system of preventive and curative medicine. Thus, universal health would include all aspects of a clearly defined set of healthcare entitlements including preventive, primary and secondary health services. In setting targets for achievement in the Twelfth five year plan period, we must re-examine the methodology used to arrive at the Eleventh five year plan- targets, especially for the states. State specific targets will be set for reduction of IMR, MMR, TFR and disease prevalence. In case of IMR, target for each State will be to reduce IMR by 40% and MMR by 55% over the 5 year period of 12th Plan. Similarly for TFR and disease control programs, state specific targets will be set in the MoU to be signed with the states
2. At the national level, we could “repeat” the following targets:
 - a. Reduction of MMR to < 100 per 100000 live births.
 - b. Reducing IMR to < 27 per 1000 live births.
 - c. Reduction in NMR to < 18 per 1000 live births
 - d. Reducing TFR to 2.1
 - e. Providing clean drinking water for all by 2017
 - f. Reducing wasting among children of age group 0 to 3 to half its present level
 - g. Reducing anaemia among women and girls by 30% with a 50% reduction in moderate and severe anaemia in pregnant women.
 - h. Raising the sex ratio for age group 0 to 6 to 950 by 2016-17.
3. In terms of service delivery goals, we could aim for the following:
 - a. Over 80% institutional delivery in high focus states and over 95% in non high focus states and 100% safe delivery in all states.
 - b. Over 80% Immunisation in all states with over 95% immunisation in non high focus states.
 - c. Over 90% antenatal and post natal care in all states with 100% in non high focus states.
 - d. Met emergency obstetric care rate of over 50% to be provided in a cashless manner. (15% of all pregnancies are the expected complications in pregnancy rate and the number of complications managed is the met emergency obstetric care rate. When institutional delivery is being demand driven this may be a better indicator of what is happening to maternal mortality.)
 - e. Universal access to safe abortion services
 - f. Meeting the unmet need for contraception with equal emphasis on spacing and limiting methods

- g. An average public sector OPD attendance in each district of 2 per year per capita for the district. At least 70% of this load should be managed in the PHCs and CHCs.
- h. A bed occupancy rate in each district of over 70% for in-patients.
- i. An assured referral transport system between facilities and an emergency response system in every district.
- j. Access to emergency life saving services and trauma care in every district.
- k. Free distribution of medicines as per the Essential Drug List and basic diagnostics should be provided free of cost in public sector hospitals.

II. Resource Allocation and the District Health Plan

1. Achieving the above health outcomes and service delivery outcomes would require an estimated health expenditure that would be 2.5% of the GDP or approximately 3 lakh crores over the plan period.
2. Current pattern for determination of Resource Envelope of States under NRHM will be continued. States should allocate higher resources to the high focus districts to bridge the gap between the high focus and the non high focus districts.
3. The district NRHM grant would have five components- One part of the sum allotted would go to finance the *community processes costs*- ASHA programme, the VHSC, the BCC activities, and action on social determinants. Another part of the sum allotted to districts would go to every health facility as *institutional support costs* (equivalent to the current untied funds, RKS fund and maintenance fund and up-gradation funds as of now plus costs of supervision and quality assurance and training costs – to be spent within and by the district) – and a third part would be a district level untied fund to be used to pay for *institutional operational costs* of hospitalisations and outpatient case load at the block PHC or CHC, SDH and DH. This could be made available per institution as reimbursement for in patients seen over and above a minimum specified case load. The operational costs includes referral transport costs where admissible, includes costs of drugs and supplies (provided in kind to facility, but with costs booked against the facility in the TNMSC approach); costs of local support staff and services- diet, security, cleanliness, sanitation and laundry; and where admissible provider incentives. The fourth component is the *demand side cash transfers* (JSY and sterilisation compensation). The fifth component is the *skilled HR costs* and this is made against a district HR plan that would be able to link additional HR to additional work outputs expected. The district HR plan would also bring clarity on what part the state government is paying for, and what it is committed to taking over the payment for in the future. The HR plan would ensure that HR is deployed keeping both case load and equity considerations in mind and that there is commensurate increase in service delivery outputs for additional human resource deployment. The institutional costs- support and operational could be used for purchase of some services from private sector, which is not available in public sector, but available in the private and judged as essential and complementary.
4. In return for this district grant, the district would have to ensure that within the first three years, the minimum standards of universal access to quality RCH services would be achieved and there would also be progress on achieving standards of access to three more packages of care as defined in their district plan towards- a. emergency medical and trauma care and b. care for infectious disease and c. for chronic diseases over the plan period. An MOU between the State and District Health Society and the District Health Society would be useful to give clarity on what is expected as the

outcomes and to make explicit and public the road-map on which the district is expected to proceed towards universal health care. The strategic five year district plan must be the road map for providing assured universal preventive, promotive, curative and rehabilitative care needed for a population within the district itself- with only very few disease conditions requiring highly specialised care needing to go outside the districts. Areas within the districts and districts which are more marginalised or have greater problems of access would receive a greater investment of human and financial resources.

5. **Assured services- building a district road map:** The Twelfth Plan thus envisages that every district would announce as part of its five year strategic district plan, the package of services each facility would guarantee such that taken together the district health system would ensure universal access to a good quality of comprehensive RCH services, emergency care and trauma related services, infectious diseases management and chronic disease management. Such a district plan would become the instrument to be used for programme audit by the government and for social audit and community monitoring purposes.
6. While the States should be allowed flexibility, quality assurance should be standardized across all the States.
7. To achieve minimum standards of universal access to quality RCH services, every sub-centre, PHC and CHC is not expected to develop equally. A number of health facilities within the district will be prioritised for development such that between them they could ensure that there is access on a 24 * 7 hour basis to a skilled birth attendant, to basic and comprehensive emergency obstetric care and corresponding levels of safe abortion services, institutional care for sick newborn and sick child, and for RTI/STI management and contraceptive services. This system should be interconnected by referral transport, such that once the user enters the public health system at any point, the facility network acts as a single unit to provide the appropriate level of care, wherever it is available. This first point of entry or contact should be within 30 minutes - preferably by local transport – but at least by an assured referral transport system. For remote and underserved areas such timely access is not possible, provisions must be made for birth waiting rooms where a one week or two week stay anticipating onset of labour is possible. Services to pregnant women and sick neonates should be made available free of cost in public sector facilities. There should be no withdrawal of existing services in other facilities. Sub-centres and PHCs not prioritised for delivery services or emergency obstetric care will still have to perform outreach functions and out-patient clinic management.
8. The quality of RCH services provided would be based on minimum standards laid down and would emphasise the processes that need to be in place and the use of clinical protocols of care. This should qualify the facility for a higher rate of payment of “*institutional operational*” costs. Periodic evaluation of quality parameters will be

undertaken at all levels. Rational Prescription of drugs, use of generic medicines, standardised clinical protocols which are subject to medical audits are to be mandated.

9. The district plan would also specify the development of care for emergency medical services and trauma care. This will be funded by a national programme, which would expand to all districts in the Twelfth five year plan. Similarly the district plan would also specify the facility development required to implement the national disease control programmes as well as the respond to district specific infectious diseases, based on epidemiological data. Finally the district plan would also specify the facility development plan in order to provide care to chronic diseases. In setting priorities for facility development and for action on social determinants and preventive action for each of these three areas of care- community participation play a major role in deciding the content of the package and in the choice of the technology. The choices cannot however be driven by community alone, for the system must have the capacity to respond, and public health considerations will need to be taken into account. Therefore the community representatives, the district health management, and public health experts, would have to enter into a dialogue to finalise the priorities of packages and facilities. Districts which have already achieved universal access to RCH care could rapidly advance to make the same assured services available in these three areas as well.
10. In financing district level care for emergency services, infectious diseases and chronic diseases the same approach as suggested for RCH, could be applied, i.e., show the community process costs which includes preventive action and action on social determinants, the institutional support costs, the institutional operational costs, the demand side cash transfers required and the skilled HR costs separately and then resource allocation is made to the facility based on the volume and package of services provided. For top management, the advantage of this approach is that it will help correlate financial expenditure (inputs) with outcomes in terms of service delivery improvements. For the grassroots, it would enable the system to respond to community expectations generated by participatory planning. This could also be shaped to help close the gap between vertical programmes and the convergent district plan as well as to close the gaps between programme implementation (eg RCH plans) and facility development (NRHM plan).
11. Development of emergency response systems and development of referral transport systems – two distinct but overlapping objectives is also an important part of the district plan. The former is more resource intensive and addresses trauma care best, then emergency health care needs and currently plays a limited role in referral transport for pregnancy. Voucher based partnerships with local small scale public transport service providers like the Janani express of Orissa are quite effective in referral transport for pregnancy, but do not constitute an emergency response system. The department would develop guidelines for developing an appropriate system of emergency medical transport for all the districts.

12. Since it is unlikely that all these areas of care can be developed upon, even in a selected number of facilities in most districts, the only facility where we should aim to provide *assured services* in all four of these areas is the district hospital. The Twelfth Five year plan should specially emphasise that all 640 district hospitals would provide a minimum level of assured care in all these four areas- RCH, infectious disease care, emergency medical and trauma care and chronic disease care. The district hospital must provide advanced level of secondary care. Where the district hospital role is being played by a medical college hospital or where the district hospital has been handed over to support a medical college, it should continue to attract the financial support from NRHM that a district hospital would have got. Since the district hospital also serves as human resources development centre in a number of areas, there is even greater urgency to get in place a district hospital which can be the standard of excellence in the use of standard clinical protocols of care, and in quality management systems which provide certified level of quality of care. In the past, the district hospital has been relatively neglected in financing, and as a result the increasing case load is addressed with decreasing quality of care. There is a need to de-pressurise the district hospitals from primary care work, but even if we decentralise and distribute primary care, as a consequence of doing so, secondary care needs would rise high enough to merit such a major investment in the district hospital.
13. When planning for the district hospital- in infrastructure, staffing and organisation of work, it would be the endeavour to also develop the district hospital as a district knowledge centre for training on a broad array of health workers including nurses, mid-level health workers, paramedicals, and other public health and health management professionals. In many larger districts, these would also be developed as hospitals attached to medical and nursing colleges.
14. There is a need to differentially plan for the health sub-centre and also for its human resources. In upto 10% Sub-Centres where deliveries are taking place, an additional ANM may be provided taking the number of ANMs posted in such centres to two. Thus, in such sub-centres there would be two ANMs and a male paramedical worker who would be supported by ASHAs as the community mobiliser. The ASHAs would provide for all preventive and promotive care – which would include not only provide antenatal and postnatal care for approximately 125 pregnant women and immunisation and health care for 500 children below 5, conduct RDK test for individuals with fever, but also screen every person over 30 for hypertension and diabetes annually, and ensuring that those with hypertension and diabetes are referred and maintain control etc. They would also promote tobacco control, prevent and support disability. In all other sub centres there would be one ANM and one male paramedical worker. The ANMs would also provide school health in the primary or middle school in their area and adolescent counselling and services to every eligible couple.
15. Careful resource allocation to the districts and facilities along these lines should lead to substantial reductions of out-of pocket expenditures for all elements of care as

provided by public health facilities and this improvement in the social protection function of the public health facility would be measured and reported upon. The JSSK is a welcome first step in this regard- eliminating OOPs in care for pregnant women and newborn- but it should gradually extend to more and more dimensions of health care delivery. Without such a commitment, it would be difficult to eliminate OOPs for only select categories of care. The government would consider a situation in which most categories of drugs on the essential drugs list and most diagnostics when used in consonance with standard treatment guidelines would be available for free.

16. All of the above steps require a higher degree of institutional capacity for planning than has been available hitherto. Such institutional capacity needed for effective district health planning would include skills in epidemiology, health care financing, quality assurance systems and human resource development, systems of generation and use of real-time information validated by both external surveys and community feedbacks and an institutional memory of past plans, outcomes and constraints and systems of resource allocation which are responsive to the planning effort and performance audit based on the district plan. One of the challenges of the 12th five year plan would be in building up such district level capacity. Focus on development of faculty and capacity in public health, planning and management at all levels, an improved functioning of state level resource centres and other technical support units, the development and expansion of courses in public health which are multi-disciplinary, open to physicians and non physicians, problem-solving oriented, attuned to the needs of district health systems and made available both as a full time option and on distance education formats, are all essential supplementary strategies needed to develop this capacity.
17. Untied funds and RKS grants will be merged and named as Untied Funds which will be utilized as per the decisions of RKS.

III. Infrastructure Development

1. Infrastructure development would be parallel with the facility development priorities as discussed above. Further expansion in sanction of new facilities other than sub-centres should be undertaken only when mapping of access demonstrates the need for new facilities to improve accessibility. In public hospitals we need to add more beds and staff in existing facilities than add more secondary care hospitals- provided a minimum base line –of at least one 30 bed hospital per block is met. A norm of minimum 500 beds per 10 lakh population in an average district (additional 100 beds for every additional 10 lakh population in the district) could be followed such that 200 beds are at the level of District Hospitals and the remaining are distributed judiciously at the CHC level.
2. Presently, we are following the norm of one sub-centre per 5000 population in general and one sub-centre in 3000 population in hilly areas. The provision of healthcare should move closer to people to enable easy and timely access to quality care. The approach paper to the 12th plan mentions that the aim should be to locate a Sub Centre in every Panchayat, If the sub Centre norms are aligned with the Gram Panchayat it may result in the reduction of the number of Sub Centres in some States, as the average population covered by a Gram Panchayat is much more than 5000 in these States. Hence, there would be provision for at least one health Sub Centre in every Panchayat and if the population of the Panchayat so requires, there may be more than one Sub Centre also. In hilly/tribal/desert areas the existing norm may be further relaxed to ensure that the people do not have to travel long distances or for long durations to reach the health Sub Centres.
3. Ideally one must be able to access the health services in their village itself. For which, we require a long a long term goal of setting-up of one sub-centre in each village. However, since there are constraints of skilled manpower this may not be possible to achieve in the Twelfth Five Year Plan, the number of sub-centres would be increased as per the current norm to meet the needs of increased population as per the Census 2011 figures. A dispensation will be made whereby the villages in hilly and hard to reach/ inaccessible areas will get health sub-centres at a further relaxed norm.
4. For PHCs (that serve 30,000 population), the increase in population within a village should be met with more staff in existing PHC. Infrastructure development must be prioritised accordingly by taking into consideration both population served and standards of access. Those large blocks with population above two lakhs, where only one or two PHCs are functional, must be given the priority for facility development- combining both construction of new PHCs where needed and revitalising existing PHCs which have become moribund.

5. NRHM and Eleventh five year plan made a commitment to move towards an FRU in every CHC. The gap in the High Focus States is larger than in other States and this should be bridged in the Twelfth Plan. Optimum functioning of the existing FRUs needs to be ensured to provide referral services for maternal and child health. Similarly, the District Hospitals need to be strengthened to provide advanced secondary level of care.
6. Every state is to develop a team to manage infrastructure development and they must be trained and certified by an appropriate agency to understand the needs of hospital design, as well as the intricacies of tendering, contracting and quality control. This team shall then be deployed to plan, contract out and supervise the construction of the health facilities and ensure that is achieved with quality. Third Party monitoring of infrastructure projects should be undertaken to ensure quality of work. A sub-centre which by its location in relation to PHCs and CHCs is unlikely to become a site for midwifery services would be built without the labour room but for the most part, the design of the buildings is the same as currently recommended. It is only the priority of construction that would change to meet the needs of achieving assured universal access at the earliest. The state plans should indicate a clear road map to complete the infrastructural gaps for health care delivery by the end of the 12th five year plan period- and this should include a rational prioritisation plan- so that the most urgent gaps are filled first.

IV. Human Resources for Health

1. In the generation of human resources- the effort would be to give preference to candidates from districts which are “HR-constrained” for admission into training schools for ANMs, nurses, para-medics and medical doctors set up in these districts/divisions. If the seats remain vacant, candidates from other districts/states may be considered subject to signing a bond with adequate security amount for serving in the district for 5 to 10 years. The second major effort would be to open publicly funded institutions within states which have a major short-fall of educational institutions. A third effort would be for faculty development and accreditation and support to the faculty of both public and private institutions.
2. Present recruitment process calls for major reforms to speed up recruitment process to fill up the vacant posts. State Governments would be encouraged to carry out reforms in this area. States where graduates from government accredited private nursing and medical education institutes are not eligible for government employment may consider doing away with these conditions to improve availability of health human resources.
3. Implementation of human resource policies which ensure transparency and fair play, regarding place of posting, transfers, promotions, would need to be clearly articulated and effectively implemented by the States. The creation of minimum posts needed (as defined by IPHS) in the state non plan budget and the gradual movement away from contractual appointment to regular recruitment should be the major direction. Each health Sub Centre will have one ANM and one multi –purpose worker (Male). Additional ANM will also be considered for upto 10% of Sub Centre having high delivery load.
4. Clear roles of ANMs, ASHAs and AWWs would be articulated and a more effective supervisory role of ANMs on ASHAs is envisaged. Similarly, role of Male Multi-purpose worker would also be clarified.
5. A package of financial and non financial incentives should be considered to attract and retain skilled workers in difficult, most difficult and inaccessible areas. A ceiling of 30% of total number of facilities in high focus states and 15% of total number of facilities in other States would be there for provision of such incentives. The facilities located in such areas will be identified by the State Government in consultation with Government of India. “Efforts would be made to improve the working conditions and remunerations of all frontline workers- both contractual and regular- and build positive practice environments which will reduce their sense of isolation.”(approach paper quote)
6. A nursing division at State level with proper staffing and with distinct responsibilities for both ANM and GNM should be developed. Simultaneously, developing mid-

wifery cadre, developing public health midwives and creating management/supervisory cadres of midwives will be focused in the twelfth plan.

7. The network of training institutions- for skill based in-service training and for training of multi-purpose workers would have to be revitalised. The capacity of these training institutions should be adequate for them to be accountable for all those in service provision in their allotted districts to have the necessary skills. Non governmental institutions could also be encouraged to participate. A scheme for faculty development and quality assurance in all the training institutions and training programmes would be put in place. The outcome/impact of all training programs will be monitored. Use of Information Communication Technology should be encouraged at all levels. A pool of dedicated trainers at State and district level for supervision, monitoring and hand holding of trainees should be developed. Performance monitoring and organising CME/ refresher courses for updating knowledge and skills of the health personnel should be done.
8. District hospitals should also function as training centres. Medical colleges should be linked to the district public health system for technical assistance and program monitoring support.
9. In the high focus districts of the high focus states, the training requirements are very high, but internal capacity to accelerate current rate of achievement is very limited. We need training in every aspect of RCH delivery- conventional tubectomy and mini-lap, non scalpel vasectomy, IUD insertion, RTI/STI management, safe abortion services, sick newborn care, management of nutrition rehabilitation centres- other than the core of skilled birth attendance training and training in emergency obstetric care. Not only do we have to catch up with these basic skills, there is also the need to train and deploy supervisors who can ensure that clinical skills taught are practiced and who can provide on the job training. Further, there is a mind-set in training and in work culture that would have to be contended with, if a change has to be brought around in the quality of care. For these reasons, as a supplement to the training institutions and their faculty, a number of suitable agencies should be hired from all over India, train and support additional training faculty who shall work in the training institutions of the poor performing states to improve the quality and number of skilled workers. The training faculty should also act as motivators and change agents in the way such services are provided. Such an infusion of fresh blood and skills into the training hierarchy will cost resources and will need active cooperation of many public health institutions and civil society organisations but potentially it can help. After a two to three year period when this additional faculty go back, the local training teams would have become functional. Those who do opt to stay could be retained.
10. There would also be major initiatives in multi-skilling, in skill upgradation in-services and pre-service programmes leading to the creation of many mid-level cadres. ASHAs could be given preference in admissions in ANM schools and ANMs could be given extra preference in admission to GNM/Nursing Schools. Adequate weightage may be

given to knowledge, skills and training already received by these ASHAs/ANMs over the years to reduce duration of course for them. Paramedicals in laboratory work, pharmacy, radiology, and even dressers and supervisors, could get multi-skilled to play the role of a multi-skilled paramedical who provides a comprehensive support to clinical services at the PHC level. Similarly, ANMs could be upgraded into staff nurses in places where ANMs are working, but staff nurses are not available.

11. Efforts of State Governments to start three year course of Rural Health Practitioners would be encouraged. All these measures for creation of mid- level cadre or multi-skilled cadres would be a priority in the Twelfth Plan.
12. There is a need to re-introduce specialist public health nurses, and merge the now almost defunct LHV programme into this. A special national level faculty development programme for ANM and nursing schools and well equipped skill labs in all district training centres to refresh skills and on the job training support are all essential for improving the quality of nursing and midwifery services.
13. In the mid-level provider training programmes discussed above there are four important things to be considered: 1. The trainee must be from the areas where their services are required. The best proof that they would go to work in these areas, is that they are already working in these areas with commitments to stay on there. 2. The training prepares them and certifies them for service in the public system and not to enter into the general provider market, that too in the over-crowded provider situation of urban areas. 3, the training content is carefully oriented to the needs of the situation they would occupy, preferably in the state language- as this would help retention. 4. The training institution should be as near their residence and final work place and enable considerable practical postings in this area. If new cadres are created without attention to these important considerations, it could create numerous problems of its own.
14. One area of human resource development that would be addressed by building it into all training programmes is gender sensitivity in all service providers and in all facilities. The need for starting up of help desks and public grievance mechanisms and indeed the understanding of health rights must be part of the consciousness of every service provider- more so in the public health system which caters to the poorest and most marginalized sections of society.
15. One concern is that almost half the doctors and nurses in the public health system and almost all the skilled professionals added on in the eleventh five year plan period are on contractual basis. This has advantages in the short term and needs to be retained and their workforce issues and performance managed more professionally. But there are disadvantages related to both in house skill upgradation and retention of such staff especially after skill upgradation, and in the long run to both quality of care and system performance. Contractual appoint is therefore not to be seen as a substitute to developing sustainable health care capacities and the state level for which states

would need to invest in expansion of sanctioned posts in the facility level- in line with the IPHS recommendations. The approach paper indicates a desirable threshold of 2.5 health workers per 1000 population– counting only midwives, nurses and doctors. There is also a desirable ratio of three nurses and midwives to one doctor. Even with full implementation of the IPHS recommendations and counting in the qualified private sector, most districts would have their skilled worker strength well below this norm and this understanding should inform states when planning for their human resources for health.

16. The Twelfth Plan should thus begin with states adopting a plan for human resources for health which commits to reaching the IPHS in human resource deployment and builds a road map to achieving this. The plan would also “establish a human resource health management system for improved recruitment, retention and performance, rationalise pay allowance and incentive structures, and create career tracks for competence –based professional advancement.”(approach paper quote)
17. The ongoing programme of mainstreaming AYUSH would be continued. Both co-located facilities and the stand alone AYUSH facilities should continue to be strengthened. A clear road-map for mainstreaming of AYUSH should be developed and role of AYUSH doctors need to be defined and a policy on the same needs to be articulated for guidance.
18. The main direction of mainstreaming is to give service users a choice of both systems and make AYUSH services easier to access. Efforts would be directed towards better integration of AYUSH with Primary Health Care system for meeting public health goals.
19. Inclusion of information on AYUSH services and their utilisation in surveys should be introduced. Similarly, information on utilisation of AYUSH services in the facilities where AYUSH has been collocated under NRHM should be incorporated in the HMIS.
20. In the proposed budget for the Twelfth Five Year Plan, requirement of Rs. 2332 Cr has been projected for AYUSH doctors. Provision has also been made for engaging AYUSH paramedics and training of AYUSH manpower, which is a part of the overall Human Resource and Training budget and has not been quantified separately for AYUSH.
21. The representative of Deptt of AYUSH during discussions in the Working Group, and subsequently followed up through a written communication, pointed out that with the present system of release of funds under NRHM, the objective of mainstreaming of AYUSH as set out in the National Policy ISM&H, 2002, and as included as part of NRHM mandate, was not having the desired impact at the State level, since health is a State subject and States are free to set their own priorities from the funds received by them. The Deptt of AYUSH further pointed out that in the light of this position, the states when faced with shortage of resources to the extent sought by them, quite often

tend to restrict the outlay in the AYUSH sector. The Department of AYUSH, therefore, has proposed allocation of Rs. 10160 crore for earmarking out of NRHM fund for the man power requirement and training for AYUSH personnel for mainstreaming of AYUSH.

22. Earmarking of funds under NRHM for AYUSH activities, as suggested by Department of AYUSH is not possible since it runs against the basic tenet of NRHM. States decide what activities are to be taken up during the financial year. As proposed by Department of AYUSH as an alternative, the Steering Group may take a view to allocate the funds separately to Department of AYUSH. In that case it would become necessary to rework the strategy for mainstreaming of AYUSH under NRHM mandate. The projected requirement for NRHM will reduce by Rs. 5000 Cr (approx), which can then be allocated to Department of AYUSH for promotion of Indian Systems of Medicine in the country.
23. Family Medicine should be treated as a specialist discipline. This would help in better provision of primary health care at CHC level.
24. Availability of paramedics like Optometrists, physiotherapists, dental hygienists and Multi Purpose Workers will be improved by focussing on increasing and strengthening of paramedical and MPHWSchools.

V. *Procurement and Logistics*

1. Procurement and logistics should be built up similar to the TNMSC, where the emphasis is on ensuring uninterrupted drug supply at the facility level with the district warehouse as the hub, where the supply is responsive to the pattern of needs and forecasting of the needs is no longer necessary except for some items like vaccines which have limited availability in the open market. The procurement system allows huge cost savings and ensures very good quality and safety in drug purchase. This is a good example of the balance between centralisation and decentralization, with rate contracting done at the state level to gain economies of scale and ensure quality and safety of drugs done centrally where such and the district being the unit for which orders are placed and to which supplies are sent, where such supply is responsive to actual consumption patterns. Minor equipment (thermometer, hemoglobinometers, weighing machine, BP apparatus, colorimeters, Hb pipettes, wall mounted tapes, etc.) should also be a part of the essential drugs and supplies list and should be purchased, stocked and procured on similar lines to drugs.
2. A central procurement authority is being set up at the national level. This would ensure that all central procurement adheres to the highest standards of quality and transparency and that states are supported in terms of capacity building and regulation with regard to procurement for the public health sector.
3. Efficient procurement and logistics system needs to be supplemented by an essential drugs and supplies list, a state drug formulary that is based on this list, and standard treatment protocols – all printed in adequate quantities and supplied to each facility with a fixed periodicity of not less than once a year. This has to be accompanied by advocacy and promotion of the concept of rational drug use and prescription audits to monitor improvements. Additional technical capacity has to be recruited or this process of advocacy and audit outsourced. Otherwise given all the other deadlines and commitments, and the existing mindsets, this task would get marginalized.

VI. Programme Management

1. To avoid duplication, and enable a holistic approach to health, convergence among all the existing National Health Programmes, including Urban Mission, HIV- AIDS control and of the State Directorates with existing NRHM set up would be focused on.
2. Set up for policy making as well as implementation will be strengthened at Central as well as State level for better planning, implementation and monitoring.
3. The State programme management unit and the district programme management units function as the implementing structures and secretariat of the state and district health societies. Better integration of State and District Health Program Management Units with State Health Department at various levels will be focussed on. An expert committee has been set up to look into the issue. The state and district programme management unit should not only have the contractual staff- but both regular programme officers and contractual management or public health consultants or contractual staff working together.
4. The NRHM has in place the annual common review missions and the joint review missions, the concurrent evaluation process led by the IIPS, and the number of studies and evaluations done by the international advisory panel, and various national institutions. The SRS, the NFHS and DLHS and now the annual health surveys also provide important health data. These would be encouraged and strengthened.
5. Mandate of NIHFW and SIHFW should be expanded to include health promotion. SIHFW could play a role in skill development, and provide technical assistance like an SHSRC and also provide leadership to community process like an ASHA or community process resource centre. A process of capacity development and apprenticeship in knowledge management for each of these structures using the best of national and international public health and management experience would also be necessary, since states may have insufficient internal capacity to grow and guide these three institutions.
6. Territorial responsibilities of Medical Officers and Programme Managers should be fixed and their performance monitored and appraised. An accountability framework needs to be built with clearly identified responsibilities for all officers at all levels. Involvement of communities should be strengthened to ensure that the accountability framework is implemented effectively. The principles of good governance are to be emphasized and practices such as display of expenditures on the district and state websites on a monthly basis could be mandated to ensure transparency in the 12th Plan.
7. Logical Framework Approach could be used to identify and quantify inputs, outputs, outcomes and means of verification.

8. The financial management process and financial monitoring in both state and district level will need further strengthening especially if the proposed form of district financing is undertaken..
9. The health information management systems must support regular analysis of data and providing the same at decentralised level to help in decision making at State, district and sub-district levels. Information systems would need at a minimum to integrate service delivery information and death reporting (which is the current HMIS), with hospital information systems, disease surveillance systems, human resource management systems, finance management systems, drug inventory management systems, and information for private sector regulatory systems, e.g., PCPNDT implementation. Further there must be linkages to GIS application and to mobile transmissions. States differ in a major way in their health and management priorities and their readiness in terms of technical and human capacity to absorb technology. The health information architecture opted for should conform to common data standards with high standards of interoperability in an information grid, so that each user can draw down the information they need. The Centre would have a national web-portal- which could “communicate with” the state and district level systems and other national health information systems, from which it would take the information needed for its working.
10. There is an existing HMIS data system in place, and the problems of its data quality have been studied and noted. While not insurmountable, managing these problems requires patient understanding of the details clear implementation strategy. One urgent corrective measure could be a system of independent assessment of data quality by accredited agencies identified by the States, which samples and verifies recorded and reported data from each district and provides a feedback on data quality. Another is the dissemination of the analysis of key data elements like “maternal mortality reports by district” to community monitoring groups, Panchayat leaderships, VHSCs etc, with assistance from them to correct gaps in information. These inputs for identifying and correcting data quality gaps should be on a continuing basis. The most important step for making data quality better and more usable is to use the data on a regular basis for monitoring the implementation of various programmes and planning for activities at all levels.
11. The DLHS and AHS should be further strengthened with the use of more qualified researchers and quicker analysis and provision of results. It would also gather data on height & weight measurement, blood test for anaemia and sugar, blood pressure measurement and testing of iodine in the salt used by households would also be collected. It could be adapted to include certain state specific components. It could be built upon to add some more relevant elements related to service delivery for communicable and non communicable disease and for information on costs of care. These could be included especially both in the household and facility survey component. The direction of change would be to integrate the various undertaken by the Ministry of Health and Family Welfare over different periods, into one integrated

‘National Health Survey’ with a periodicity of three years. Meanwhile programme evaluation of specific strategies would be continued using appropriate methodologies to assess the contribution of each programme to the overall goals.

12. The National Urban Health Mission (NUHM) would be launched and kept as a separate entity in the 12th Plan to provide the necessary focus. The two missions could be merged in the 13th Plan. The NUHM should have the same National Mission Steering group and the same state health society and in most cases the same district health society as well- but with addition of concerned stakeholders for the urban component.
13. Medical colleges should be involved for improving the health status of the population. A defined area for jurisdiction should be defined for each of the colleges.

VII. Private Sector Regulation and Public Private Partnerships:

1. The private sector is a major contributor to curative health care services and would play an important supplementary role to the development and strengthening of public health services. PPPs could bring in additional professional skills or additional investment. However all PPPs must have a minimum standards of quality and cost of care monitoring and good contract management. Adherence to terms of contract and prompt payments for services should be strictly monitored. Priority for not for profit providers of essential services should be built in- for example charitable hospitals providing emergency obstetric care services where even the district hospitals are not doing so- so as to ensure cashless services and access to the poor. Preference would be given to private sector units who are willing to get totally contracted in- thus becoming a public sector equivalent with private management. PPPs made for the explicit purpose of strengthening public provision of services – like outsourcing ancillary and auxiliary functions of the hospital if well managed can add efficiency and quality to public health services. District plans must indicate which services cannot be currently provided in the public sector but are available in the local private sector. Partnership with professional bodies such as FOGSI, IMA, IAP etc could be explored.
2. Containment of cost of care and promotion of ethical care requires urgent measures for regulation of the private sector in health care delivery. The implementation of the clinical establishments act or equivalent state acts in all the states is one of the priorities of the Twelfth five year plan period. PPPs would do better in an environment where the overall regulation of private sector is robust.
3. One major concern is in the introduction of new drugs and technologies – in terms of containing health care costs, in terms of provision of quality care and in terms of avoiding iatrogenic health hazards. This will also need to be addressed.
4. The approach Paper to the 12th Plan says that the 12th Plan will explore the possibilities of introducing a government funded Health Insurance Plan, which will focus on both preventive and curative aspects. The working group is of the view that it would be prudent to continue strengthening the public health infrastructure, keeping quality in mind and recommends that preventive health care and also primary health care should be delivered through public health infrastructure and should be kept outside the ambit of health insurance and health Insurance for secondary and tertiary care should be introduced with caution.

VIII. Community Processes and action on social determinants of health

1. For the ASHA programme to impact on maternal and child survival the ASHA must be taught the skills for counselling pregnant women and families with children on nutrition and improved health care practices as well as community level care for the newborn and sick child. Just ensuring increased attendance at immunization and promotion of institutional delivery exclusive of other strategies, cannot make a dent on child survival, nor be able to reach out to the most marginalized. Modules 6 and 7 for the ASHA programme for home based new born care must be scaled up rapidly and effectively. The current emphasis on community mobilisation must be strengthened. ASHAs can also be used in prevention, behaviour change and screening of non-communicable diseases. All this in turn would mean strengthening the support structures and creating high quality training teams at state and district levels. Additionally, training cum demonstration sites at the State level would be developed.
2. Sustaining the ASHA programme in the next phase of NRHM requires planning for an annual turnover and fresh recruitment of the ASHA from between 5% to 10%. Increasing the avenues for career progression of those ASHA who have such an aspiration, will enable expanding the human resource pool at the local level by giving them preference in education in local training institutions. Senior and mid level managers would be appraised of the role and contribution of ASHAs, which is of utmost importance in implementation of the programme.
3. The voluntary nature of the ASHA programme needs to be preserved. Her work should be such that it is done without impinging on her main livelihood and adequate monetary compensation for the time she spends on these tasks- through performance based payments.
4. Managing the turn over, retraining ASHAs and facilitators and enabling the implementation of newer interventions by ASHAs requires established training and development centers at the state level.
5. The Village Health, Sanitation and Nutrition Committee (VHSNC) remains the key mechanism to address the action on social determinants including age at marriage, literacy, water and sanitation, nutrition, substance abuse etc. This aspect was always part of the design, but there was no management capacity to handle this. There is a need to train and support VHSNCs to play a role in addressing social determinants of health in a meaningful way. This VHSNC programme with an adequate support structure is also needed to support the ASHA to play her mobilisational and health education roles. The VHSNC would need recurrent rounds of training- and just one round would not suffice. It would also require linkages with block level and district level committees. Incentives in the form of awards can be introduced to VHSNCs for specific achievements.
6. The approach paper for the 12th Plan suggests that the Anganwadi Centre and the Sub Centre both could be brought under the oversight of Panchayat level Health Nutrition

& Sanitation Committee. However, the Health Sanitation & Nutrition Committees under NRHM are set up at the level of village and not the Gram Panchayat. While the number of Gram Panchayats is approximately 2.45 lakhs in the country, the number of Village Health Sanitation & Nutrition Committees (VHSNC) is approximately 5 lakhs at the moment. Hence, the appropriate course would be to put the health Sub Centre, Anganwadi Centre and also the Village Health, Sanitation & Nutrition Committees under the oversight of the Gram Panchayat.

7. In the Eleventh Plan NRHM flagged the issue of action on social determinants. In the Twelfth Plan, the VHSNCs supported by civil society organisations could take the lead in action on social determinants of health, especially on equity of access. Block level health committees would provide coordination to this VHSNC action and these committees would report to the district health societies. An important aspect of this approach is that the VHSNC's action gets focussed on identifying and acting on inequities within panchayats and between panchayats. The village health plan should express health priorities as perceived by people, it should identify and address inequities in access, and it should address social determinants. On determinants like roads and township planning, it should ensure convergence with rural development and urban development plans so that health concerns are adequately addressed in their plans.
8. NGO participation would be enhanced. The provision that upto 5% of the resources of NRHM can be spent through NGO assisted interventions should be retained. The support from these NGOs should be broad based in the twelfth five year plan. A substantial proportion would be for capacity building and support for community processes (the VHSC, the ASHA programme, public participation in RKS, public participation in district planning and in community monitoring). The element of community monitoring could be further expanded in areas such as improving data quality in HMIS and MCTS, measuring availability of drugs, monitoring support to JSSK, support to users in RSBY and other cashless PPP arrangements. NGOs must be supported to mobilise additional technical capacity from a national canvas, where intra-district management capacity and training capacity is overwhelmed by requirements in high focus districts. A National Resource Centre and Regional Resource Centres would be set up to coordinate and support country wide NGO assisted interventions, provide support, develop capacity and monitor performance of NGOs. While the engagement with NGOs will be operationalised in a decentralised way, the Centre may offer direct grants to a few NGOs for very innovative projects.
9. NGOs must also be used for supplementing capacities in some key areas where they have interest and a high priority, but where medical professionals are unable to give continued attention to it. Examples include the monitoring of PCPNDT implementation, assessing environmental health impact, monitoring of food and drug adulteration (consumer education and assistance to inspection roles), promotion of rational drug use- amongst the population and amongst professionals.

10. The Rogi Kalyan Samitis should be strengthened by having better rules in place for public participation and transparency and by orientation to ensure quality of care and improved access to care. It should act as effective grievance redressal mechanism at the facility level. The engagement of PRIs should be very active in RKS. The exact position that the PRI leadership has in the RKS will vary from state to state depending on the context, but there should be an institutionalised process of capacity building so as to ensure their increasing role – in the RKS. Regularity in their functioning would be ensured by improved supervision and support. In fact, RKS should take leadership role in the management of the facility to give it a patient friendly orientation.
11. Community monitoring which emerged as a viable strategy in the Eleventh plan needs to be built upon in Twelfth plan and scaled up. VHSNCs and service user groups should have the capacity to undertake monitoring. This is one area where NGOs can play an important role in capacity building and support as for the line department staff, building capacity at the local level to monitor itself would understandably a low priority activity. However this must be closely linked to village health planning and facilitation of service delivery- and efforts must be made to bring community and service provider closer together and develop mutual trust and support.
12. The platform of Village Health and Nutrition Day would be more effectively utilised to provide MCH services. Increased participation of the PRI members and community is envisaged. Utilisation of this platform for other services like measurement of anaemia, etc, will also be explored.
13. Effective district level grievance redressal systems for the public to address their grievances and have it redressed with timely feedback on action taken- would be an important step forward. The grievances not addressed by RKS and VHSNC may be escalated to district level grievance redressal system. These systems and mechanisms would need adequate publicity and public participation to be effective across a wide form of contexts.

IX. RCH Services

1. Approach to achieving assured delivery of RCH services has already been discussed in detail. The JSY programme would continue with necessary fine tuning based on implementation experience. Timely payments to beneficiaries under the scheme should be ensured and states should put in place effective monitoring mechanisms for the same. The Janani Shishu Suraksha Karyakaram (JSSK) should be strengthened and universalised in the 12th Plan which would guarantee free services with no out of pocket expenditures for all pregnant women coming for delivery in public institutions and sick newborn. This would include referral transport and drop back home. Complications in the ante-natal and post natal period should also be covered. Maternal death reviews should be ensured by the States and the information should be analyzed for taking appropriate corrective actions to reduce maternal mortality. The emphasis on promoting institutional delivery would continue, but in areas where home deliveries cannot be avoided due to difficult terrain or cultural reasons, facility of ANM assisted home deliveries would also be developed. By popularising minimum standards of care and certification of its achievement and measurement of the gaps, by a better HR policy, the quality of care issues associated with institutional delivery as presently recognised would be addressed. Accreditation of private facilities for provision of RCH services could be encouraged and the accreditation should be carried out by a national authority to ensure quality. A framework for the same which is being developed by the Planning Commission could be used.
2. For achieving accelerated reduction in mortality, both pregnant women and newborn shall be provided a comprehensive and integrated continuum of care package. The package shall provide care during the crucial peri-natal period (after 28 weeks) for preparing the prospective mother, ensuring safe delivery (both facilities and home deliveries), reducing still birth, strengthening facility level care and post-natal home visits for all mothers and newborns till 6 weeks after delivery. To ensure quality and assist functionaries, it proposes using separate checklists for ANC, birth planning, delivery, immediate post delivery period, discharge criteria and post natal home visits.
3. The high focus district approach is another major feature of the NRHM. The exact number of districts and criteria for being on the list should be reassessed with an RCH focus. The existing list of high focus districts was based on many considerations – LWE affected, high SC /ST population, poor socio economic indicators and poor RCH performance indicators- and though mostly these districts overlapped, there were some LWE and SC districts included in the list which have good RCH performance while some other districts with poor RCH performance have been left out. The annual health survey results could be the new basis for identification of high focus districts.

4. In a high focus district, there would be enhanced thrust on capacity building as indicated earlier and on technical assistance and monitoring. There would also be urgency and more investment available for facility development. Death reporting would also be closely monitored with community support in these districts and under-reporting investigated and acted upon. Birth Waiting Homes in the health institutions in remote and tribal areas with poor road connectivity should be constructed, where such an intervention is needed.
5. Availability of safe and quality abortion services would be included as part of the standards for provision of RCH services.
6. Given the major load in referral medical college hospitals and large district hospitals on account of JSY, there would be an effort to strengthen the district hospitals and increase the number of beds for providing quality antenatal, intra-natal, postnatal and child care to cope with increasing case loads of pregnant women, newborns and children, and with a focus on post partum family planning services. Separate Maternal and Child Wings may also be constructed wherever they are required to cater to the higher case load.
7. Other priorities would include a scheme for the prevention and control of moderate and severe anaemia among children, adolescents and pregnant and lactating mothers. Universal screening of pregnant women for anaemia may help in detection and reduction of moderate anaemia among women. The data should be recorded in the moher and child protection card. Weighing of preschool children by Aanganwari centres should be undertaken for screening them for undernutrition. There would also be a new focus on prevention and control of endemic diseases in children; notably sickle cell anaemia, thalassemia, haemophilia, rheumatic heart disease, congenital heart diseases and congenital syphilis. Emerging issue of childhood obesity also need to be attended to.
8. There would be improvement in the quality of ante-natal care with better detection and treatment of hypertension and anaemia. This would require technical improvements like supply of better BP apparatus, better weighing machines, measuring tapes and improved methods of anaemia measurement made available at every VHND site. It would also require better monitoring and supervision. Moderate and severe anaemia would be actively detected and treated and the reduction of moderate and severe anaemia in pregnant women would be an important measured objective. There would be a major focus on scaling up of HIV Testing & Counselling during Ante-Natal Care - up to 24X7 PHC level in convergence with NACP-4 as well as free treatment for children with HIV infection. Testing for syphilis should also be expanded based on epidemiological grounds. Prevention & control of Malaria in Pregnant Women in identified endemic areas would also be a priority.
9. The elements of prevention, community outreach and extension education would be emphasized in the training of ASHAs, Anganwadi Workers, ANMs and block

extension educators. They would be sensitised to the special needs of disadvantaged sections. Panchayat functionaries, members of village health and sanitation committees and Rogi Kalian Samitis would be oriented to the importance of preventive and promotive health. Active cooperation and synergy between the ASHAs, Anganwadi workers and ANMs would be actively promoted to facilitate changes in health care practices and improvements in utilisation of health services. This synergised action on health promotion by front line workers would be promoted by innovative use of folk and electronic media, mobile telephony and multi-media tools- which would create an enabling environment for changes that lead to healthy living.

10. Other major features of the Twelfth five year plan would be making the school health programmes universal, strengthening a national framework on adolescent health, currently the weak pillar of RCH and expansion and strengthening of cold chain system through identification of more cold chain points near the community.
11. There would be a major thrust on improving access to facility based newborn care. Provision of services for sick newborn through establishment of SNCUs in every district of the country would be a target. Establishing newborn care corners at every delivery point and some level of stabilisation care at all 24*7 PHCs which provide basic emergency obstetric care would be a priority. Such facility based newborn care would be complemented by a nationwide effort in improving home based post-natal and newborn care through the ASHA programme.
12. One major area of intervention would be the development of Joint field operational plans in convergence with ICDS for result oriented management of malnutrition. This would include the establishment of NRCs for management of severe acute malnutrition and their subsequent follow up in the community. Such follow up would be IT enabled for better monitoring. Interoperability between the IT enabled monitoring systems of the ICDS and the health department would play an important role in bringing the two departments together – the link between nutrition surveillance and disease surveillance/prevention and response to illnesses- for the elimination of malnutrition. Breastfeeding support in the first year of life, complementary feeding and prompt management of illness would be key interventions to prevent malnutrition. Food supplementation programmes would be needed for elimination of malnutrition, and whether in schools, or in below 5 age group, it should be implemented in a manner where it leads to measurable reductions on malnutrition. All sections which are nutritionally stressed or when they are nutritionally stressed should have access to such supplementation programmes- but such access is most important for adolescent girls and pregnant women as malnutrition in these sections.
13. Addressing the challenge of skewed sex ratio would be through tighter implementation of the PCPNDT Act and through active support to reaching the girl child for care in illness. For implementation of PCPNDT act, better monitoring and sensitization of the medical community, greater role for civil society action in both

addressing son preference and in monitoring sex determination practices are key steps that are envisaged. For addressing neglect of the girl child in illness care, observing sex ratios in hospital admissions for illness in children, and proactive support to girl children through the ASHA and Anganwadi system should be undertaken.

14. The Tenth Plan had clearly articulated that 20% of the current population growth is due to unmet need for contraception. A further 20% is due to high wanted fertility due to high under 5 mortality. Thus reduction in IMR will contribute to lower wanted fertility. Therefore, in the Twelfth Plan meeting the unmet needs of contraception and reduction in the under 5 mortality will be prioritised.
15. For addressing population stabilization we need to take a differential approach between the seven high fertility states- and the rest. Whereas in the rest, the focus is on promotion of spacing measures, without reducing the levels of achievement required for sterilization, in the high fertility states, we need to think out of the box. Intensification of skill development strategy of government providers and thrust in recruiting and deploying private providers will be focused upon for both spacing and limiting methods. Post partum contraception would also be promoted. In all states there would be a planned effort to promote spacing methods, especially the IUD for spacing, and better family planning counseling, and focus on motivation for male sterilizations. Efforts will be made to introduce injectable contraceptives. Social marketing of contraceptives through ASHAs will be actively promoted and ASHAs will be paid incentives/commission for their efforts.
16. Efforts for addressing infertility by providing assisted reproductive technology at identified public facilities such as medical colleges would be introduced.

X. National Urban Health Mission

1. The health care needs of the urban poor and vulnerable populations have long been neglected, with the result that health indicators in some urban areas have been found to be poorer than their rural counterparts. Recognizing the seriousness of the problem, urban health will be taken up as a thrust area for the 12th Five Year Plan. National Urban Health Mission (NUHM) will be launched as a separate mission for urban areas with focus on slums and other urban poor. This will be done by investing in health professionals, appropriate technology, creating new & upgradation of existing infrastructure and strengthening the extant health care service delivery system.
2. NUHM would ensure adequate resources for addressing the health problems in urban areas; need based city specific urban health care system to meet the diverse health needs of the urban population with focus on urban poor and other vulnerable sections; institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population; partnership with community for a more proactive involvement in planning, implementation, and monitoring of health activities; and partnerships with NGOs, charitable hospitals, and other stakeholders.
3. NUHM would cover all cities/Towns with a population of more than 50000. Thus, 779 cities/towns (including 7 Mega cities) Towns with a population below 50000 will be covered under NRHM. Principally NUHM will cover the entire urban areas irrespective of dwelling status (including general population/listed slum/unlisted slum). But outreach services will be targeted for slum/slum like areas and other vulnerable populations including street vendors, railway and bus station coolies, homeless people, and street children, construction site workers, who may be in slums or on sites. Intersectoral coordination mechanism and convergence will be planned between the Jawaharlal Nehru National Urban Renewal Mission (JNNURM), Rajiv Awas Yojana (RAY) and the NUHM.
4. An effective monitoring and evaluation framework - regular monitoring at District/ City and at State level by the respective PMUs, Societies and Mission and feedback. A web based M&E framework effectively integrated and leveraging MIS of other National programmes like IDSP will be set-up and community monitoring will be done through Rogi Kalyan Samiti/ Mahila Arogya Samiti.
5. In the 12th Plan period NUHM and NRHM will be separate programmes which may be merged in the 13th Plan period or later. The budget allocation for NUHM in the 12th Plan period is envisaged to be approximately Rs 30,000 Crores.

XI. Other areas:

1. Disease control programmes: There is a separate working group on disease control programmes. In order to align State requirements and priorities, flexibility needs to be built into the Disease Control Programme framework. The reporting and performance evaluation system for the officers of various DCPs should have a clearly defined role for the Mission Director NRHM of the State to facilitate better integration and coordination. The policy and guidelines in different areas like HR, Infrastructure etc. of various DCPs should be synchronized.
2. There is a separate working group on non communicable diseases which will provide its recommendations.
3. On drugs and technologies a separate group would make its recommendations. This working group has flagged the following areas of concerns: better access to essential medicines and technologies through the public health system, promotion of rational use of drugs and diagnostics, cost controls and its relevance in both public and private sector and the need for a technology assessment institution on the lines of NICE-National Institute of Clinical Excellence, UK.
4. Research and development is also a priority. There is a need for policies and investment that identify gaps and opportunities for innovation and build a favorable environment for innovation in the area of pharmaceuticals, medical devices and non drug technologies, health information and communication technologies and health systems and programmes. There is a need for systems that would encourage and absorb innovations and evaluate and scale up successful innovations.
5. An Operation Research Group will be set up under the aegis of NRHM drawing experts from public health institutions, medical colleges, Ministry of Health and Family Welfare and other Centres of Excellence. Experts in the group will be drawn from the field of Epidemiology, Bio-Statistics, Reproductive and Child Health and other relevant public health disciplines. The group will facilitate building up a repository of comprehensive data and commission its analysis to academic and research institutes. An exercise of mapping such organizations with specific expertise would be undertaken. Funds will be earmarked for supporting the Operation Research Group and for carrying out studies, reviews, evaluations etc. The group will be housed in NHSRC.
6. The Planning Commission may ask all central ministries to set up the Population Stabilization Incentive Fund which would be utilized to incentivize those States/UTs that have already achieved a replacement TFR of 2.1 or less. This fund will also be utilized to incentivize States with high TFR which are taking positive steps towards controlling population growth. This additional allocation would be a kind of 'untied fund' available with the State governments, with the rider that with this money, works can be taken up in the same sector. This will incentivize the states which have

checked their population growth or are taking effective steps to continue to maintain this. This will also encourage other states with high rate of population growth to take necessary steps urgently.

Proposed Budget for the 12th Five Year Plan		
Sr. No	Activity	Amount (Rs in Cr)
1	Infrastructure Development	
1.1	New Construction	31668
1.2	Renovation	1288
1.3	District Hospitals	16000
1.4	Child Health (Construction of NBCC, SNCU, NBSU and NRCs)	2100
2	Human Resources	
2.1	Salaries (both for Treasury route and contractual engagement)	70747
2.2	Incentives for hard areas	7075
2.3	Training Programmes	2589
2.4	Strengthening of training institutions	1700
3	Facility - Maintenance and overheads	
3.1	Untied Grants to facilities	5266
3.2	Annual Maintenance Grants	1936
3.3	Quality assurance	260
3.4	Infection Management and Environment Protection	447
3.5	Maintenance to Urban Family Welfare Centres/ Health Posts and Family Welfare Bureaus	6244
4	Maternal and Child Health	
4.1	Maternal Health Package	10996
4.2	JSY	10000
4.3	Child Health Package	2862
4.4	Immunisation	15965
4.5	Referral transportation	13628
4.6	Adolescent Sexual and Reproductive Health	756
4.7	Menstrual hygiene Promotion	3712
4.8	School Health Programme	1012
4.9	PNDT Implementation	1530
5	Family Planning	
5.1	Family Planning Incentives	5165
5.2	Contraceptives (other than sterilisation)	100
5.3	Incentive to States for Population stabilisation	1600
6	Outreach services through MMU	2450
7	Community Processes	
7.1	ASHA	20331
7.2	VHSNC	4790
7.3	Community Monitoring	200

Sr. No	Activity	Amount (Rs in Cr)
8	NGO	8631
9	IEC/BCC	4450
10	Procurement and Logistics	
10.1	Drugs and supplies	5511
10.2	Establishing corporations and Warehouses (TNMSC type)	600
11	Monitoring and Evaluation	
11.1	Concurrent Monitoring and Evaluation	2120
11.2	Management Information Systems (MIS)	750
11.3	Third Party Evaluation	1500
11.4	Periodic Evaluation surveys - DLHS/AHS/NHS/CES	550
11.5	Research study and reports	2245
12	NHSRC, SHSRC, District Planning	850
13	Training Institutions	
13.1	National Institute of Health and Family Welfare (NIHFW), New Delhi	182
13.2	International Institute of Population Sciences, Mumbai	501
13.3	Population Research Centres	142
14	Management cost	
14.1	Manpower and operational Cost	14386
14.2	IT initiatives (MCTS, HMIS, others)	2877
15	Disease Control Programmes	17276
16	Urban Health Mission	30000
	GRAND TOTAL	334987

Basis for budgeting provisions

Major assumptions:

- ▶ Projections based on Census 2011 population(121 Crores)
- ▶ Rural population assumed as 70% , i.e. 84.71 Crores
- ▶ Rate of construction works as per CPWD schedule
- ▶ Existing norms for Programme Management, M&E, IEC/ BCC and PPP/ NGOs
- ▶ Norms for untied fund, AMG and RKS enhanced by 50%
- ▶ Incentive fund for population stabilization for States who have achieved TFR targets.
- ▶ One Regular MPW at each Sub-Center, contractual 2nd ANM to be provided only in up to 10% sub-centers conducting deliveries.

1. Health Infrastructure:

1.1 New constructions:

- ▶ Gaps in the health infrastructure are analyzed as per Census 2011 population. The population norms for setting up health facilities have remained unchanged. The norms for construction cost are enhanced by 100% as CPWD rates have gone up by 73% since 2005.
- ▶ One sub-centre is proposed to be set-up at each gram Panchayat. Thus, there is a total requirement of 2,45,655 sub-centres. Since there are only 56,896 sub-centres in government buildings currently, 1,55,478 new sub-centres need to be constructed. As this is difficult to achieve in 5 years period, it is proposed that 20000 new sub-centres could be constructed per year on an average at the rate of Rs. 18 lakh per sub-centre. Funds required for construction of sub-centres is Rs. 18000 Cr.
- ▶ At the current norms of population for PHCs and CHCs, there is a requirement of 11,337 new PHCs and 2933 new CHCs. Cost of new PHC and new CHC construction is estimated to be Rs. 65 lakh and Rs. 210 lakh respectively. Funds required for construction of PHCs and CHCs is Rs. 7369 Cr and Rs. 6159 Cr respectively.
- ▶ 1320 birth waiting homes are proposed to be constructed in remote and inaccessible blocks in 264 high focus districts to encourage institutional delivery in remote areas at an approximate rate of Rs. 10 lakh per birth waiting home. Funds required for construction of birth waiting homes is Rs. 140 Cr.

1.2 Renovations:

- ▶ 1/6th of all the existing facilities in the government buildings are proposed to be renovated in the plan period. Funds required are Rs. 1288 Cr.

1.3 Strengthening of District Hospitals:

- ▶ Rs 16000 Crores for Strengthening of District Hospitals in 640 districts @ Rs 25 Cr per district is proposed inclusive of Rs. 5035 Cr for maternity wings in DH.

2. Human Resources in Health:

2.1 Salaries of Permanent and the contractual staff

- ▶ HR requirements determined as per Indian Public Health Standards 2010.
- ▶ Every Sub Centre (SC) is to have one ANM and one Male Multi Purpose Worker (MPW) supported by Central Government. The present norm of providing one LHV for 6 SCs is maintained. The salaries of ANM/ LHV will continue to be borne by the GoI through the Treasury Route. Salary of MPWs will also flow through the same route.
- ▶ The training capacities of the States have been considered while calculating the number of MPWs that can be employed. Training capacities are set to be doubled every year. Thus, by the end of the 12th Five Year Plan, 2.09 lakh MPWs are proposed to be employed.
- ▶ It is assumed that 20% of the posts will be vacant at any given point of time. Appointment of contractual personnel will be supported to bridge this gap.

2.2 Incentives

- ▶ Incentives for hard to reach areas is calculated at the rate of 10% of total salaries.

2.3 Training:

- ▶ Training under RCH, Training of ASHAs & PRI members, Training of AYUSH doctors, Training for M&E and Training under Immunization are supported here. A 10% increase in the budget of training per year is calculated.
- ▶ Training of ASHA is included in the ASHA package.

2.4 Grants for Training institutions:

- ▶ Grants to ANM training centers (ANMTC), LHV training centers (LHVTC), MPW training centers (MPWTC) and Health and Family welfare Training Centers (HFWTC) will be supported with a 40% increase in grants over the current level for the first 2 years followed by 10% increase in every year from the third year of plan.
- ▶ Additionally Rs. 50 lakhs per year to SIHFW, Rs. 5 lakh per year to HFWTC, LHVTC, ANMTC and MPWTC, and Rs. 2.5 Cr for setting up training institutes for cold chain mechanics as maintenance grants is proposed.

3. Facility Maintenance:

3.1 Untied grants to the facilities:

- ▶ The norms of annual Rogi Kalyan Samitis and annual Untied grants have been revised as follows:

	Rogi Kalyan Samiti Grants (Rs)		Untied Funds (Rs)	
	Old norms	New Norms	Old Norms	New Norms
Sub-Centers			10000	15000
PHCs	100000	150000	25000	37500
CHCs	100000	150000	50000	75000
District Hospitals	500000	750000		

3.2 Annual Maintenance Grants:

- ▶ The norms for Annual Maintenance Grants has been revised as follows:

Facility	Old norms	New Norms
SC	10000	15000
PHC	50000	75000
CHC	100000	150000

3.3 Quality Assurance:

- ▶ Accreditation and external certification: Cost of accreditation is approximately Rs. 10 lakh per district hospital as per NHSRC norms. So total cost for 604 hospitals will be Rs 60.4 crores
- ▶ ISO Certification for PHCs/ CHCs – A lump sum amount of Rs. 200 Crores for assistance to States for certification of designated centres.

3.4 IMEP:

- ▶ Biomedical waste Management in higher facilities is based on unit costs of Tamil Nadu. Funds required for the same is Rs. 375 Cr.
- ▶ Construction of sharp pits and burial pits is based on WHO standards and estimated for Rs. 72 Cr.

3.5 Maintenance of Urban Family welfare Centers/ Health Posts/ Family welfare Bureaus:

- ▶ Annual increase of 10% in budget over current norms is assumed while calculating grants for State and District Family Welfare Bureaus, Urban Family Welfare Centers and urban Family welfare Posts. Total fund requirement for maintenance of these institutions is Rs. 6244 Cr.

4. RCH Programme:

4.1 Maternal Health Package

Sr. No	Component	Rs. In Crore
1.	Free Drugs and Consumables with supplementation	5152
2.	Free Diet	3450
3.	Free Blood	431
4.	Free Diagnostics	1917
6.	Iron Sucrose Intervention	46.22
	Total	10996

4.2 Janani Suraksha Yojana:

- ▶ The demand has been projected on the response received to JSY in the Eleventh Five Year Plan. Expenditure in 2010-11 on JSY was Rs. 1609 Cr. Based on these, Rs. 10000 Cr. is proposed for meeting the demand of JSY in the Twelfth Five Year Plan.

4.3 Child Health Package:

- ▶ Rs. 2862 Cr for control of specific diseases in children.

4.4 Immunisation:

S. No	Component	Rs. In Crore
1.	Procurement of Routine vaccines	750
2.	Procurement of new vaccines (Pentavalent, MMR, IPV, Rota, Pneumococcal)	6500
3.	Procurement of AD syringes	403
4.	Expansion of Cold Chain points	35
5.	Modernization of Alternate Vaccine Delivery and expenditure on mobile network	1184
6.	Establishment of regional mobile workshops	18
7.	Mobility to district cold chain mechanics & PHCs	65
8.	Procurement of OPV	3870
9.	Operational Cost	3140
	Total	15965

4.5 Referral Transport and Emergency Services:

A. First Referral (From Home to Health institution) through Emergency Response Services with one vehicle per 1 lakh population (norm as per existing services in Gujarat, Karnataka, Uttarakhand etc)

- ▶ One ambulance would be placed per one lakh population. Replacements to be provided by the State/UT governments. Out of the total requirement (7350) of ambulances, it is proposed to provide 10 % Advanced Life Support (ALS) ambulances and 90% Basic Life Support (BLS) ambulances.
- ▶ Thus, calculated at a unit cost of Rs. 15 lakh for Advanced Life Support and Rs. 13 lakh for Basic Life Support and provision of 40% of operational cost on an average; total funds required for Emergency Response services is Rs. 5038 Cr.

B. Second Referral (From Health Facility to Higher Health Facility) through referral vehicles/ ambulances at selected PHCs.

- ▶ 15000 PHCs, and all CHCs, SDHs, Taluk Hospitals and District Hospitals will be provided with operational cost.

C. Drop back (From Health Facility to Home) in case of institutional deliveries at public health facilities and for sick neonates. Total requirement of funds is Rs. 1875 Cr.

6. Mobile Medical Units:

- ▶ At least one Mobile Medical Unit is proposed to be supported per district. For the districts with large population one MMU per 10 lakh population will be admissible. For tribal/ desert/ hilly areas more than this may be considered on a case to case basis.
- ▶ No. of Districts with MM Units in 2009-10 is 343, which will be replaced. MMUs provided in 2010-11 and 2011-12 not to be replaced.
- ▶ Overall nearly 1500 MMUs might be required. Operational cost is estimated for all 1500 districts.
- ▶ The norms of providing new mobile medical units and its operational cost are revised. The proposed amount is based on a revised norm of Rs. 10 lakh for providing a mobile van with staff and Rs. 25 lakh for providing a Mobile Unit with diagnostic facilities. Similarly, norm for operational cost is revised to RS. 25 lakh per unit except in States of the NE region, Jammu and Kashmir and Himachal Pradesh where an operational cost of Rs. 30 lakh per Unit is estimated keeping in view the difficult terrain.

7. Community Processes:

7.1 ASHA:

- ▶ The current norm of one ASHA per 1000 rural population will continue. However for hilly and tribal areas, norms will be relaxed to have one ASHA per 600 population.
- ▶ Activities of ASHAs will be expanded to enable them to earn incentives of Rs. 2500 per month on an average.
- ▶ The ASHA package excluding the incentives is maintained at the current Rs. 10000 and includes all cost like training, drugs, etc., borne by the States per ASHA.

7.2 Village Health, Sanitation and Nutrition Committee;

- ▶ Revised norm of Rs. 15000 per VHSNC per year is applied to be set-up at each revenue village.

7.3 Community Monitoring:

- ▶ Up-scaling of the community monitoring initiative piloted in 9 States to the entire country to ensure greater community participation and social accountability @ Rs. 20 lakh per district per year.

8. NGO:

- ▶ Requirements are calculated as per the norm of 5 % of total budget.
- ▶ It is budgeted in the budget plan for 3%. The remaining 2% is suggested to be accommodated from budget of existing activities.

9. IEC/BCC:

- ▶ Present norm of Rs. 10 per capita is maintained. One third of which is to be utilized at National, State and District levels each.

10. Procurement and logistics:

10.1 Drugs and supplies:

- ▶ 15% annual increase in allocation is proposed. Thus, total requirement for the 5 years is Rs. 5511 Cr.

10.2 Drug Warehouses and Cooperations:

- ▶ Rs 500 Crores for constructing new drug warehouses and renovating the existing ones
- ▶ A lump sum amount of Rs. 100 Crores is proposed to provide support to the States to set up corporations to streamline procurement of drugs and equipments at the State level.

11. Monitoring and Evaluation:

11.1 Concurrent Monitoring and Evaluation:

- ▶ It is proposed to allocate funds for Monitoring and evaluation up to Rs. 5 per capita; 25% to be used at the national level, 25% at the State level and rest at district level and below.

11.5 Research Studies and Preparation of State and District Annual Health Reports:

- ▶ Existing norm of Rs. 5 per capita for research is maintained.
- ▶ Additionally, Rs. 50000 per District per year and Rs. 2 lakh per State per year is proposed to be provided for preparation of State and District Annual Health Reports.

12. NHSRC, SHSRC, Decentralized Planning:

- ▶ Rs. 17 Cr is the estimated budget for NHSRC per annum.
- ▶ Rs. 1 Cr per year per State is proposed for SHSRC.
- ▶ Rs. 10 lakh per State and Rs. 20 lakh per District per year is proposed for effective decentralized planning.

14. Management Cost:

- ▶ Management cost for Human Resources and Operational Cost is calculated at 5% of the total outlay for NRHM excluding the Vector Borne Diseases.

1% of the total outlay of NRHM is proposed to be used for development of IT initiatives like HMIS, MCTS, etc.

Annexure 1 - List of Publications of relevance to working group on NRHM

(NB- this is not a comprehensive list- this is only to initiate sharing of resources for the working group on NRHM)

Ministry of Health Family Welfare's documents

- 1- Rural Health Statistics 2010(under printing) ,2009 (available at www.mohfw.nic.in)
- 2- First Common Review Mission Report 2007, Second 2008, Report 2009, Fourth 2010(available at NRHM website: www.mohfw.nic.in/NRHM.htm)
- 3- Update on ASHA program, June 2010, January 2010: (available at NHSRC website: www.nhsrindia.org)
- 4- Concurrent Assessment of JANANI SURAKSHA YOJANA (JSY) SCHEME IN SELECTED, STATES OF INDIA, 2008, (available at NRHM website: <http://mohfw.nic.in/NRHM.htm>)
- 5- Five years of NRHM, Meeting the needs of the people in partnership with the states 2005-2010. (available at NRHM website: www.mohfw.nic.in/NRHM.htm)
- 6- Annual Report 2010-2011(available at MOHFW website- www.mohfw.nic.in)
- 7- Concurrent Evaluation of National Rural Health Mission 2009(available at NRHM website)
- 8- Family Welfare Statistics 2009,
- 9- [State wise Progress as on 31.12.2010, http://mohfw.nic.in/NRHM.htm](http://mohfw.nic.in/NRHM.htm)
- 10- Mid-term Appraisal of Eleventh Five Years Plan, Planning Commission of India(Planning commission website)

National Sample Surveys:

- 1- Sample Registration Survey Reports- released annually. Latest July 2011. – has details on IMR, U5 MR, MMR , birth rate, death rates and still birth rates and institutional delivery rates.
- 2- India Report, DLHS-3(2007-2008) - International Institute of Population Sciences: Available at IIPS website.
- 3- State reports,DLHS3(2007-2008)- ibid. available at IIPS website
- 4- Compendium India, State & UTs of DLHS-3 (2007-2008) ibid. available at IIPS website

- 5- India Report NFHS-3(2005-06)-
- 6- State Reports, NFHS-3(2005-2006)
- 7- Coverage Evaluation Survey, 2005, UNICEF
- 8- Coverage Evaluation Survey, 2009, UNICEF

NHSRC's Studies and Evaluations-

(All documents available at NHSRC website- <http://nhsrcindia.org/>)

- 1- “An Evaluation of the ASHA programme in eight states, ASHA: which way forward?”
National Health Systems Resource Centre, 2010
- 2- “Programme evaluation of the JSY”, National Health Systems Resource Centre ,2010
- 3- “*Status and Role of AYUSH and Local Health Traditions, under National Rural Health Mission*”, National Health Systems Resource Centre, 2010
- 4- “EMRI – an evaluation”, National Health Systems Resource Centre, April 2009,
- 5- “HMRI evaluation”, National Health Systems Resource Centre, December 2010
- 6- “ HR studies – Nursing in five states, medical officers and specialists in six states, retention case studies from over 5 states”, National Health Systems Resource Centre, September 2009
- 7- Common Review Mission Reports- 2007. 2008, 2009, 2010

Other Publications on NRHM

- 1- Bajpai Nirupam , Sachs D. Jeffrey and Dholakia H. Ravindra , “Improving access, service delivery and efficiency of the public health system in rural India” Mid-term evaluation of the National Rural Health Mission, CGSD Working Paper No. 37 October 2009
- 2- “Primary evaluation of service delivery under the National Rural Health Mission (NRHM): Findings from a study in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan” <http://www.accountabilityindia.in/article/document-library/769-primary-evaluation-service-delivery-under-national-rural-health-mission>

- 3- Mukherjee Srabanti , “A Study on Effectiveness of NRHM in Terms of Reach and Social Marketing Initiatives in Rural India”, European Journal of Scientific Research ISSN 1450-216X Vol.42 No.4 (2010), pp.587-603 <http://www.eurojournals.com/ejsr.htm>
- 4- Arun Kumar Sharma; National Rural Health Mission: Time to Take Stock, Indian J Community Med. 2009 July; 34(3): 175–182. doi: [10.4103/0970-0218.55268](https://doi.org/10.4103/0970-0218.55268)
- 5- [Singh MK](#), & Al, Factors Influencing Utilization of ASHA Services under NRHM in Relation to Maternal Health in Rural Lucknow, Indian J Community Med. 2010 Jul;35(3):414-9
- 6- [Mani MK.](#), The National Rural Health Mission (NRHM) in review; Natl Med J India. 2008 May-Jun; 21(3):1489.
- 7- [Kapil U](#), [Choudhury P](#). National Rural Health Mission (NRHM): will it make a difference, Indian Pediatr. 2005 Aug; 42(8):783-6.

Annexure 2 – Minutes of the First Meeting of the Working Group

Secretary Health & Family Welfare chaired the 1st Meeting of the Working Group on Progress and Performance of NRHM and Suggestions for the 12th Five Year Plan on 10th June, 2011 in Room No. 155-A, 1st Floor, Nirman Bhawan, New Delhi. The list of members of the Working Group and other officers who attended the meeting is annexed.

At the outset Sh. Amit Mohan Prasad JS (Policy), MoHFW welcomed the members of the Working Group and other officers present in the meeting. Thereafter, he made a presentation on progress of NRHM and challenges.

Secretary HFW in his remarks highlighted the progress of NRHM and the benefits that have accrued due to integration of various programmes. He also informed the members that the Planning Commission has formed 4 Working Groups for the 12th Five Year Plan (FYP) on Primary Health Care, Tertiary Care, Communicable and Non-Communicable diseases, Drugs and a Sub Group on Human Resources.

Thereafter, Secretary H&FW invited members of the Working Group to put forth their views. The members made following observations/ suggestions. The main points discussed by the Working Group are as follows:

Mrs Poonam Muttreja, ED- Director PFI shared the following suggestions: Clarification regarding High Level Expert Group (HLEG) Committee on Universal Health Coverage may be provided – what it means in terms of infrastructure and tie – ups with private sector.

- More information and assessment studies on NRHM are needed to make useful suggestions for the 12th Plan.
- HMIS – Quality and data reliability needs to be stressed upon. Additional investment is required with a systems approach to improve HMIS.
- While the ASHA programme has been successful, more investments in training (health skills, managements and counselling) and supervision is required. In addition, the ASHAs supervision and management needs to be looked at (the 2nd ANM may be given some managerial skills in this regard).
- The Catch programme underway in Sikkim is an example of a successful screening programme for Non-communicable Diseases where the PHC doctor screens individuals in the field setting. This programme needs to be evaluated to determine if it can be scaled up in other parts of the country.

- Repositioning of Family Planning for Maternal and Child Health is important.
- Differential incentives for HR in difficult areas should be given.
- For effective Community Monitoring a robust redressal mechanism needs to be institutionalised.

Dr Nerges Mistry, Director FRCH, FMR mentioned that:

- Convergence of NCDs with TB and HIV/AIDS for better disease management and control should be looked at.
- There is a perpetual shortage of essential drugs at health facilities – replenishment of drugs should be prioritised.
- ASHA - Shortage and replenishment of ASHA drug kits remains an issue.
- Better methodology for evaluation of JSY & RSBY should be looked at.
- Lack of fund flow at sub – district level leads to reduced motivation among PRIs and communities.
- Quality of care provided at public health facilities is an issue.
- Career growth and accreditation and training of ASHAs needs to be defined.
- In terms of institutional deliveries the link between 24x7 PHCs and higher referral centre needs strengthening.
- A holistic approach to Infrastructure Development should include provision of power, water and ensure road connectivity for all public health facilities.

Dr. NK Arora, INCLEN informed the group that:

- A comparative analysis of public and private sector health facilities in 16 districts has reported that the public sector has better infrastructure, trained HR and supplies. However, it lags behind the private sector in terms of efficiency and utilisation of resources. This needs to be rectified.
- The Currently available HMIS needs more investment. Real time analysis of HMIS data should be done.

- Malnutrition is a major cause of childhood morbidity and mortality. More emphasis at the national level is required on the issue of child nutrition.
- Anemia among children, adolescents, adult men and women is a major public health issues in India. A systematic review of Anemia and Iron Deficiency is required and provision of Vitamin B12 (an important cause of pernicious anemia) should be a part of the anemia control strategy.
- The JSSY scheme launched on 1st June is a step in the right direction towards controlling MMR and IMR. However, due importance needs to be given to Still Births, Ante Natal Care and Care in the first 6 weeks of life. The role of AWW, ASHA and ANM needs to be defined clearly to make the initiative a success.
- To deal with the problem of shortage of skilled doctors a 2 year postgraduate course in Family Medicine is being developed by the MCI - training in Child health, maternal health, Adult and Geriatric medicine and essential surgical skills will be imparted. These trained post graduate doctors could be utilised to fill vacant positions in CHCs and PHCs.
- Partnerships with Private sector to help people set up private practice in remote areas with a shortage of doctors may be looked at.

Mrs Anita Das said that:

- Better evaluation and assessment studies for NRHM are required.
- Malnutrition in children is a significant public health problem and it needs greater attention. A subgroup to examine strategies for combating malnutrition in the 12th plan is suggested.
- AYUSH doctors – role of AYUSH doctors in primary health care needs to be clarified. A policy thrust on AYUSH is required. The role of AYUSH in preventive medicine may be explored.
- Rational deployment of the 7 lakh AYUSH trained manpower should be done to provide better traditional health care.

- ICMR can undertake studies to validate the remedies offered under the traditional systems of medicine, and to put the tested drugs into the Essential Drug List.

Dr. Mohan Rao, JNU was of the opinion that:

- In terms of the numbers provided in the presentation – proportions (with denominators) would be more useful in assessing the current situation and providing informed inputs.
- Quality and Cost of Care is an issue.
- Rational use of technology in health care, especially in private sector.
- Regulation of care needs attention especially in the private sector.

Dr. M. Prakasamma, ANSWERS, Hyderabad mentioned that:

- More clarity on processes and proportions in the presentation would have been useful for the group members.
- Details on indicators for ANC, Facilities used viz Abortion, contraception, Utilization of IFA tablets, Anaemia control; etc could be furnished to the group.
- States should have functional Maternal Death Review system
- Clarity regarding 2nd ANM, and the role description of 1st ANM and 2nd ANM is required
- Public Health Nursing cadre needs to be revitalised.

Dr. Prema Ramachandran, Director NFI, New Delhi emphasised that:

- HMIS – is important but the quality and reliability needs to be prioritised. Local capacities should be developed to improve HMIS.
- Quality of care and optimal use of resources at each level should be stressed on.
- Interventions like the mother and child card are a step in the right direction and need to be multiplied.

- Curative part of PHCs should be strengthened.

Dr. P.K.Shah, President Elect, Director General, FOGSI, Mumbai:

Dr. Shah appreciated the significant reduction in IMR in Odisha (30 points). He suggested that the strategies that helped the State to bring down the IMR could be replicated across the country. He further stated that:

- The JSY scheme has led to dramatic increase in institutional deliveries. However, this has not been accompanied by decreasing MMR. Increasing case load of normal deliveries at tertiary centre has burdened the staff and indirectly diverted attention from complicated cases.
- Rationalisation of case load needs to be done at facilities so that normal deliveries are handled at the primary level and tertiary facilities can focus on handling complicated deliveries.
- Teams of Gynaecologist, Anaesthetist, Neonatologist and the requisite infrastructure must be made available at the PHC level in order to rein in MMR and IMR.
- Better living conditions and monetary and other incentives for doctors in rural areas.
- Compulsory posting of post graduate medical students for 6 months in rural areas to provide the necessary care.
- Drugs like injectable iron sucrose, Magnesium sulphate and Misoprostol must be widely available at all maternal health facilities to reduce maternal mortality.
- Joint effort from MoHFW, WCD, and HRD Ministry is required to control the current MMR in the country.

Mrs. Nirmala Nair, EKJUT, Jharkhand said that:

- Impact of community mobilisation on women's health should be evaluated.
- ASHAs role in community mobilisation needs greater attention.
- In addition, ASHAs need to be sensitized to attend to the marginalised communities.
- Robust progressive surveillance system is required and the HMIS data needs to be analysed.

Prof. Deoki Nandan, Director, NIHF suggested that:

- A Cadre of public health specialists should be set up to address the shortage of trained public health staff.
- Redefine responsibilities of public health professionals with proper deployment according to their skills.
- Pre- service and In- service training of health professionals is required.
- Linkage between training centres at National, State and District level.
- A training cadre may be established.
- There should be an interface between teaching institutions and public health services.
- Investment in supportive supervision for ASHAs with one facilitator for 20 ASHAs.
- ASHAs should identify local influencers in cluster communities who can facilitate BCC and IEC for which they can be incentivised.
- Capacity building of district level staff for data management and analysis is required to improve data quality and use of the data for programmatic corrections. HMIS needs to be linked with PRIs, VHSCs for social audits.

Shri S.K. Mahajan, Advisor – Planning Commission said that:

- Terms for recruitment and retention of doctors in rural areas need to be made more attractive.
- Other factors in addition to population should be taken into account when formulating norms like consumer based appraisal.
- 24x7 facilities should provide other services in addition to deliveries.

Shri Anil Kumar, Secretary, AYUSH observed that the traditional system of Indian Medicine is underutilized. He suggested that:

- Integrative system of medicine should be instituted so that patients should have the right to choose the form of therapy.
- Salaries of AYUSH and Allopathic doctors should be equalised.
- Allopathic doctors should be oriented in AYUSH.

Shri John Ekka, MD NRHM – Assam opined that:

- Training of AYUSH doctors in BEMOC to increase their skill level can be done.
- There is a need of annual surveys so make remedial actions in the programme if required in real time
- SBA, F-IMNCI training should be included in the medical curriculum.
- Non communicable disease prevention and control should be included under NRHM.
- Support should be given to tertiary care centres – medical colleges by NRHM.
- An outreach programme for data collection on NCDs in the community should be instituted to find out the public health burden of NCDs in the population.

Dr. T Sundaraman, ED NHSRC suggested that:

- Wealth of studies on NRHM are available on national portal, NHSRC, IAP etc, which could be utilized by the members.
- EMRI has had a huge transformative response in the last 6 years.
- There has been different strategies and response between states: the Non High Focus states have performed better in terms of infrastructure development but the High Focus States have shown a greater change in health indicators.

Shri P K Pradhan, MD NRHM & Special Secretary Health & Family Welfare, summarised the discussion and put forth the following suggestions:

- Best practices of States should be compiled so that evidence based strategies can be adopted under NRHM.
- Focus on facility based care to make it more effective.
- Performance benchmarks to be linked to incentives in the 12th plan.
- Maternal and Child Tracking System is being implemented, it is required to use this data for better implementation.
- Fund flow at the sub district level needs to be streamlined.
- Better coordination between ICDS and MoH&FW is needed.

- A national protocol for injectable iron sucrose and injectable contraceptives need to be developed which can then be rolled out in all states. A protocol is being developed by FOGSI which can be evaluated and submitted to the GoI for consideration.
- Strengthening of District hospitals to provide advanced secondary care.
- SNCU at all DH should be in place.
- Strategies for the 12th FYP would include: Nutrition issues, Adolescent health, School health, Joint Health card, rolling out of MCTS.
- Help Desk and redressal mechanisms for ASHA.
- Timely referral should be prioritized.
- Public Health cadre needs to be developed for the 12th Plan with focus on compensation of HR and reducing attrition.

Shri Chandramouli, Secretary Health and Family Welfare summarised the discussion and added that:

- Positioning of one MPW Male at every sub centre with clearly defined role may be supported by NRHM in the 12th FYP.
- A draft strategy paper for the 12th FYP would be prepared by the NHSRC before the next meeting of the Working Group and shared with the members.
- Training and Career progression for ASHA, ANM, and Nurses needs to be emphasised.
- District wise assessment is required to analyse the differential achievement between districts (facility wise monitoring, data validation).
- Capacity building at State and District level for data analysis, validation and monitoring is required.
- Differential planning and provision of funds should be done for facilities according to case load.

In the end, the Secretary thanked the members of the working group for their support and contributions and informed that the next meeting of the Working Group would take place after the meeting of the Steering Group.

Annexure 3 – Minutes of the Second Meeting of the Working Group

Shri. K. Chandramouli, Secretary Health & Family Welfare chaired the 2nd Meeting of the Working Group on Progress and Performance of NRHM and Suggestions for the 12th Five Year Plan on 28th July, 2011 in Room No. 155-A, 1st Floor, Nirman Bhawan, New Delhi. The list of members of the Working Group and other officers who attended the meeting is annexed.

At the outset **Sh. Amit Mohan Prasad JS (Policy), MoHFW** welcomed the members of the Working Group and other officers present in the meeting. Thereafter, **Dr. Sajjan Yadav, Director NRHM** made a presentation on issues identified through the discussions in the previous meeting and the correspondences received from the Members, State Governments, Experts and civil Society groups. He also outlined the proposals for the 12th Five Year Plan.

It was observed during the presentation that some States particularly the NE States find it difficult to commit the existing 15% of State share. This was discussed and it was decided that a call on the matter would be taken by the Planning Commission. **Ms. Renu Khanna, SAHAJ**, pointed out that nothing much had happened in Community Monitoring after the first pilot phase. She suggested that it should be made a part of the 12th FYP. **Dr. Shakeel, Patna** suggested that VHSCs should be set up at village level and not at Panchayat level as is done in states like Bihar to ensure inclusion of the socially excluded groups. It was clarified that as per NRHM framework ,VHSC is to be set up in each revenue villages. **Smt. Girija Vaidyanathan, Principal Secretary,Health & Family Welfare, Tamil Nadu** suggested that in the nationwide surveys like DLHS and AHS, States should be allowed to include certain State specific components.

Smt. Girija Vaidyanathan, suggested that instead of restricting upgradation to only District Hospitals, States should be allowed to choose one major hospital in the district, which could include medical colleges for upgradation in the 12th Plan .At this, **Sh. P.K. Pradhan, SS&MD NRHM**, was of the opinion that while District hospitals which have been upgraded into Medical Colleges could be covered, It will be difficult to allow States to choose other major hospitals for upgradation. **Dr. M. Prakasamma, Director, Academy of Nursing Studies** stressed on the need to specify and highlight the exact areas of inter-sectoral convergence to address social determinants of health.

Ms. Renu Khanna, brought to the notice of the gathering that one round of capacity building through training is not sufficient to ensure proper functioning of the VHSNC and this requires greater investment. Further, she pointed out that the linkages between the VHSNC and health committees at the block level and above are non-existent and this required immediate attention.

Dr. M. Prakasamma suggested that VHSNCs could be given monetary incentives/rewards to ensure 100% immunization and 100% institutional deliveries to improve their participation in these programmes. **Dr. Shakeel** stressed on the need for renewed emphasis on spacing methods in Family Planning and pointed out that the lack of trained personnel for methods such as Cu. T insertions is a major reason for the methods not being currently utilized.

Dr. Dhruv Mankad, Lead Consultant, Project Evaluation Team at Sir Dorabjee Tata Trust, pointed out the need for special efforts for infrastructure development to reach SC/ST and unreached populations.

Dr. Shakeel pointed out that while population norms for infrastructure may remain unchanged, it is essential that the same are followed and that there should not be one PHC for 2 lakh population as is the case in some States like Bihar.

Ms. Renu Khanna reflected that while we should focus on strengthening of District Hospitals it's important that focus on PHCs is retained in the process. **Dr. Dhruv Mankad** pointed out that while developing infrastructure it should be remembered that road access to the facility is ensured. Construction costs can include the cost of development of roads to reach the facility if required using the currently prominent township planning approaches and convergence with PWD department should be an important focus area.

Dr. Nerges Mistry, Director FRCH, emphasized the need for outreach/ extension services and also maintaining quality and standards of services at the health facilities. Linkages between facilities for referrals should be strengthened.

Dr. M. Prakasamma gave some important pointers towards improving the nursing and ANM cadre in the country. She pointed out that a course on Community Midwife should be introduced in the country and that other countries have greatly benefitted from this initiative. This would entail expanding the course of the ANM by 6 months. She also pointed out that it is not required that every nurse should be a midwife and thus specialized trainings could be imparted to only those nurses posted at the labour rooms. She focused

on the need for revival of Public Health Nursing Cadre. She also identified that while nursing schools are being established there is a great deficiency of faculty for these institutions and thus a National level Training Institute for training of Faculty for nursing is the need of the hour. Most of all she pointed to the need for setting up skill labs at District hospital Level which would facilitate comprehensive training at the district level with the help of patients as well as mannequins.

Shri. P.K. Pradhan, SS & MD, NRHM observed that there is a need to speed up recruitment processes and to address this some States have modified their recruitment processes to include campus recruitments and walk in interviews. **Dr. Shakeel** pointed to the need to invest further in skilled HR production and suggested that more Nurses/ ANMTCs and Medical colleges should be opened by the government. Addressing the point raised about Rural Medical Practitioners **Shri. K. Chandramouli, Secretary HFW**, clarified that discussions with MCI were on regarding their recognition.

Dr. Mohan Rao, Professor, Center of Social Medicine and Community Health, JNU, New Delhi emphasized that a subgroup on regulation of private sector, technologies and health care costs was the need of the hour.

Dr. Nerges Mistry observed that performance based payments should be encouraged. **Dr. Shalini Bharat** mentioned that it was time that the existing yardsticks are reevaluated and the present criteria for infrastructure development should be expanded beyond population norms.

Shri Amarjeet Sinha, Prinicpal Secretary (H&FW) Bihar, mentioned that outreach services through MMUs at village level were essential and an experiment in this regard in Bihar was very well received. He said that if adequate amenities are provided to doctors, they are encouraged to join government service. He recognized the need of one skill lab at every district. Most importantly he pointed to the need for central support to State governments in setting up Medical Colleges. Innovations in HR recruitments at the State level should be encouraged in the next plan period.

Addressing queries on procurement, **Shri. K. Chandramouli**, informed the group that a Central Procurement Authority is being set up at the National Level. **Dr. Sudarshan, Karuna Trust** observed that management structures under NRHM required to be strengthened including at the National level. **Smt. Anuradha Gupta, JS (RCH), MoHFW** agreed with Dr. Sudarshan and further pointed out that RCH management structures at the

State and District levels also needed strengthening. **Smt. Girija Vaidyanathan** shared that in her State where they have initiated tie ups with doctors from medical colleges for strengthening of directorate since the doctors were unwilling to work full time at the directorate for technical inputs. **Shri. Amarjeet Sinha** also described similar arrangements in Bihar and agreed that such arrangements could be encouraged.

Smt. Girija Vaidyanathan suggested that while there is need for strengthening of RKS and making the structure more transparent and community oriented, States should be given the liberty to decide whether the PRI member should be made a chairperson of the RKS. **Shri. Amit Mohan Prasad**, remarked that RKS meetings are not taking place and its role as a grievance redressal forum is currently lacking and thus there is a great need for PRI involvement.

Ms. Renu Khanna emphasized the need for formation of teams of ANMs, ASHAs and MPWs at the ground level, with greater convergence between the three. She suggested that MPWs can play an important role in NACP and RCH convergence and can act as a role model for the male community in areas of ARSH and prevention of STDs.

Dr. Shalini Bharat pointed out that focus on sexual health and health promotion is missing. She also suggested that the role of ASHA's should be expanded to include geriatric care.

Ms. Poonam Mutreja suggested that ASHAs should be given fixed remuneration. **Dr. Sudarshan**, suggested conversion of ASHAs into full time employees instead of keeping her as a volunteer. However many other members of the working group did not support this suggestion saying that governance and accountability issues related to other regular human resources would also arise in the ASHA programme seriously affecting her current functionality. **Shri. P. K. Pradhan** informed the group about the ministry's inclination to substantially increase the incentives to ASHAs.

Dr. Prema Ramachandran, Director NFI, pointed out that there is a need to redefine the goals to ensure that they are more specific and achievable such as redefining the goal of 'reducing anemia' to 'reducing moderate and severe anemia'. She also suggested that a strong link between detection of undernutrition and involvement of concerned aanganwadi centre needs to be developed. **Shri. K. Chandramouli** supporting the above suggestion, stated that there was a need for clear articulation of the areas and strategies for

convergence. **Dr. Prema Ramachandran**, suggested that Annual Health Survey could be conducted by staff from the health department instead of school children.

Dr. N.K. Arora, International Clinical Epidemiology Network (INCLEN), New Delhi raised the issue of role clarity between ASHA, AWW and ANM and stated that ASHA's should not be given curative tasks and her work should be restricted to community mobilization. He also suggested that RKS should accept public grievances. **Ms. Anuradha Gupta**, seconding his observations said that RKS could be empowered for handling grievance redressal.

Shri. Amit Mohan Prasad, suggested that every village should have one health centre. Other members and Secretary HFW also agreed and asked this to be made part of the recommendation. **Ms. Renu Khanna** specified that while fixing a goal of 80 % institutional deliveries it is important to remember that the focus should be on safe deliveries than on institutional deliveries. **Dr. Shalini Bharat** also supported her suggestion that safe deliveries require greater focus. **Dr. Shakeel** suggested that the role of TBA in safe deliveries should be recognized. **Shri. Manohar Agnani, MD (NRHM), Madhya Pradesh**, pointed out that while safe deliveries should be on focus, the emphasis on institutional deliveries should not be reduced as it puts a tremendous pressure on the Government system and the hospitals to perform, strengthening the system in the bargain. **Ms. Anuradha Gupta**, also mentioned that Janani Shishu Suraksha Karyakram, launched by the GOI, also puts pressure on the system to perform better. She clearly stated that the scheme looks at reducing the causes of MMR in totality and does not promote a standalone strategy of institutional delivery. Also State governments have been encouraged to identify areas where home deliveries are prevalent and plan for ANM assisted home deliveries in these areas.

Dr. N. K. Arora, International Clinical Epidemiology Network (INCLEN), New Delhi pointed out that in the wake of JSSK, introduction of a course on community midwifery is of great importance. He also shared that a checklist has been devised on identification of mothers who require 48 hours stay in the hospital. If the checklist is filled by the doctor at the time of discharge of the mother, then mothers who require 48 hours stay could be easily identified and maternal deaths could be avoided. He thus suggested that the same be introduced in the system. **Shri K Chandramouli** requested him to submit the details and other suggestions for further follow up.

Smt. Girija Vaidyanathan, requested that with regards to EMRI, Central Government assistance should not be completely stopped and GoI should continue to provide minimum support.

Dr. N. K. Arora suggested that addressing childhood obesity should also be a priority. At this, **Dr. Prema Ramachandran** suggested that Hemoglobin estimation, weight check up and height checkups should be mandatory for every patient entering the hospital to address the issue of malnutrition.

Dr. Renu Khanna shared that health care providers are getting cautious about conducting MTPs and have started refusing MTPs to women in the second trimester with the fear of prosecution under the PC & PNDT act. This may be detrimental to provision of safe abortion services for women and thus caution is needed in the implementation of the act. She also pointed out that special focus is required to address female under five mortality and **Shri. P. K. Pradhan** agreed to include the same in the proposal.

Dr. Shakeel brought out the point that Emergency contraceptive pills are being used by patients as regular contraceptives which is harmful to the health of women. **Dr. P.K. Shah, President, Federation of Obstetric and Gynecological Societies of India, (FOGSI) Mumbai** supported this and suggested that while over the counter availability of EC pills should not be restricted, IEC on the same definitely needs to be strengthened. **Ms. Poonam Muttreja** suggested that injectible contraceptives should be introduced. It was informed that many MPs have also made request in this regard. It was also suggested in the meeting that GOI should write to the States that post partum acceptance of IUCD should be encouraged.

Shri. P. K. Pradhan pointed out that currently, integrating NRHM in the health system and improving governance are the major challenges faced by NRHM. **Dr. Dhruv Mankad**, put in a caution that it should be taken care that insurance programmes should not replace primary health care systems in the country. Secretary HFW agreed with this and mentioned that strong public sector in healthcare is required in the country.

Dr. Pankaj Shah, Self-Employed Women's Association (SEWA) Rural Gujarat suggested that Sickle Cell Disease Control should be given priority. He specifically urged that duplication of record keeping at the facility level should be avoided and there is a great need for streamlining the reporting system. **Shri. P. K. Pradhan** suggested that Dr. H. Sudarshan should submit a proposal for strengthening capacity building of NGOs for

community monitoring. **Ms. Poonam Muttreja** suggested that a National and State level resource centres for capacity building of NGOs are the need of the hour. **Dr. Shalini Bharat** pointed out that quality of care needs to include gender sensitivity as an integral part and help desks should be available at all public health facilities. Dr. N.K.Arora pointed out that patient safety and quality of care require greater focus.

There was a great concern among members for clarifying the role of AYUSH doctors under NRHM. There was a general understanding that a greater focus is required on mainstreaming of AYUSH and that States need to be given the detailed understanding of the responsibilities of AYUSH doctors under NRHM. **Shri. K. Chandramouli** instructed the representative from the AYUSH department to submit a document specifying the role of AYUSH doctors under NRHM. **Ms. Renu Khanna** pointed out that AYUSH medicines need to be a part of the treatment guidelines under public health system.

Dr. N.K Sethi, former Sr. Adviser (Health), Planning Commission GoI, gave two important suggestions namely that essential drugs should be made completely free at all public health facilities and that all investigations and diagnostic services should be made free for all patients at public health facilities.

Shri. Manohar Agnani suggested that State share under NRHM should be increased to 25 % if State Governments' spending on health is to be increased. **At the end, Shri. P. K Pradhan** thanked all the members for their active participation and involvement and stated that amendments would be made in the draft paper based on the discussions and suggestions received. The meeting ended with vote of thanks by **Shri Amit Mohan Prasad,JS(Policy)**
