Mission for Rural Health Care Delivery in Selected States

Draft Document for Discussion

For meeting on 7th Oct. 2004
4/10/04

Preamble

This Mission seeks to improve rural health care delivery in states where it is weakest at present by ensuring a provider in each village, effective hospital care to the rural population and converged action on health and the determinants of health for maximum impact. The Mission will be the instrument to integrate multiple vertical programmes at the District level along with their funds. The Mission will ensure the right of every child in these states in India to basic health services

Current Situation

- Health status of the people is extremely poor in the rural areas of the 10 states of Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, Assam, Jammu and Kashmir and states in the North-East
- Poverty and ill-health are mutually reinforcing
- Status of public provisioning of health care weak where it is needed most
- These states also contain the 150 population-focus districts: New national response required

Current Situation

- Health Sector has not utilised opportunity for intersectoral action provided by panchayat raj
- Health output dependent on action for health combined with action on key determinants of health like safe water, sanitation, nutrition etc. Panchayat Raj has mandate also over these determinants
- Opportunity to redesign ineffective national programmes mandate in NCMP/PM's directive to revamp delivery

Rural Health through a Citzen Lens

- " Burden of disease high on account of poverty and illiteracy"
- " There is no official health provider in the village"(in most villages in these states)
- " There is a designated ANM(MPW). Located elsewhere so visits, at best, twice a month"
- "Most deliveries take place at home—the nearest PHC (20 kms) anyway cant provide institutional care"
- "The nearest effective unit for hospital care is the CHC, about 40 kilometers away"
- " There are private providers close by whose services are paid for"

Rural Health Care through Government Lens

- There is a Multi-Purpose Worker (Male and Female) for population of 3000-5000 at the Sub Centre as First Unit
- The next unit is one for hospital care- Sector PHC for a population of 30,000-1,00,000 (about 40 villages) with one doctor, one nursing assistant, one ward boy, dresser, 2 sector supervisors and 2 MPW. It also has 6 beds
- There is a Community Health Centre for a population of over 1 lakh. With over 10 doctors, nursing staff, lab technicians, radiologists etc and about 40 plus beds. High occupancy rate ?
-

Rural Health and Government Provisioning: Why does it fail?

- First Unit of MPW (ANM) fails because not a resident of the village
- Second unit of PHC a planning failure of serious proportions. Utilisation of beds 0 to 2%. A mixed-up model combining inpatient care and outreach function not doing either
- Means citizen gets effective referral care only at CHC- about 40 Kms away
- Though private providers exist, there is no link with them for public health

Rural Health and Government Provisioning: Why does it fail?

- MPW (ANM) is an extension of the government into the village—not a "finger of the community going up" – therefore comes with government's health agenda and not structured to respond to people's health needs
- Government does not simultaneously act on the causes of ill-health (preventive action on determinants)
- Private providers are not accredited and therefore do an entrepreneurial function, not a public health one
- Government has " programmes for individual diseases" and not a plan for comprehensive health care
- Health care delivery is completely top-down with priorities set in Delhi and flowing down

Some serious planning errors/ need for correction

- ANM(MPW) conceived on population- norm and needs to be based on habitation-norm
- Sub Centre has no autonomy
- Sector PHC cannot do inpatient care and so needs to be reconfigured as outreach unit only
- CHC can be strengthened to become first effective referral unit
- District has no space to plan for itself—therefore cant link effectively with determinants

Some serious planning errors/ need for correction

- No collective platform for health at district-level which includes private providers, other non allopathic providers
- State level budgets being spent mostly on salaries and medicines, GOI has become the real player in programme design—more so for poorer states
- Resource constraints and importance of health goals have brought in large number of donors: in the absence of an integrating framework donor-catalysed programmes further fragment comprehensive health care into" selective" goals

Some serious planning errors/ need for correction

- Within states, areas are carved out for different donor agencies
- Each programme operates as a vertical silo
- Too many vertical programmes with no horizontal connections
- Every programmes exhorts "intersectorality" but in practice fragment resources and dissipate energies
- In short health sector which needs "extra-sector action" to be effective, is internally fragmented

What could be done?

- Step 1: Simple horizontal integration at the district level of all vertical programmes under the format of Rural Health Care Delivery Mission
- A " funnel" approach to doing this: May be many on top but flow into one common pool at district level
- GOI will create one omnibus Centrally Sponsored Programme called " District Rural Health Care Delivery Mission" and put under it the following programmes

What could be done?

- **Programmes for integration of funds at district level under the common head of the Mission:**

(a) **Strengthening of Rural Health Infrastructure (b) Population Control © Reproductive and Child Health (d) National Malaria Programme (e) National Leprosy Eradication Programme (f) National Kala Azar Programme (g) National Programme for Control of Blindness (h) National Iodine Deficiency Disorders programme (I) National Filaria Programme (j) Revised National Tuberculosis Programme**

(b) **National Aids Programme and National Cancer Programme may be separately considered**

What could be done?

(f) District Health Plan

- This plan should detail action under components (a) to (e) and suggest collaborative action for determinants through other sectors like safe water, sanitation, nutrition etc.
- It could contain ideally an (g) untied fund for supporting local action
- The District Health Society will have on it intersectoral functionaries who can operationalise such a plan

What could be done: Supportive Action

- District Health Society will pool existing personnel under different societies for managerial support: Gaps here will be provided for(example, accounts staff)
- Private sector, NGO collaboration would be enabled at district level through district health plans
- District Public Health Report will be presented each year on status under key components
- Concurrent review will be done by non government organisations

Mission Output

- At the village level, every village gets a provider--either MPW or Community Health Activist
- At the village level, if possible, a health room
- At the village level, a trained dai in each village
- At the village level, a sensitised frontline team of panch,MPW,Anganwadi worker etc
- At village level, action on determinants of health
- At village (cluster) level, a better functioning sub Health Centre with untied funds for community health action

Mission Output

- A better functioning CHC for hospital care
- Each CHC working under community control, with local resource mobilisation
- At District level, a coordinated plan that links with private providers
- At District level, a coordinated plan with action on determinants
- At District level, integration of resources internal to health sector and combining with outside sector funds
- At District level, effective support staff
- At District level, effective programme review and public accountability
- Impact on IMR, MMR, Universal Immunisation, Reduction in Communicable Diseases in 4 years, mainstreaming Aids prevention, leading to population stabilisation

Everybody wins

- Citizens get improved health services
- Local bodies/ District gets leadership roles in planning for their area
- State governments/ state managers get freedom from vertical programmes that dissipate energies
- Government of India is able to target its resources better and ensure better outcomes
- Private Sector, NGOs get space to collaborate
- Development Partners get value for money

Mission Implementation: Structure (for all Missions)

- Mission Coordinating Group headed by the Prime Minister with Deputy Chairman Planning Commission, Ministers of Mission areas, Cabinet Secretary and Principal Secretary to PM.
- National Mission for Rural Health Care Delivery located in the Ministry of Health (Family Welfare).
- Mission Steering Group headed by Minister of Health, Secretaries of the three wings of health, Member Planning Commission, Secretaries of WCD, Elementary Education and Literacy,Experts. Mission located in Department of Family Welfare with a Mission Director (at JS level)

Mission Implementation

- State level Missions headed by the Chief Minister with similar composition
- State level Steering Group headed by the Chief Secretary
- District level Mission with ZP as Chairperson, Collector as Co-Chairperson and CMHO as Secretary and heads of Committes for health, education, WCD in ZP etc as members along with district heads of Departments, representatives of private providers, NGOs, experts on public health etc.

Next Steps

- Circulation of the draft Mission outline to a selected group of experts and representatives of states taken up under the Mission: 15-18 September
- Meeting to finalise Mission and setting deadlines for state-level documents: 1st week of October
- Finalisation of National Mission Document: 15 October
- Cabinet Clearances etc 15-30 October
- Mission to commence: 14 November

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CHC

From: "PHM-Secretariat" <secretariat@phmovement.org>
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Sent: Tuesday, October 05, 2004 5:13 PM
Attach: Strategy for 150 CMP districts.doc
Subject: [pha-ncc] Fw: Rural Health Mission

Dear Friends,

Greetings from PHM Secretariat (Global)!

While we await Amit's report about the 22nd September dialogue on Health with National Advisory Council (Jayaprakash's paper on Health Care), I am enclosing another document which has been received by many of us (we don't know who are the others on the invitation list as yet), about a 'Mission for Rural Health Care Delivery in selected states' – to be discussed at a meeting in Delhi on 7th October organized by Sri Prasanna Hota (Health and Family Welfare secretary) in the presence of the Health Minister. This is a Mission that is to be launched on 14th November (why the populist hurry??).

Hope you have all seen the critiques and responses to Jayaprakash's paper by JSA, Sundar, JNU and CHC all of which have been circulated to continue to evolve a healthy consensus on inputs to the Ministry's initiatives.

Any comments on this Rural mission may be sent before 7th in case you wish some of us to raise the issue and also after as a continuing interactive dialogue. Just as we were forwarding it, another complimentary paper arrived m(see below). On checking with the Ministry, the first paper is by the PM's office and the second one is by the Ministry (of Health Department of Family welfare)

Best wishes

Ravi Narayan

Attahements:

a. Mission for Rural Health Care Delivery
b. Selected states – Draft document for Discussion from PMOs office

STRATEGIC INPUTS

INSTITUTIONAL:

- Expanding the EAG mechanism to Rural Healthcare Mission (RHM) for focused attention on 17 States- 8 EAG States (U.P., M.P., Bihar, Rajasthan, Orissa, Jharkhand, Uttaranchal and Chhattisgarh), 7 North Eastern States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura), Jammu & Kashmir and Sikkim

- 5 States to be covered under Common Minimum Programme (CMP) Strategy for

focus on population stabilization

- 8 States to be covered under North East Health Mission (NEHM)
- Graded packages for varying needs, based on State ownership and articulation
- At national level, RHM to be presided over by PM/HFM
- At state level, RHM to be presided over by CM/State Health Minster
- RHM to include agendas of the 3 Departments of Health, FW and AYUSH

INTRA & INTERSECTORAL CONVERGENCE:

- All vertical national health programmes and donor funds to converge at the State/District level
- Funds for civil works, drugs equipment, training management and IEC pooled together into a District Health Fund for which a composite District Health Plan shall be made
- Creation of a District Health Development Agency (DHDA)
- District Health Plan to address issues of Health, Nutrition and sanitation
- Convergence of infrastructure, including manpower, of AYUSH at district and sub district levels. AYUSH products/medicines to be promoted in Reproductive & Child Health (RCH) Programme.

PROGRAMME AND FINANCIAL MANAGEMENT INPUTS:

- Engaging skilled professionals like CAs, MBAs and MIS specialists to strengthen State Programme Management Unit (PMU) and District management unit (DMU)
- Creation of a National Health Resource Centre (NHRC) to provide Technical Assistance at GoI/State level
- Introducing e-banking, GIS based MIS etc, for improved programme management
- Formalizing strategy for timely procurement and appropriate logistics arrangement at district and sub-district levels

COMMUNITY PARTICIPATION:

- Giving functional responsibilities and powers to the Panchayati Raj bodies for planning and supervising discharge of public health duties

- Constitution of District, Block and Village Level Health Committees
- Raising a cadre of voluntary Accredited Social Health Activists (ASHA) at village levels
- Convergence between ANM, AWW and ASHA –Anganwadi to be the hub of health and nutrition activities in the village
- Creation of a Drug & Contraceptive depot at village level
- Providing Flexifund at panchayat/sub-centre/district level to enhance control over local issues for health and family welfare.

STRENGTHENING PUBLIC HEALTH INFRASTRUCTURE:

- Operationalising FRUs- all CHCs and 50% PHCs
- Addressing mismatch of manpower and equipments at health facilities
- Performance benchmarking of public health facilities
- Constitution of Health Committees empowered to levy user fee- GoI to contribute matching share
- Overcome manpower deficiencies through engaging private doctors
- Depending on availability of Budget, options like second ANM at Sub-centre and salary payment of MPW (Male) by GoI could be considered.

PUBLIC PRIVATE PARTNERSHIP FOR HEALTH:

- Social Marketing/ Social Franchising of services (sterilization, IUD insertion, institutional delivery, immunization) and products (contraceptives) through a network of Sukhi Parivar Clinics
- Enhanced Quality Transaction Cost (QTC) for sterilization, IUD insertion and institutional delivery to incentivise private participation
- Arranging soft loan from banks for setting up/ upgradation of FW Clinic
- Declaring income from family planning services income tax free
- Adding other RCH and curative services gradually, through Community Insurance

QUALITY CONTROL:

- Enhanced transaction cost in CMP States to provide quality service
- Introducing quality protocols for family planning procedures
- Widening the basket of contraceptives under National Family Welfare Programme
- Strategy to increase contribution of NSV in sterilization procedures
- Provision of continuing Medical Education and hands on training for both public and accredited private sector doctors
- Setting up an Ombudsman at National/State level
- Constituting Quality Assurance Committees at State/District level
- Insurance cover for acceptors and service providers of sterilization services in Government & accredited private clinics
- Accreditation process and branding of public/private health facilities
- Social audit by NGOs, PRIs- triangulated verification system
- Inclusion of the subject of Reproductive Health in syllabi of Medical Education

OUTPUTS OF THE RURAL HEALTH MISSION

PROCESS OUTCOMES:

- Decentralization and convergence at village/district levels for Health, Family Welfare, AYUSH & nutrition
- Strengthening preventive and promotive care at community levels
- Improved system of referrals
- Strengthened public health infrastructure – provision of Maintenance Fund
- Accountability and responsiveness to elected Bodies of the community
- Simplification of planning and implementation of Schemes of Health and Family Welfare and Donor Programmes
- Optimization of resources
- Graded packages to cater to State specific unmet needs – health infrastructure in NEHM and focus on population stabilization in CMP States

- Improved systemic capacity for programme implementation and fund flow
- Creation of health infrastructure in backward districts
- Improving access to family welfare services and healthcare in CMP districts through Public-Private Partnership
- Quality assurance in public health programmes
- Increased utilization of public health infrastructure
- Extending financial risk protection to poor for health and family welfare services
- Community financing for maintenance of public health infrastructure

IMPROVEMENT IN DEMOGRAPHIC INDICATORS:

- Raising level of universal immunization from 50% to 90%
- Improved Infant Mortality Rate and Maternal Mortality Ratio through increased institutional deliveries and focus on IMNCI and immunization
- Reduction in Total Fertility Rate to enable attainment of goals of National Population Policy for 2010
- Early treatment of infectious diseases

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Current Situation:

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What could be done?

- **Step 1: Simple horizontal integration at the district level of all vertical programmes under the format of Rural Health Care Delivery Mission**
- A "funnel" approach to doing this: May be many on top but flow into one common pool at district level
- GOI will create on Omnibus Centrally Sponsored Programmed called "District Rural Health Care Delivery Mission" and put under it the following programmes
- **Programmes for integration of funds at district level under the common head of the Mission:**
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    b) **Population control**
    c) **Reproductive and Child Health**
    d) **National Malaria Programme**
    e) **National Leprosy Eradication Programme**
    f) **National Kala Azar Programme**
    g) **National Programmed for Control of Blindness**
    h) **National Iodine Deficiency Disorders programme**
    i) **National Filaria Programme**
    j) **Revised National Tuberculosis Programme**

    National AIDS Programme and National Cancer Programme may be separately considered

- These different programmes will be budgeted under the common head and resources passed on to districts through states
- Monitoring would be done by the centre and states for which separate streams for monitoring will be retained at Centre/State levels
- This will mean dissolving the multiple societies that now exist for managing these programmes into one common Health Society at the District level. Could be chaired by the Chairperson ZP, with collector as Co-Chair and CMHO as secretary. Operation of cheque by any two
- All of the above to be done by GOI

Step 2: District Health Plan as Programme Instrument and following components

a) Provider in Each Village: Government provider mapping and filling up gaps by training one person in each village as a barefoot doctor (in those villages where none exist)

- **Government to provide training, kit, link with the sub Health Centre/PHC. She/He entitled to practice as government certified community health activist**

b) **Facility: Government will try and provide a health room in each village (if resources permit: this is not considered essential, especially in low -density population villages)**

- **Every untrained dai will be trained in each village (many have already been trained)**

c) **Organisation**

A Frontline team for health in each village with elected Panchayat, ANM/Community health Activist, Dai/teacher/anganwadi worker

d) **Support from Private providers**

District to identify and register all private providers and link them effectively with public health provisioning

e) **Strengthening Facilities at Sub Centre, PHC, CHC**

- Untied fund of Rs. 5000 per year as Community Health Action Fund to ANM/MPW to catalyse frontline team for action on health and determinants
- Sector PHC given territorial responsibility and its medical staff deployed with CHC, if state so wishes
- CHC strengthened with community monitoring through Patients Welfare Committee
- CHC allowed to levy user charges, more for accountability (poor can be exempted to avoid any such criticism that poor are being charged)

f) **District Health Plan**

- This plan should detail action under components (a) to (e) and suggest collaborative action for determinants through sectors like safe water, sanitation, nutrition etc..
- It could contain ideally an (g) untied fund for supporting local action
- The District Health Society will have on it intersectoral functionaries who can operationalise such a plan

g) **What could be done: Supportive Action**

- District Health Society will pool existing personnel under different societies for managerial support: Gaps here will be provided for (example, accounts staff)
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- District Public Health report will be presented each year on status under key components
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Mission Output

- At the village level, every village gets a provider – either MPW or Community Health Activist
- At the Village level, if possible, a health room
- At the Village level, a trained dai in each village
- At the Village level, a sensitised frontline team of panchayat, MPW, Anganwadi, etc.,
- At the Village level, action on determinants of health
- At Village (cluster) level, a better functioning sub health centre with untied funds for community health action
- A better functioning CHC for hospital care
- Each CHC working under community control, with local resource mobilisation
- At district level, a coordinated plan that links with private providers
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- At District level, integration of resources internal to health sector and combining with outside sector funds
- At district level, effective support staff
- At District level, effective programme review and public accountability
- Impact on IMR, MMR, Universal Immunisation, Reduction in Communicable diseases in 4 years, mainstreaming AIDS prevention, leading to population stabilisation.

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- State Governments/State managers get freedom from Vertical programmes that dissipate energies
- Government of India is able to target its resources better and ensure better outcomes
- Private Sector, NGOs get space to collaborate
- Development partners get value for money

Mission Implementation:

Structure (For all Missions)

- Mission Coordinating Group headed by the Prime Minister with Deputy Chairman Planning Commission, Ministers of Mission areas, Cabinet Secretary and Principal Secretary to PM
- National Mission for Rural Health Care Delivery located in the Ministry of Health (Family Welfare)
- Mission Steering Group headed by the Minister of Health, Secretaries of the three wings of Health, Member Planning Commission, Secretaries of WCD, Elementary education and Literacy, Experts. Mission located in Department of Family welfare with a Mission Director (at JS level)
- State level Missions headed by the Chief Minister with similar composition
- State level Steering Group headed by the Chief Secretary
- District level Mission with ZP as chairperson, Collector as Co-chairperson and CMHO as Secretary and heads of Committees for health, education, WCD in ZP etc., as members along with district heads of Departments, representatives of private providers, NGOs, Experts on public health etc.,

Next Steps:

- Circulation of the draft Mission outline to a selected group of experts and representatives of states taken up under the Mission: 15-18 September
- Meeting to finalise Mission and setting deadlines for state-level documents: 1st week of October
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- Cabinet Clearances etc.: 15-30 October
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Executive Brief

"Mission for rural health care delivery"

Goal:

To improve rural health care delivery in selected states (Namely Bihar, Jharkhand, MP, Chhattisgarh, UP , Uttranchal, Orissa, Assam, J&K, and states in North East region).

Rationale:

Health care system is weak in these states. These stases cover 150 special focus districts.

Strategies:

1. **Horizontal integration of all vertical programmes at the district** under one common centrally sponsored programme, " District Health Care Delivery mission".

   Common budget head for programmes for strengthening rural infrastructure, population control, Reproductive and child health, malaria, leprosy, blindness, iodine deficiency, filarial and tuberculosis.

   Management of he programme through one common health society at the district.

2. **Development of district health plan to ensure**

   - Health service provider at each village (Government health staff, Training local volunteer to act as "Bare Foot doctor")
   - Health room in each village
   - Training of untrained dais
   - Health team in each village comprising of elected Panch, ANM/ Community volunteer, Dai, Teacher, Anganwari worker.
   - Identifying qualified private service providers in the district and linking them to government service provider.
   - Strengthening of CHC, PHC, SC.
   - User charges for services at CHC for those who can afford
   - Monitoring of services of CHC through patient Welfare Committee.

3. **Operationalisation of district health plan**

Through District Health Societies

4. **Monitoring of plan**

- Concurrent review by NGOs
- Annual review of district report on key indicators

Organisational structure:

1. **Centre**

i. **Mission co-ordination group**

Headed by Prime Minister, Deputy Chairman planning commission, Ministers of related areas, Cabinet secretary, Principal secretary to Prime Minister.

ii. **National Mission for rural health care delivery located at Ministry of health & family welfare**

iii. **Mission steering group**

Headed by Minster of Health & Family Welfare, secretaries of three wings of health, member planning commission, secretaries of women and child development, elementary education and literacy, experts

2. **State**

i. **State level Mission**

Headed by Chief Minister, head state planning unit, Ministers of related areas etc.

ii. **State Steering group**

Headed by chief secretary

iii. **District level group**

Headed by chairperson of Zilla Parishad, co-chairperson collector, secretary Chief medical officer, district heads of other related departments, representatives from NGOs, Private practitioners and public health experts.

Time frame:

i. Meeting to finalize mission document and setting deadlines for state level mission documents **By 7th October 2004**

ii. Finalization of National Mission document **By 15th October 2004**

iii. Cabinet clearance **By 15-30th October 2004**

iv. Mission to commence **On 15th November 2004**

Discussion points on the mission

1. Do you think this mission is useful and relevant to your state, if yes give justification and if no why?

2. Please consider your state and identify what are strengths and weakness in your health services to implement this mission in your state.

2. What changes you would suggest in the mission document for its successful implementation?

3. Any other remarks

OVERVIEW OF RURAL HEALTHCARE MISSION

STRATEGIC INPUTS

INSTITUTIONAL:

- Expanding the EAG mechanism to Rural Healthcare Mission (RHM) for focused attention on 17 States- 8 EAG States (U.P., M.P., Bihar, Rajasthan, Orissa, Jharkhand, Uttaranchal and Chhattisgarh), 7 North Eastern States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura), Jammu & Kashmir and Sikkim
- 5 States to be covered under Common Minimum Programme (CMP) Strategy for focus on population stabilization
- 8 States to be covered under North East Health Mission (NEHM)
- Graded packages for varying needs, based on State ownership and articulation
- At national level, RHM to be presided over by PM/HFM
- At state level, RHM to be presided over by CM/State Health Minster
- RHM to include agendas of the 3 Departments of Health, FW and AYUSH

INTRA & INTERSECTORAL CONVERGENCE:

- All vertical national health programmes and donor funds to converge at the State/District level
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PROGRAMME AND FINANCIAL MANAGEMENT INPUTS:

- Engaging skilled professionals like CAs, MBAs and MIS specialists to strengthen State Programme Management Unit (PMU) and District management unit (DMU)

- Creation of a National Health Resource Centre (NHRC) to provide Technical Assistance at GoI/State level
- Introducing e-banking, GIS based MIS etc, for improved programme management
- Formalizing strategy for timely procurement and appropriate logistics arrangement at district and sub-district levels

COMMUNITY PARTICIPATION:

- Giving functional responsibilities and powers to the Panchayati Raj bodies for planning and supervising discharge of public health duties
- Constitution of District, Block and Village Level Health Committees
- Raising a cadre of voluntary Accredited Social Health Activists (ASHA) at village levels
- Convergence between ANM, AWW and ASHA –Anganwadi to be the hub of health and nutrition activities in the village
- Creation of a Drug & Contraceptive depot at village level
- Providing Flexifund at panchayat/sub-centre/district level to enhance control over local issues for health and family welfare.

STRENGTHENING PUBLIC HEALTH INFRASTRUCTURE:

- Operationalising FRUs- all CHCs and 50% PHCs
- Addressing mismatch of manpower and equipments at health facilities
- Performance benchmarking of public health facilities
- Constitution of Health Committees empowered to levy user fee- GoI to contribute matching share
- Overcome manpower deficiencies through engaging private doctors
- Depending on availability of Budget, options like second ANM at Sub-centre and salary payment of MPW (Male) by GoI could be considered.

PUBLIC PRIVATE PARTNERSHIP FOR HEALTH:

- Social Marketing/ Social Franchising of services (sterilization, IUD insertion, institutional delivery, immunization) and products (contraceptives) through a network of Sukhi Parivar Clinics
- Enhanced Quality Transaction Cost (QTC) for sterilization, IUD insertion and institutional delivery to incentivise private participation
- Arranging soft loan from banks for setting up/ upgradation of FW Clinic

- Declaring income from family planning services income tax free
- Adding other RCH and curative services gradually, through Community Insurance

QUALITY CONTROL:

- Enhanced transaction cost in CMP States to provide quality service
- Introducing quality protocols for family planning procedures
- Widening the basket of contraceptives under National Family Welfare Programme
- Strategy to increase contribution of NSV in sterilization procedures
- Provision of continuing Medical Education and hands on training for both public and accredited private sector doctors
- Setting up an Ombudsman at National/State level
- Constituting Quality Assurance Committees at State/District level
- Insurance cover for acceptors and service providers of sterilization services in Government & accredited private clinics
- Accreditation process and branding of public/private health facilities
- Social audit by NGOs, PRIs- triangulated verification system
- Inclusion of the subject of Reproductive Health in syllabi of Medical Education

OUTPUTS OF THE RURAL HEALTH MISSION

PROCESS OUTCOMES:

- Decentralization and convergence at village/district levels for Health, Family Welfare, AYUSH & nutrition
- Strengthening preventive and promotive care at community levels
- Improved system of referrals
- Strengthened public health infrastructure – provision of Maintenance Fund
- Accountability and responsiveness to elected Bodies of the community
- Simplification of planning and implementation of Schemes of Health and Family Welfare and Donor Programmes
- Optimization of resources
- Graded packages to cater to State specific unmet needs – health infrastructure in NEHM and focus on population stabilization in CMP States
- Improved systemic capacity for programme implementation and fund flow
- Creation of health infrastructure in backward districts
- Improving access to family welfare services and healthcare in CMP districts through Public-Private Partnership
- Quality assurance in public health programmes
- Increased utilization of public health infrastructure
- Extending financial risk protection to poor for health and family welfare services
- Community financing for maintenance of public health infrastructure

IMPROVEMENT IN DEMOGRAPHIC INDICATORS:

- Raising level of universal immunization from 50% to 90%
- Improved Infant Mortality Rate and Maternal Mortality Ratio through increased institutional deliveries and focus on IMNCI and immunization
- Reduction in Total Fertility Rate to enable attainment of goals of National Population Policy for 2010
- Early treatment of infectious diseases

PHM-Secretariat

COMH-84.4

From: "sushama rath" <sushamarath@yahoo.co.in>
To: <secretariat@phmovement.org>
Sent: Tuesday, October 05, 2004 3:12 PM
Subject: Rural Health Mission

Dear Sir,

As already informed in the invitation letter TA/DA will paid to you including air travel by economy class.

Overview of Rural Health Care Mission is hereby sent.

Sushama Rath
Under Secretary (ID/EAG)

OVERVIEW OF RURAL HEALTHCARE MISSION

STRATEGIC INPUTS

INSTITUTIONAL:

- Expanding the EAG mechanism to Rural Healthcare Mission (RHM) for focused attention on 17 States- 8 EAG States (U.P., M.P., Bihar, Rajasthan, Orissa, Jharkhand, Uttaranchal and Chhattisgarh), 7 North Eastern States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura), Jammu & Kashmir and Sikkim
- 5 States to be covered under Common Minimum Programme (CMP) Strategy for focus on population stabilization
- 8 States to be covered under North East Health Mission (NEHM)
- Graded packages for varying needs, based on State ownership and articulation
- At national level, RHM to be presided over by PM/HFM
- At state level, RHM to be presided over by CM/State Health Minster
- RHM to include agendas of the 3 Departments of Health, FW and AYUSH

INTRA & INTERSECTORAL CONVERGENCE:

- All vertical national health programmes and donor funds to converge at the State/District level

- Funds for civil works, drugs equipment, training management and IEC pooled together into a District Health Fund for which a composite District Health Plan shall be made
- Creation of a District Health Development Agency (DHDA)
- District Health Plan to address issues of Health, Nutrition and sanitation
- Convergence of infrastructure, including manpower, of AYUSH at district and sub district levels. AYUSH products/medicines to be promoted in Reproductive & Child Health (RCH) Programme.

PROGRAMME AND FINANCIAL MANAGEMENT INPUTS:

- Engaging skilled professionals like CAs, MBAs and MIS specialists to strengthen State Programme Management Unit (PMU) and District management unit (DMU)
- Creation of a National Health Resource Centre (NHRC) to provide Technical Assistance at GoI/State level
- Introducing e-banking, GIS based MIS etc, for improved programme management
- Formalizing strategy for timely procurement and appropriate logistics arrangement at district and sub-district levels

COMMUNITY PARTICIPATION:

- Giving functional responsibilities and powers to the Panchayati Raj bodies for planning and supervising discharge of public health duties
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- Addressing mismatch of manpower and equipments at health facilities

- Performance benchmarking of public health facilities
- Constitution of Health Committees empowered to levy user fee- GoI to contribute matching share
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- Reduction in Total Fertility Rate to enable attainment of goals of National Population Policy for 2010

- Early treatment of infectious diseases

PHM-Secretariat

From: <dreze@econdse.org>
To: <chaukhat@yahoo.com>; <secretariat@phmovement.org>
Cc: <pha-ncc@yahoogroups.com>
Sent: Monday, September 20, 2004 3:00 PM
Attach: Strategyin150CMPdistricts-revised[1].doc
Subject: [pha-ncc] CMP for real

Vandana: You must have seen this but just in case (words in bold are mine). One could not hope for a clearer statement of what is cooking,

Jean

Delhi meeting 3/10 + 7/10/04

5/10/04

Com H. 84.5

Government of India
Ministry of Health and Family Welfare
Department of Family Welfare

STRATEGY IN 150 CMP DISTRICTS FOR FAMILY PLANNING

CMP Mandate

The Common Minimum Programme (CMP) of the United Progressive Alliance (UPA) Government states that "the UPA Government is committed to replicating all over the country the success that some Southern and other States have had in family planning. A sharply targeted Population Control Programme will be launched in the 150 odd high fertility districts". The Department of Family Welfare is initiating a CMP Programme accordingly in the identified 150 high fertility districts of the country. The strategy of the Department for the CMP Programme is as follows:

Selection of Districts

The districts were arranged in descending order of Total Fertility Rate (TFR) as per the Census 2001 data. By excluding better performing States with one or two districts from the list, like Haryana (Gurgaon), Uttaranchal (Hardwar), West Bengal (Uttar Dinajpur, Maldah), Gujarat (Dohad, Banas Kantha), Chhattisgarh (Sarguja) and Assam (Dhubri, Goalpara, Marigaon), a list of 150 districts has been arrived at. These districts belonging to the better off States will be taken care of by improved attention of the concerned States. These 150 districts are concentrated in the 5 EAG States of Bihar (36), U.P. (58), M.P. (24), Rajasthan (20) and Jharkhand (12), as at **Annexure-I**. *However, since it would be administratively inconvenient to limit the proposed initiatives to select districts within the State, it is proposed to cover all 209 districts in the 5 CMP States under the new Strategy.*

The Vision

The National Population Policy aims at achieving a National Total Fertility Rate (TFR) of 2.1 by 2010. It would still take another 35 years for the population to stabilize by 2045 at the expected level of 160 crore. However, the present trends indicate that if the present pace of reduction in growth rate continues, the TFR of 2.1 may at best, be attained by 2016. The population may touch 180 crore before stabilizing. It is, therefore, important to adopt strategy for addressing the high order births (above two children per family) in the identified high fertility districts, at a scale which will prevent at least 40 crore additional births by 2045 permitting the country's population to stabilize after peaking at about 135 crores. The plans arrived through Community Needs Assessment Approach (CNAA) in these districts also reflect a high level of unmet needs, basically due to weak service delivery mechanisms. Of the total 48 lakh sterilizations being reported in country, only around 13 lakhs are being reported in the CMP States where as their high order births in these States are in the range of 93 lakhs per annum (of the total 170 lakh high order births in the country). It is hoped to **raise the level of sterilizations in these CMP States to 50 lakh per annum within the next four years**. In fact, we should thereafter increase the scope of our programme and add another 150 high fertility districts to really

tackle the **unwanted births all across the country**. It is also a fact that against the average annual growth rate of population of 1.7% in rural India, the same is 2.7% for urban India and 4% for urban slums. The high growth rate in urban slums is also largely due to the factor of **immigration of BPL** labour and families from high fertility and poor districts to urban areas, especially the metros. It would therefore be necessary to cover the urban slum pockets in the CMP strategy. Then only the **systematic prevention of 40 crore unwanted births** will actually happen.

Lessons from Southern States

Over the last 5 decades, the performance of the Family Welfare Programme has been distinctly better in the Southern States like Kerala, Tamil Nadu, and Karnataka as against the CMP States. Higher levels of literacy and women empowerment in these States contributed to the success of the programme. However, improved performance levels in these States also owe largely to **the political will, administrative commitment and good governance in these States**. A major lesson to be learnt from the Southern States is their **success in involving the private sector in service delivery**. In the State of Tamil Nadu, of the total 4 lakh sterilization being reported per annum, 1.5 lakh procedures are being reported through the private sector. In the State of Andhra Pradesh, the spectacular success in bringing down the growth rate of population in the last decade has been possible, despite the low level of literacy, due to the involvement of private sector and Self Help Groups, provision of insurance cover to family planning acceptors, and a higher Compensation package for sterilization in the State. Strong monitoring and the supervisory mechanisms in the Southern States have ensured better accountability of the service providers. **Under the CMP Strategy, the lessons from the Southern States would be replicated in select States of U.P., M.P., Bihar, Rajasthan and Jharkhand.**

Strategy in CMP Districts

The Thrust Areas in these districts would be family planning, immunization and safe delivery. Letters have been sent to Chief Ministers, Chief Secretaries and Secretaries (FW) of the selected States, and also to District Collectors of 150 CMP districts. Copies of the letters are enclosed at **Annexures II, III & IV. The strategy aims at bringing back the District Administration into the Family Planning Programme**. Detailed CMP Manual is being prepared for the District Collectors of the CMP districts, to provide them with a roadmap and suggested strategy. National/Regional Consultations with State Governments and District Magistrates of 150 CMP districts shall be held.

Emphasis on Family Planning services

The emphasis would be on **targeting unmet need for family planning services in these districts**. Additional funds would be provided for improved services for sterilization and IUD insertion. The Compensation package for sterilization is being revised, to adequately over the transaction costs of the procedures in public and private health facilities. Additionally, an imprest fund of Rs.10 lakhs would be provided to District Administration as a revolving fund for family planning. **Professional Indemnity Insurance cover shall be extended to doctors conducting sterilization operations in both public sector and accredited private health facilities, so as to cover them against legal and financial costs of possible consumer cases.** Detailed assessment of the requirement of drugs, equipments, contraceptives and laparoscopes is being done

for CMP districts, and a strategy shall be formalized for timely procurement and appropriate logistics arrangements.

Partnership with Private Sector

Partnerships with the private sector through accreditation, indemnity insurance coverage and suitable higher payment nearer to basic market cost are the major hope for attainment of the goals in the CMP districts. A revised Compensation package is being extended to accredited private/NGO health facilities for conducting sterilization/IUD insertion. A package of around Rs.1200 for sterilization in a private nursing home and Rs.600 in public health facility, inclusive of transactional cost to the Trained Birth Attendant (TBA), and the client to cover the expenses on travel, food, and access to the public/private hospitals for sterilization will energize the demand and supply chain in family planning. Availability of family planning services is thus hoped to increase through **social marketing and social franchise of such services**. It is aimed to provide quality assurance among such accredited facilities and to provide them with a logo so as to generate publicity of the availability of such family planning services in the private sector. **Accrediting 15 to 20 private providers per district** is an attainable task. Banks are being approached to announce a special package of loan of Rs.5 lakhs to Rs.10 lakhs to these accredited doctors in CMP districts to improve their infrastructure, space, equipment, Operation Theatre etc. These loans will be viable as an accredited clinic is expected to earn at least Rs.25,000 to Rs.30,000 extra per month and so repayment of the loan will be possible. This itself is likely to help achieve 25-35% extra family planning procedure. In Tamil Nadu, an average 30 to 40 private facilities have been accredited per district. In spite of a well functioning governmental system and low levels of fertility, 35% of all sterilization in the State are at accredited private clinics.

Promotion of maternal healthcare

The National Maternity Benefit Scheme is being revised as the proposed Janani Suraksha Yojana (JSY), with the aim of promotion of institutional delivery to bring down the high Maternal Mortality Rate (MMR) in these districts **(Annexure-V)**. It is hoped that the JSY would prevent female foeticide through raising consciousness for the girl child. **It is aimed to provide an amount of Rs.1000/girl child and Rs.400/male child, if delivered in a health institution, by a BPL mother.** Additionally, transport assistance upto Rs.150, and incentive to Dais @ Rs.200/150 for female/male child is also envisaged in lieu of appropriate antenatal and postnatal care and referral for institutional delivery. The scheme also aims at adoption of tubectomy by the pregnant women after the delivery. It is aimed to operationalize First Referral Units (FRUs) at district levels to ensure 24-hour service delivery for improved healthcare. Emphasis is also being laid on provision of health infrastructure in urban slums.

Engagement of TBAs

It is proposed to engage around 2.6 lakh Trained Birth Attendants (TBAs) at the rate of one per 500-1500 population aiming at one TBA for village under one AWW in the CMP States as the grass root level worker for the FW programme. The TBA would be the key to social mobilization in these districts. **She would be recruited by the AWW, in consultation with the Women Self Help Group of the village, on payment of an honorarium of Rs. 100/- per month only**. The ANM will countersign and confirm this appointment.

The TBA will get IEC material and other support from District Health administration through the ANM. She will counsel the village women for adopting contraception, safe delivery and institutional delivery. She would also escort the client to the hospital, whether to a public or an accredited private facility, for family planning and institutional deliveries and be paid a transaction cost for each such procedure. She will also mobilize the children and expectant mothers on immunization days. She is expected to earn Rs. 7500 to Rs. 8000 per annum from her work. Additionally, she will be given products such as basic medicines, contraceptives and ORS etc. for social marketing in the village. She will also counsel for newborn care, breast feeding and adolescent hygiene and age of marriage. She will assist in registration of births. All these, she will do under the supervision of AWW and ANM among the women/girls of the community where she normally resides.

Strengthening Immunization Programme

Efforts shall also be made in these districts for improved immunization, including strengthening of cold-chain, induction of Auto Disposable Syringes and holding of Immunization Sessions on fixed days at village/habitation level, in convergence with the ICDS workers. A major strategy is to make the vaccine reach the immunization site on Vaccination Day so that the ANM can carry out longer sessions. It is proposed to bring in legislation to make it mandatory for all medical establishments, whether public or private, to render immunization services. Medium-term Plan for strengthening of Immunization has been moved to World Bank through Department of Expenditure. Copy of the same is enclosed at **Annexure-VI.**

Management Strengthening

The work in the CMP districts is proposed to be undertaken in a Mission mode. This would necessitate organizational restructuring of the Department of Family Welfare at the GoI level, and setting up of a National Resource Centre for providing Technical Assistance under different components of the Reproductive & Child Health Programme. It is also proposed to upgrade the management capacities at State and district levels for consolidation of the Programme Management Units through induction of key skilled professionals like MBAs, CAs, Inter Costs, MIS Specialists etc. under the leadership of an additional IAS Officer as Executive Director, SCOVA at State level, and ex-service men at district levels, to steer the programme. The strengthening of the financial and programme management would be a key input of the envisaged programme. Improvement of financial flows, improvement in accountability through better maintenance of accounts by induction of professional financial personnel, and use of e-technology to handle the huge number of transactions and sites efficiently is the management key to the CMP strategy.

Improved convergence, publicity and programme monitoring

A programme-specific IEC campaign shall be launched for the CMP districts, including wall writings, hoardings, posters, brochures, CDs and briefing kit for various stakeholders, informing the key players of the new initiatives and the public-private institutions partnering in this activity. Intersectoral convergence with related Departments would be strengthened and involvement of members of Panchayati Raj Institutions and Self Help Groups stressed to make the programme a people's programme. The monitoring of the Family Welfare Programme shall be improved through e-linking with video-conferencing in CMP

districts and with the 5 EAG States' Secretaries. We also propose to use e-technology for social auditing, consumer suggestion/grievance monitoring, handling fund flow and other related issues. A concept note on the subject is enclosed at **Annexure-VII**.

Financial Implications

Detailed costing has been done of all the additional activities proposed above. The Department of Family Welfare is of the view that it should be possible to undertake the additional activities in the current year by regrouping funds available under different Budget Heads of the Department. It should also be possible to accommodate the additional financial requirements for the remaining period of the 10th Plan within the Budget of the Department, if the officially indicated Outlays for the 10th Plan are fully funded. This would, however, require some intersectoral adjustments within the Budget Heads of this Department, for which orders of competent authorities would be obtained. It is possible to continue funding these new initiatives not only in these 150 CMP districts, but also in additional 100 to 150 districts in the 11th Plan with only a normal increase in the Budget, by 50%. The Common Minimum Programme already states that over a period, the Health Budget would be doubled. Also, from 9th Plan to 10th Plan, our Budget increased by 80%. We are thus looking at a very practical financial plan. **The savings to the country, by way of avoiding 40 crore unwanted births would be far more.**

COMH-84-6

OVERVIEW OF RURAL HEALTHCARE MISSION

Mandate of the National Common Minimum Programme (NCMP)

- Healthcare is one of the 7 Sutras of NCMP.
- Investment in health to grow to 2-3% of GDP over next 5 years.
- Focus on primary healthcare.
- National Scheme for Health Insurance for poor families.
- Special care to the girl child.
- Public investment in programmes to control communicable diseases to grow.
- Special attention to poorer sections for healthcare.
- Focused Programme in high fertility districts.

Rural Health: The Scenario

- High burden of disease due to poverty, illiteracy and poor outreach of health system.
- Out-of-pocket expenses on healthcare of the poor is a major cause of rural indebtedness
- Emphasis on vertical programmes of health and family welfare.
- Lack of convergence with social sector programmes related to women & child development, rural development, panchayati raj, education, sanitation and drinking water
- Health system based on promotive and curative system rather than preventive approach.
- Ownership and accountability of HFW Programme at community level missing.

Objectives of Rural Healthcare Mission (RHM)

- Provide access to integrated package of health services to poor in rural areas and urban slums
- Extend financial risk protection to poor seeking health services
- Ensuring accountability of public health system and cooperation with the private sector for achieving national goals
- Promote synergy between health and non-health determinants
- Strengthen Local Government Institutions to provide leadership for Health Programmes
- Strengthen the ongoing process of women empowerment

Framework for RHM

- Expanding the EAG mechanism to Rural Healthcare Mission (RHM) for focused attention on 17 States - 8 EAG States, 8 North Eastern States, and Jammu & Kashmir
- 5 States (U.P., M.P., Bihar, Jharkhand, Rajasthan) to be covered under Common Minimum Programme (CMP) Strategy for focus on population stabilization
- 8 States to be covered under North East Health Mission (NEHM)
- Graded packages for varying needs, based on State ownership and articulation
- Rural Health Mission also to be constituted at state level
- RHM to promote integrated model of healthcare

Key Strategies under RHM

- Ensuring intra and intersectoral convergence
- Strengthening public health infrastructure
- Increased community ownership and participation
- Village level cadre of Health Workers
- Public-Private Partnership for health
- Emphasis on quality services
- Enhanced programme management inputs

Intra & Intersectoral Convergence

- At State level, constitution of one Society for all Health Programmes
- Creation of a District Health Development Agency (DHDA) to integrate multiple programmes of Health under one umbrella
- Convergence at the State/District level of all vertical national health programmes (including external assistance) for civil works, drugs, equipment, training, management, IEC etc. into a District Health Fund
- District Health Plan to address issues of Health, Nutrition and Sanitation
- Convergence of infrastructure, including manpower, of AYUSH at district and sub district levels. AYUSH products/medicines to be promoted in Reproductive & Child Health (RCH) Programme.

Strengthening Public Health Infrastructure

- Operationalising FRUs- all CHCs and 50% PHCs
- Addressing mismatch of manpower and equipments at health facilities
- Strengthening the PHC with an additional doctor (AYUSH practitioner ?)
- Performance benchmarking of public health facilities
- Constitution of Health Committees empowered to levy user fee- GoI to contribute matching share
- Overcome manpower deficiencies through engaging private doctors
- Options like second ANM at Sub-centres, and salary payment of MPW (Male) by GoI, could be considered depending on availability of Budget.

Community Participation

- Giving functional responsibilities and powers to the Panchayati Raj bodies for planning and supervising discharge of public health duties
- Constitution of District, Block and Village Level Health Committees
- Raising a cadre of voluntary Accredited Social Health Activists (ASHA) at village levels
- Convergence between ANM, DOTS provider, Malaria Link Volunteer, AWW and ASHA –Anganwadi to be the hub of health and nutrition activities in the village
- Creation of a Drug & Contraceptive depot at village level
- Providing Flexible Fund at panchayat/sub-centre/district level to enhance control over local issues for health and family welfare.

Community Worker

- Accredited Social Health Activist (ASHA) at AWW level for HFW activities
- Honorarium of Rs. 100/- per month and performance based remuneration, to ensure earning of about Rs. 10000/- per annum
- Flexible State level model, ensuring selection by and accountability to community organisations
- 5 day initial training at Sub-centre level, to be followed by periodic on-job training
- ASHA to support immunization, ANC/PNC, counseling and escort for institutional deliveries & family planning, TB and Malaria detection, and referrals
- To act as Drug Depot for health, family welfare and AYUSH medicine at the village level

Public-Private Partnership for Health

- Social Marketing/ Social Franchising of services (sterilization, IUD insertion, institutional delivery, immunization) and products (contraceptives) through a network of accredited HFW Clinics
- Enhanced Quality Transaction Cost (QTC) for sterilization, IUD insertion and institutional delivery to incentivize private participation
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Quality Control

- Setting up an Ombudsman at National/State level
- Constituting Quality Assurance Committees at State/District level
- Accreditation process and branding of public/private health facilities
- Social audit by NGOs, PRIs – triangulated verification system
- Inclusion of the subject of Reproductive Health in syllabi of Medical Education and emphasis on Continuing Medical Education for both govt. and accredited private sector doctors

Quality Control (Contd.)

- Quality Transaction Cost in CMP States for family planning, to provide quality service
- Enforcing quality protocols for family planning procedures
- Insurance cover for acceptors and service providers of sterilization services in Government and accredited private clinics
- Widening the basket of contraceptives under National Family Welfare Programme
- Strategy to increase contribution of NSV in sterilization procedures

Funding for Rural Healthcare Mission

- RHM to retain the EAG flexible funding mechanism
- Proposal for funds under non-lapsable pool for North East in MoHFW to be merged into RHM Outlay – priority of spending to be retained for North East States
- Funds under Departmental/Donor Scheme to converge at State/district levels
- Resource mapping – shared funding for RHM through GoI/State/Local Body Budgets
- Funding for ASHA to be performance based under Schemes of Health & FW
- Initiatives under RHM need no additionality, if the 10th Plan Outlay for Department of FW is fully funded

Programme and Financial Management Inputs

- Engaging skilled professionals like CAs, MBAs and MIS specialists to strengthen State Programme Management Unit (PMU) and District management unit (DMU)
- Creation of a National Health Resource Centre (NHRC) to provide Technical Assistance at GoI/State level
- Introducing e-banking, GIS based MIS etc, for improved programme management
- Formalizing strategy for timely procurement and appropriate logistic arrangement at district and sub-district levels

Process Outcomes of RHM

- Decentralization and convergence at village/district levels for Health, Family Welfare, AYUSH & nutrition
- Strengthening preventive and promotive care at community levels
- Improved system of referrals
- Strengthened public health infrastructure – provision of Maintenance Fund
- Accountability and responsiveness to elected Bodies of the community
- Simplification of planning and implementation of Schemes of Health and Family Welfare and Donor Programmes
- Optimization of resources

Process Outcomes (Contd.)

- Graded packages to cater to State specific unmet needs – health infrastructure in NEHM and focus on population stabilization in CMP States
- Improved systemic capacity for programme implementation and fund flow
- Creation of health infrastructure in backward districts
- Improving access to family welfare services and healthcare in CMP districts through Public-Private Partnership
- Quality assurance in public health programmes
- Increased utilization of public health infrastructure
- Extending financial risk protection to poor for health and family welfare services
- Community financing for maintenance of public health infrastructure

Improvement in Health Indicators

- Burden of communicable diseases reduced
- Reduction in Disability Adjusted Life Years (DALYs)
- Raising level of universal immunization from 50% to 90%
- Improved Infant Mortality Rate and Maternal Mortality Ratio through increased institutional deliveries and focus on IMNCI and immunization
- Reduction in Total Fertility Rate to enable attainment of goals of National Population Policy for 2010
- Early treatment of infectious diseases

THANK YOU

COM H - 84.7

Concept Paper

RURAL HEALTH SERVICES FOR INDIA: CURRENT NEEDS AND FUTURE CHALLENGES

1. HEALTH CARE DELIVERY SYSTEM IN INDIA

The health care delivery system in the country can be broadly divided into four sectors:

i. Public sector including government run hospitals, dispensaries, primary health centres, community health centres etc.

ii. Private not-for-profit sector, including charitable institutions, NGOs, Trusts, Missions and Churches etc.

iii. Organised private sector for profit including private hospitals, clinics and private practitioners.

iv. Private informal sector including practitioners not having any formal qualifications (faith healers, herbalists, vaidyas etc.).

2. RURAL HEALTH INFRASTRUCTURE IN PUBLIC SECTOR

The rural health infrastructure in public sector comprises of Community Health Centres, Primary Health Centres and Sub- centres.

Rural HealthCare Mission - GOI, MOHFW
11.1.05

Community Health Centre

For a successful primary health care programme, effective referral support is to be provided. For this purpose one community health centre (CHC) has been established for every 80,000 to 1,20,000 population, and this centre provides the basic speciality services in general medicine, paediatrics, surgery and obstetrics and gynaecology. The CHC are established by upgrading the sub-district/taluka hospitals or some of the block level Primary Health Centres(PHC's), or by creating a new centre wherever absolutely needed.

Primary Health Centre

At present there is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Many rural dispensaries have been upgraded to create these PHCs. Each PHC has one medical officer, two health assistants - one male and one female, and the health workers and supporting staff. For strengthening preventive and promotive aspects of health care, a post of community health officer (CHO) was proposed to be provided at each new PHC but most States did not take it up.

Sub-centre

The most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker. At present, in most places there is one sub-centre for about 5,000 populations (3,000 in hilly and desert areas and in difficult terrain).

Village Level

Though one says that the most peripheral health institutional facility is sub-centre, at the village level for about 1,000 population there is one health guide and one trained dai or traditional birth attendant (TBA), both selected from the community. They are trained at the PHC and the sub-centre. These two village level functionaries are voluntary workers and not regular government employees. They receive technical support and continuing education from the multi-purpose health workers (male and female) posted at the sub-centre. Administrative support and supervision are normally carried out by the village health committee or the village panchayat.

3. CURRENT SITUATION OF RURAL INFRASTRUCTURE IN PUBLIC SECTOR

3.1 Infrastructure

As per the Bulletin of Rural Health Statistics published by the department of Family Welfare, MOHFW, (2003), there are 3043 Community Health Centres (79% have government accommodation), 22842 Primary Health Centres (60% have Govt. building) and 1,37,311 Sub centres (44% have Govt. building).

13.3% of positions of Medical Officers at Primary Health Centres; 48.6% surgeons, 47.9% OBG specialists, 46.1% Physicians and 56.9% of Paediatrician posts at Community Health Centres were vacant (2003). The vacancy position for paramedical staff was 7.6% for ANMs, 16.1% for Multipurpose health workers (M), 14.1% for Health Assistants (F), 13.4% for Health Assistants (M),17.4% for Radiographers , 10.7% for Pharmacists, 14.7% for lab Technicians, and 12.5% for nurses(2003).

If we compare the current position of medical and paramedical manpower in rural areas against the recommended norm the deficit becomes much more serious. The shortages against the recommended manpower norms was 75% for surgeons, 75% for OBG specialists, 86% for Paediatricians. For paramedical staff the shortage was 14.2% for ANMs, 49% for Multipurpose health workers (Male), 14% for Health Assistants (F), 15% for Health Assistants (M), 47% for radiographers, 19% for pharmacists, 49% for lab technicians and 39% for nurses.

The National Health Policy document (2002) also states that the utilisation rates for health facilities in rural areas are low (less than 25%). The inadequate availability of drugs, functional equipments and basic amenities affects the quality of services through these institutions.

3.2 Financial Resources

The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita public health expenditure in the country is no more than Rs. 200.

3.3. Equity

Access to, and benefits from, the public health system have been very uneven between the better-endowed and the more vulnerable sections of society. This is particularly true for women, children and the socially

disadvantaged sections of society. The statistics highlight the handicap suffered in the health sector on account of socio-economic inequity.

3.4. National Health Programmes

Over the last decade or so, the Government has relied upon a 'vertical' implementational structure for the major disease control programmes. Through this, the system has been able to make a substantial dent in reducing the burden of specific diseases. However, such an organizational structure, which requires independent manpower for each disease programme, is extremely expensive and difficult to sustain. Over a long time-range, 'vertical' structures may only be affordable for those diseases which offer a reasonable possibility of elimination or eradication in a foreseeable time-span.

3.5. Utilization of Services

As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population, which seek OPD services, and less than 45 percent of that which seek indoor treatment, avail of such services in public hospitals. This is despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition.

3.6. Manpower position

While there is a general shortage of medical personnel in the country, this shortfall is disproportionately impacted on the less-developed and rural areas. No incentive system attempted so far, has induced private medical personnel to go to such areas; and, even in the public health sector, the effort to deploy medical personnel in such under-served areas, has usually been a losing battle. In such a situation, the possibility needs to be examined of entrusting some limited public health functions to nurses, paramedics and other personnel from the extended health sector after imparting adequate training to them.

3.7. Indigenous system of medicine

India has a vast reservoir of practitioners in the Indian Systems of Medicine and Homoeopathy, who have undergone formal training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central Government public health programmes, in order to increase the reach of basic health care in the country.

Under the overarching umbrella of the national health frame work, the alternative systems of medicine – Ayurveda, Unani, Siddha and Homoeopathy – have a substantial role. Because of inherent advantages, such as diversity, modest cost, low level of technological input and the growing popularity of natural plant-based products, these systems are attractive, particularly in the underserved, remote and tribal areas. The alternative systems will draw upon the substantial untapped potential of India as one of the eight important global centers for plant diversity in medicinal and aromatic plants.

3.8. Manpower norms

It is observed that the deployment of doctors and nurses, in both public and private institutions, is ad-hoc and significantly short of the requirement for minimal standards of patient care.

3.9. Quality of medical education

Apart from the uneven geographical distribution of medical institutions, the quality of education is highly uneven and in several instances even sub-standard. It is a common perception that the syllabus is excessively theoretical, making it difficult for the fresh graduate to effectively meet even the primary health care needs of the population. There is a general reluctance on the part of graduate doctors to serve in areas distant from their native place.

It is observed that the current under-graduate medical syllabus does not cover new emerging subjects.

3.10. Need For Specialists In 'Public Health' And 'Family Medicine'

In any developing country with inadequate availability of health services, the requirement of expertise in the areas of 'public health' and 'family medicine' is markedly more than the expertise required for other clinical specialities. In India, the situation is that public health expertise is non-existent in the private health sector, and far short of requirement in the public health sector. Also, the current curriculum in the graduate / post-graduate courses is outdated and unrelated to contemporary community needs. In respect of 'family medicine', it needs to be noted that the more talented medical graduates generally seek specialization in clinical disciplines, while the remaining go into general practice. While the availability of postgraduate educational facilities is 50 percent of the total number of qualifying graduates each year, and can be considered adequate, the distribution of the disciplines in the postgraduate training facilities is overwhelmingly in favour of clinical specializations. NHP-2002 examines the possible means for ensuring adequate availability of personnel with specialization in the 'public health' and 'family medicine' disciplines, to discharge the public health responsibilities in the country.

3.11. Role of Private sector

Currently, non-Governmental service providers are treating a large number of patients at the primary level for major diseases. However, the treatment regimens followed are diverse and not scientifically optimal, leading to an increase in the incidence of drug resistance.

4. SUGGESTIONS FOR THE FUTURE DEVELOPMENT OF RURAL HEALTH SERVICES IN INDIA

4.1. Major Thrust Areas which need attention are:

- Training and development of health manpower (including available local resources) as per the needs of the country.
- Integration of health with overall development to achieve effective intersectoral co-ordination.
- Encouraging more active role of the community.
- Regionalisation of health care services with development of proper two-way referral system.
- Development of integrated health care delivery system with involvement of indigenous systems of medicine.
- Privatisation of health care service provision; and health care financing (charging for services, health insurance, community funding of services).

4.2. Proposed Strategies and Mechanisms

Main dimensions of proposed strategies and mechanisms for future actions are:

4.2.1. Training and development of health manpower

- Formation of an expert group for estimation of manpower needs in future.
- Identification of the community health needs in view of the new challenges and up coming diseases in the communities.
- Development of curriculum as per these needs for the medical and paramedical basic training programmes.

- ❖ Modification of the existing curriculum
- ❖ Development of new courses such as integrated course for Family Practitioners, special short term course for medical manpower in rural areas either after 12th class, or for the paramedical cadre after 5 years of service.
- ❖ Central agency to ensure quality of training. Medical Council Of India may be expanded to effectively carry out this task or a separate agency be formed.

4.2.2. Ensuring equity for the health

- ❖ Location of health services and facilities where these are easily accessible and available to people especially the under-privileged sections of the society. Facility location decisions to be taken purely based on technical and scientific factors and not influenced by other extraneous factors.
- ❖ Regionalisation of health care services with clearcut geographical demarcation for use of facilities (both in public and private sectors), along with proper two-way referral system.
- ❖ Rational transfer-policies, incentives and career development opportunities for health manpower working in remote areas.
- ❖ Minimising inter and intra-State differences.

4.2.3. Strengthening health promotion and protection

- ❖ Development of an integrated education and health promotion programme, with locally relevant content and media for dispersion of the messages.
- ❖ Development of Integrated Non-Communicable Diseases Control Programme.
- ❖ Implementation of preventive and promotive health activities in an integrated and comprehensive manner with involvement of all health and related sectors.
- ❖ Health has to be made an integral part of the development programme.
- ❖ Strict and effective enforcement of legislations related to health and environment.

4.2.4. Strengthening the health sector including partnership in health development

- ❖ Identification and specification of the role of public and private sector in health.
- ❖ Definition and effective implementation of coordinating and monitoring mechanisms in public and private health and related sectors.
- ❖ More effective involvement of the Indigenous Systems of Medicine in provision of health care services, with specified role and responsibilities.
- ❖ Managerial capacity building of health managers for better management of health services and programmes.
- ❖ Consolidation of health infrastructure base by adequate resources so as to improve the quality of services.

4.2.4. Developing and strengthening of specific health programmes

- ❖ Development of an area specific comprehensive health programme to cover all the major health problems in the given geographical area with linkages with other related sectors, rather than having a number of vertical health programmes, which have duplication and wastage of resources.
- ❖ Linking health programmes with related programmes of other sectors.

4.2.5. Developing and using appropriate health technology

- ❖ Development and use of locally relevant health technologies which fit into socio-cultural milieu(Including alternate approaches to health)

4.2.6. Strengthening international partnership in health

- ❖ Integrated involvement of international organisations and agencies within the important national programmes in the health sector.
- ❖ A common platform for sharing experiences.

4.2.7. Specific Mechanisms for Private Sector Involvement in Rural Health:

a) Corporate Sector

The Corporate Sector should be encouraged to take responsibility for health in a given geographical area.

i. **Identification and listing of corporate houses and big industries** in the country, which can be assigned such task.

ii. **Specifying the health related responsibilities and tasks** such as

- Opening and maintaining tertiary level hospitals/highly specialised centres.
- Opening and maintaining sophisticated laboratory or radiological diagnostic centres.
- Management of public funded tertiary level institutions
- Sponsoring public health tertiary level institutions partly or wholly for a given period.
- Sponsoring specific diagnostic or curative facilities in Tertiary Public Health institutions.
- Contribution to Public health Programmes

iii. **Allocation of geographical areas** for carrying out the Public health programmes:

There are an estimated 5843 companies registered with the National Stock Exchanges (1998). These companies can be given the responsibility of sponsoring specific public health programmes in nearly 5000 block in the country, depending upon their capacity to fund such activities.

iv. **Incentives for corporate sector:**

Incentives such as tax benefits, subsidies in raw materials, land, water, electricity etc. can be given to these companies participating satisfactorily in the public health programmes.

v. For **corporate hospitals** subsidised land, water, electricity or custom exemption on imported equipment etc. can be worked out. In these hospitals about 50% of the beds be allowed for profit earning; 20% for government functionaries on nominal rates to be re-imburesed by the concerned organizations and rest 30% for patients below poverty line/ poor patients free of cost.

b). **Non-governmental organistions (NGOs):**

Identifying the NGOs and alloting them specific areas for specific services considering the local requirements of the health system, so as to avoid the duplication of the NGOs.

These NGOs can be given subsidized equipment, drugs, supplies etc. along with the minimal parameters for performance out put in context of the specified health services.

c). **Private practitioners:**

i. **Identification parameters for private medical practitioners:**

The selection of private practitioners for their involvement in national health programmes may be done on certain criteria considering the following:

- **System of medicine practiced:**

  This may include allopathic, ISM, Ayurvedic or Homeopathic etc.

- **Number of practitioner per area/zone:**

  The number of practitioners to be involved for services under national health programmes may be fixed considering the current Govt. set up and facilities in that area.

- **Minimal infrastructure with private practitioners:**

  Minimal infrastructure for rendering satisfactory level of services under the national health programmes may be specified as one of the parameters for selection of private practitioners.

- **Type, mode and years in practice.**
- **Previous experience of working for national health programmes.**
- **Recommendations of local professional bodies.**

ii. **Role & responsibilities of private medical practitioners** :

Allopathic Practitioners:

a. **General Practitioners:** Case identification & referral; IEC & Health education activities; Follow up of cases; Rendering of services; Blood smears for passive surveillance under Malaria Control activities; Sputum smears for suspected cases of Tuberculosis and follow up smear examination of confirmed cases; Vaccination serviced to children and pregnant women in the area; Distribution of condoms, oral pills and IUCDs

b. **Paediatricians:** IEC & health education activities in the clinic; Immunisation service to children; Distribution of Vitamin A and iron folic acid to children; ORT for diarrhoea cases

c. **OBG specialists**: IEC & health education activities in the clinic; Medical termination of pregnancy as per the MTP act; Immunisation services for mothers & children; Sterilisation services ; Distribution of condoms, oral pills and insertion of IUCDs; Diagnosis & management of reproductive tract infections; Maternal care during ante-natal, natal & post natal period etc.

d. **Surgery specialists**: IEC & Health education services in clinic & indoor; Sterilisation & MTP services; No- scalpel vasectomy for males

e. **Ophthalmologists**:IEC & health education activities; Cataract screening referral and operation if facilities as per the norms; Examination of school children for eye problems under school health programme

f. **Psychiatrists**:IEC & health education activities related to HIV/AIDS ; Counselling and management of drug users

g. **Skin specialists:** IEC activities related to Leprosy, HIV/STDs/RTIs etc; Diagnosis, referral & management of leprosy, HIV/AIDS/ STDs /RTIs

h. **Radiologists:** Diagnostic support to Govt. health units if needed

i. **Pathology lab /biomedical lab/ Microbiology lab**: Diagnostic support to Govt. Health units if needed

Ayurvedic practitioner: IEC & health education activities; Immunisation of children & mothers; ORT in diarrhoea; Blood slides for passive surveillance under malaria control activities; Distribution of Vit.A & folifer tabs to children & mothers; Distribution of condoms s

Homeopathic practitioners: IEC & health education services; Distribution of Vit.A & folifer tabs to children & mothers; Distribution of condoms; Vit.A distribution; ORT in diarrhoea

Registered Medical Practitioners: (Other than above): IEC & health education activities; Condom distribution; Vit.A distribution; ORT in diarrhoea

iii. **Infrastructure for monitoring:**

The existing infrastructure can be utilised for monitoring activities of the private practitioners in national health programmes.

- **Local level-** Medical officers of Primary Health centres/ Community Health Centres, Panchayat members or municipal committees etc.
- **Distinct level-** District health officers, District Ayurvedic officers, local NGOs, Local Professional bodies etc.
- **State level-** Representatives from local professional bodies, eminent practitioners in the state, NGOs working in health & family welfare, etc. may be given due recognition in palling and management of health and family welfare activities in the state.

iv. **Monitoring mechanisms:**

- Minimal record of activities performed
- Simple single page periodic reporting format
- Meetings with Govt. functionaries once in month or quarter
- Field visits by Govt. functionaries once in month or quarter for supplies and problem solving if any
- Conditions under which the contract would be terminated
- Minimal quality control of the services provided

v. **Incentives:**

- **Provision of Logistics & supplies:**

Provision of free or subsidised drugs, equipment, vaccines, IEC materials, maintenance of equipment etc. related to national health programmes to the private practitioners.

- **Fee for services:**

Allowing the private medical practitioners to charge nominal fees for the services rendered under the national health programmes. Poor

patients may be exempted from the fees and the Govt. may pay some honorarium for the services rendered free of cost to poor patients.

- **Honorarium to practitioners:**

  Govt. may provide a fixed monthly amount as honorarium or amount per unit of the services rendered for national health programmes subject to a maximum amount per month.

- **Honorary designation:**

  The private medical practitioners who have been involved in providing services under national health programmes may be given appreciation certificates & or honorary designation in lieu of the services provided by them.

- **Representation in Govt. bodies for planning and monitoring of national health programmes:**

  The private medical practitioners or the representatives of their associations like Indian Medical Association etc. may be given due representation in bodies involved with planning and monitoring of the national health programmes.

- **Periodic training:**

  Suitable orientation training programmes may be planned for orientation of private practitioners in various aspects of national health programmes.

- **Preferential treatment for cases referred by private medical practitioners:**

  Due attention may be given to cases referred by the private practitioners to designated Govt. hospitals for consultation by senior doctors in OPD or admission, for blood bank services, biochemical and lab investigations, pathological consultation, radiological consultation etc. Nominal charges may be taken from the practitioners/users seeking such services from Govt. hospitals.

vi. **Venue for training of private medical practitioners in national health programmes**

Venue for training of private practitioners:

The training programmes can be organised at:

- District training centres
- Health & Family Welfare Training Centres
- Medical Colleges
- Regional Training Centres
- Training through existing professional bodies like Indian Medical Association etc.

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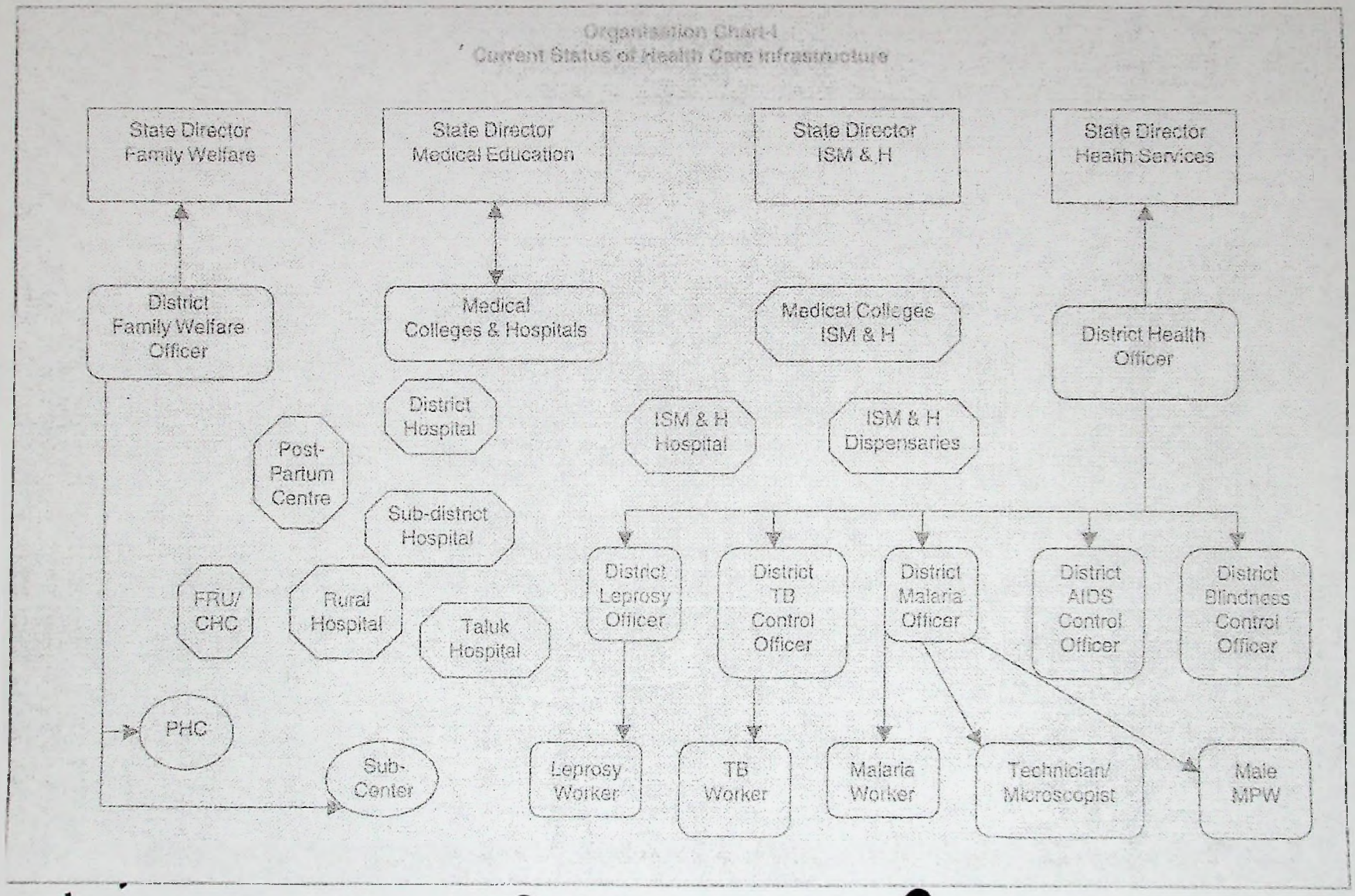
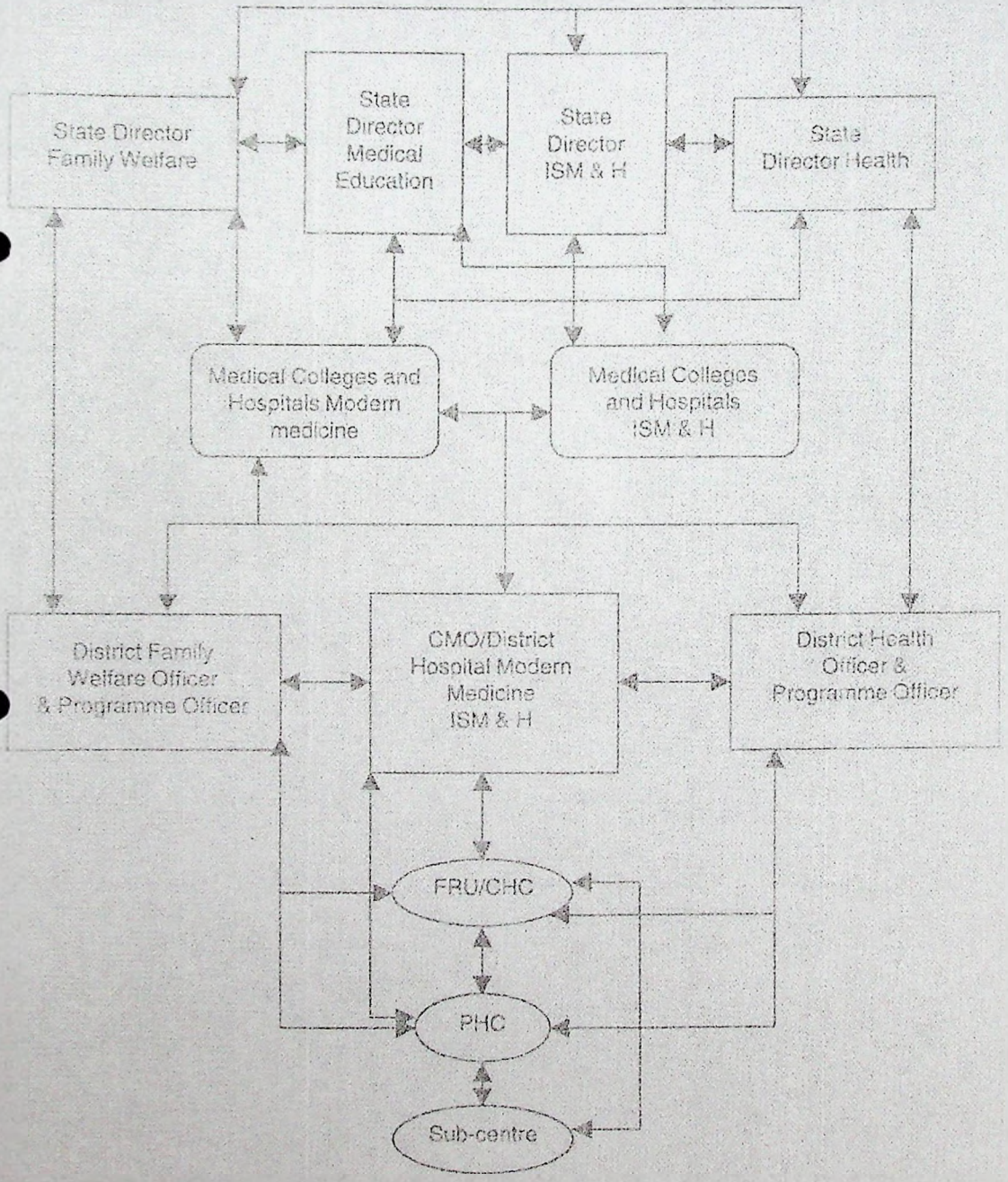
Organisation Chart-I
Current Status of Health Care Infrastructure



Organisational Chart-II
Proposed Reorganisation and Linkages



COMM-34.10

Presentation before
National Advisory Council
on
Rural Health Care Mission
Department of Family Welfare

1. Community Health Volunteers

- Department of Family Welfare proposes to engage 3.6 lakh Accredited Social Health Assistant (ASHA) in 10 States at village level
- Accreditation fee @ Rs. 100 per month + performance based remuneration for immunisation, institutional delivery and family planning - Rs. 10,000 / annum/ ASHA
- Initial five day training at PHC level
- Drug kit to be supplied containing 13 items
- Total cost for 10^{th} Plan Rs. 144 crores

II. Block Level Referral Hospitals

- 50% existing PHCs i.e. 5832 PHCs and all CHCs in 10 States under Rural Health Mission (RHM) to be strengthened during Phase-II of RCH programme
- Trained manpower to be provided at these FRUs for 24 hour emergency obstetric and child health care services
- Detailed Guidelines have been issued to the States for Operationalisation of FRUs
- Funds already released @ Rs.20 lakhs per district for Operationalising 2 FRUs per district in 8 EAG States

III. Accountability of Primary Health Care Delivery System

1. XI Schedule of the Constitution includes Family Welfare, Health and Sanitation including Hospitals, Primary Health Centres and Dispensaries to be entrusted to Panchayati Raj Institutions by the State Govts.
2. A Resolution was adopted in 8th Conference of Central Council of Health and Family Welfare Ministers (August 2003) that States would involve PRIs progressively
3. Different models for involving PRIs in Health and Family Welfare Programme are operational at State levels
4. PRIs would need to be trained and strengthened to handle such responsibilities efficiently.
5. Involving PRis is an important component of the strategy of the Department of Family Welfare for RCH-II

IV. Great Sanitation Movement

- The Department of Family Welfare supports the proposal for creation of toilet facilities under the Rural Health Mission
- Availability of safe drinking water facilities should also be linked with the health agenda
- The Department of Family Welfare seeks greater convergence with the D/o Women and Child Development on issues related to Nutrition, for pregnant and lactating women, and infants

V. Health Insurance

- The Ministry of Finance launched a Community Based Universal Health Insurance Scheme (CBUHIS) in 2003. The Ministry of Health and Family Welfare was not consulted
- Against the aim of covering 10 million BPL, 1.16 million people covered including 11,408 BPL beneficiaries
- Successful Health Insurance Scheme requires modalities for both demand generation and service provision
- Ministry of Health and Family Welfare has constituted an Inter-Ministerial Committee to examine the Schemes and options for Health Insurance Scheme
- National Commission on Macro Economics and Health is in the process of framing Community Health Insurance Scheme. Report expected in three months.

VI. Accountability of Public Hospitals

- Constitution of Hospital Committee, empowered to levy user fees to manage funds at institutional levels is an identified agenda under Health Sector Reforms

- The Agenda is being pursued with States as a benchmark activity during RCH-11

- The Department of Family Welfare supports the proposal for issue of matching grant to health institutions for user charges collected by the Hospital Committees

VII. Campaign Mode to Combat Diseases

- Campaign mode for Polio eradication has yielded good results. Hope is to declare India Polio free by 2005. Improvement in levels of universal immunization is the next priority of the Department of Family Welfare

- Detailed strategy for improving immunization includes strengthening cold chain, induction of Auto Disposable syringes

- Immunization sessions to be organized on fixed days at village / habitation level at Anganwadi centre

- Alternate vaccine delivery strategy being worked out

- Free vaccines would be provided though accredited private/ NGO Family Welfare Clinics

III Reproductive Health Services

- Department of Family Welfare has conceptualized a Strategy for focused population stabilisation programme in high fertility districts as per the Common Minimum Programme (CMP) mandate
- All 210 districts in 5 States of UP, MP, Bihar, Rajasthan and Jharkhand selected
- Aims is to service unmet need for contraception, maternal and child health in CMP States through enhanced availability and access to quality family welfare services,
- The Strategy is based on voluntary approach and addresses issues of equity, gender and quality
- It aims at energizing public health infrastructure through enhanced programme management inputs
- Hope is to create private health infrastructure in smaller districts

CMP Strategy (contd. I)

- 3.6 lakhs female village health workers to be engaged in 10 States covered under Rural Health Mission (PHM). They would be trained and provided Drug Kit.
- Launching Janani Suraksha Yojana in RHM States for promoting institutional delivery, in both public and accredited private /NGO Family Welfare Clinics
- Strengthening of routine inununization
- IMNCI package to be introduced to reduce IMR
- Operationalisation of First Referral Units
- Creating a network of branded Family Welfare Clinics for providing sterilisation, IUD insertion, contraceptives, institutional delivery (BPL women) and immunization services

CMP Strategy (contd. II)

- Arranging Bank loans on soft terms for setting up/ upgrading FW Clinics in smaller districts
- Induction of skilled professionals at State and District levels for improved programme management
- Revising quality transaction costs for sterilisation services in CMP States to improve quality of procedure
- Setting up National and State Ombudsman to ensure adherence to quality concerns in Family Planning Schemes
- Social marketing of Products (contraceptives) and Services (sterilisation and IUD insertions) in EAG States

CMP Strategy (Contd.III)

- Insurance cover to acceptors and doctors providing sterilisation services against death, medical complications and failure of sterilisation
- Promotionof NSV
- Improved programme monitoring through Video conferencing, Web enabled MIS, and GIS enabled MIS
- E-Technology for social audit, and E-banking for improved fund flow
- Wider stakeholder partnership with related Departments of Govenunent, NGOs, corporate sector, professional medical associations, PRIs
- Focus on urban slums in 118 towns of CMP States
- Improved Behavioural Change Communication focusing on Inter-Personal Communication and availability of FW services

COMH - 84.9

Note Circulated by Jan Swasthya Abhiyan
at the Consultation Workshop by the National Advisory Council
on Health Care Delivery
New Delhi, 22nd September, 2004

Jan Swasthya Abhiyan : A brief Introduction

The Jan Swasthya Abhiyan (Peoples Health Movement-India) is a coalition of eighteen national networks, including hundreds of organisations and a large number of individuals across the country, working in the area of health care. We came together on the occasion of the People's Health Assembly in 2000, to create a platform that brings together diverse concerns related to Health Care.

The JSA works, through its partner organisations and state co-ordinating bodies, in almost all the states of the country. As is underlined in the Peoples Health Charter that was adopted by the networks constituting the JSA, we affirm "our inalienable right to comprehensive health care that includes food security; sustainable livelihood options; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum - the right to HEALTH FOR ALL, NOW"!

We are encouraged that the National Advisory Council is focusing on vital concerns relating to health policy. Some of the main issues we would like to bring to your consideration in the context of the present discussion are as follows:

Incremental substantial increase in public health budget : The CMP states in unambiguous terms: "*The UPA government will raise public spending on health to at least 2-3% of GDP over the next five years with focus on primary health care*". This commitment is indeed welcome, though it still falls short of the WHO's recommendation that public spending on health should be around 5% of the GDP. However, even in order to achieve the target of 3%, yearly targets need to be formulated for the public health budget, with assured central and expected state contributions. It would require a major increase in budgetary support, as the present public expenditure on health care is just 0.9% of the GDP. It is unfortunate that the 2004-05 budget, presented recently, has not recommended any significant enhancement. If the CMP's commitment is not to remain on paper, a plan for incremental increase in budgetary support for Health needs to be worked out. This would mean a minimum 30-35% increase each year, and an additional strategy to ensure enhanced budgetary support for health from state budgets.

We note that a number of states and even the central ministry is often unable to spend the allotted funds. This is often used as an argument within the bureaucracy to limit further budget expansion. Such an argument is unacceptable in the context of such a widespread denial of the right to basic health care. This failure to spend the sanctioned amount reflects poor governance and poor systems development. A white paper should highlight the amounts of money that went unspent, at central and state levels in the last three years, and it should assign responsibility on systems and persons for this failure. The white paper should further state the criteria of good governance and good health systems that would ensure that the increased budget that is so urgently required would be spent in time and spent without gross leakages that currently characterise the system..

There is an urgent need to invest more money in health care services, food security and clean drinking water. These issues have been neglected in budgets for far too long and though we may have concerns that every paisa allocated to health may not be used as best as it could be in the present circumstances due to corruption, inefficency, lack of will etc, there is no way of improving quality without making the necessary investment.

The Village Health Worker Scheme: The CMP clearly underlines its commitment to focus on Primary Health Care. Further the Indian National Congress in its election manifesto, states: "*The Congress will introduce a new community anchored health worker scheme and implement it with the*

involvement of people's organizations and panchayati raj institutions." Similarly the Communist Party of India (Marxist) states in its election manifesto: *"The Primary Health Care infrastructure should include a National Community Health Worker scheme to deliver basic health services at the habitation (village/urban settlement) level."* Given this broad political commitment in this area we would like to propose the following:

National Community Health Worker (CHW) scheme: A woman health worker in every village of the country by 2009. Innovative experiments like the state level Mitanin programme in Chhattisgarh may be taken into account while designing this scheme. Training costs and set of basic drugs for CHWs may be Centrally funded in the initial phase, later costs of drugs and honorarium to be shared by Union and State governments. Design of training modules (to be appropriately adapted at state level) to be supported by the Union health ministry.

It needs to be understood that in our understanding and experience, the village health worker or community health worker is a formal and trained worker with a formal relationship with the existing structures of Primary Health Care Services as well as the ICDS. For this scheme to be fully effective it is essential that these basic services be made to function optimally.

Coercive population control measures: We note with dismay the CMP's reference to "*sharply targeted population control programmes in 150 Districts*" – which we see as providing tacit clearance to coercive measures to control population. Not only are such measures violative of basic human rights, they have also been shown to be almost entirely useless in stabilising population. The CMP's position on this stands in clear variance with the National Population Policy 2000 and all related international covenants accepted by the Indian government. There is little call to reopen a debate on India's stated and well considered stand on population policy. Instead of arguing for incentives and disincentives, in keeping with the spirit of the NPP 2000, steps need to be taken to eliminate all forms of coercive population control measures and the two-child norm, which targets the most vulnerable sections of society.

Health Insurance: The scheme suggested by the latest budget is not very different from such schemes suggested in earlier budgets and we have seen that they have all failed. Further the schemes run by NGOs, whether through SHGs, cooperatives etc. are not necessarily insurance schemes, they are more in the nature of mutual funds which in some cases are using the volunrtary (or private) insurance route. While the former set of schemes as mooted in the budgets are merely populist proclamations, the NGO schemes are selective schemes, largely with the poor, limited to a small population which is organised in some way by the NGO.

Insurance does not work this way. Insurance implies very large coverage and risk pooling across classes and across the sick and healthy, young and old etc. And an insurance which is equitable also means that it should be universal and non-discriminatory. Neiher the govts. proclamations nor the NGO experiments fit this bill. This means you cannot have only health insurance for the poor. Health insurance has to be for all. The question is how will the poor pay premiums. Thus the insurance program has to be a mix of social insurance where premiums are collected from those who have capacity to pay and state contributes the share of the poor from tax revenues. Secondly, for insurance to function well the healthcare system, including the private sector has to be organised and regulated.

Finally, the reality that a majority of India's workforce is self-employed creates a problem of how premiums from such working people will be collected. It is here we can learn from the NGO experiments but review them in the context of the Bismarcan era of Germany/Prussia where mutual fund societies of occupational groups were formed and later federated. Japan today follows a similar system. Thus, for example, from farmers who are a very large group, a health cess via land revenues could be collected as premium contribution and for the landless labourers they can be registered with a state agency, like EGS etc. and the state can contribute their premium. Only such a system of health

insurance would be feasible in India but for this healthcare needs to be high up on the political agenda and atleast 3% of GDP needs to be committed.

Health Tourism: Promotion of medical tourism locates medical care outside the community. It thus detracts from the whole concept of primary health care. By promoting the notion that medical services can be bought of the shelf from the lowest priced provider anywhere in the globe, it also takes away the pressure from the State to provide comprehensive health care to all its citizens.

Medical tourism involves large, specialist hospitals run by corporate entities and constitute the tertiary sector. It is a myth that the revenues earned by these corporates will be partly reverted to financing the public health infrastructure. In India, there is ample evidence to show that these hospitals have not honoured the conditionalities for receiving state subsidies - in terms of treatment of a certain proportion of inpatients and out patients free of cost. Increased demand on private hospitals due to medical tourism will increase the demand for health professionals in these hospitals, and thus divert personnel from the public sector rather than strengthen them. This essentially means that majority of the Indian population which is dependent on public provisioning will be faced with even poorer quality of care than they are getting today. Medical tourism promotes an "internal brain drain" with more health professionals being drawn to large urban centres, and within them, to large corporate run specialty institutions.

The potential for earning revenues through medical tourism will become an important argument for private hospitals demanding more subsidies from the state in the long run. In India, the corporate private sector has already received considerable subsidies in the form of land, reduced import duties for medical equipment etc. Medical tourism will only further legitimize their demands. This is worrying because the scarce resources available for health will go into subsidising the tertiary corporate sector, which constitutes only 1-2 percent of the private sector and is accessed largely by the upper middle classes. This will also mean that the investments that are so badly needed for public provisioning goes wanting. It then has serious consequences for equity and cost of services and raises a very fundamental question: why should developing countries be subsidising the health care of developed countries? Especially when this is not likely to result in any improvement of the public health infrastructure in the country.

Campaign Mode to Combat Select Diseases: A number of National Programmes focusing on specific diseases already exist and are languishing for want of implementational systems. Simultaneously, campaign modes of combating diseases like malaria and polio have been and are being experimented with. These programmes and their successes and failures need a thorough evaluation before embarking upon this particular vertical methodology of disease reduction. In the understanding of Jan Swasthya Abhiyan, the concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes need to be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation. Focus needs to be shifted from bio-medical and individual based measures to social, ecological and community based measures.

Such measures should include:

- integration of health impact assessment into all development projects;
- decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners;
- reorientation of measures to check STDs/AIDS through universal sex education, checking social disruption and displacement and commercialisation of sex, generating public awareness to remove stigma and universal availability of preventive and curative

services, and special attention to empowering women and availability of gender sensitive services in this regard.

Accountability of Primary Healthcare Delivery System and Transferring them to Local Governments: JSA, on the whole, supports the devolution of power to Panchayats and decentralised planning and implementation. However, health care administration is a skilled and complex task and transferring the Primary health care system to Panchayats would be an exercise requiring much training and planning. There are elements with Primary Health care that are amenable to quick decentralisation such as, for example, surveillance and monitoring of Primary Health Care services and the village health worker scheme. Systems for monitoring of Health rights, and building of accountability of health services at village, block and district levels need to be developed. However, 'experiment' with decentralised health planning needs to be done in phases at a small scale to fully understand its requirements and implications before being applied to the whole country.

Operationalising the Right to Health Care and enacting a National Public Health Act : In order to mandate assured provision of basic health services, the Union health ministry may initiate a discussion in the Central Council on Health (including all state health ministers) and develop a consensus on the issue of operationalising the Right to Health Care. This may be followed by passing a 'National Public Health Act' (stipulated long back by Bhore committee-1946 and Mudaliar Committee-1961), which would specify a set of basic health services to be available to all as a right, including legal obligations of public and private health care providers, health rights of citizens, standards of care and certain proportion of public funds at all levels to be earmarked for public health. State governments could pass corresponding 'State public health services rules' within specified time.

Regulation of the private medical sector: In keeping with the recommendations of the NHP 2002, the government should undertake the formulation of a Draft National Act for regulation of standards, ensuring adherence to treatment guidelines and ceiling on costs of care by private medical services. This should be followed by enactment of state level legislation in all states in a time bound framework.

Brief Comments on the Discussion Paper

We would also like to comment, briefly, on some specific issues raised in the Discussion Paper circulated for the meeting convened by the NAC. We would, of course, if the NAC so desires, be ready to comment at length – but that would require considerably more time.

Agenda for Action: Any agenda for action, if it has to be sustained, should be locally contextualized, relevant and effective in the diversity of state health systems (since health systems are primarily state subjects constitutionally) and must be supported by an integrated policy that locates the challenge of health, nutrition, population, medical education, health manpower development, rational drug policy, ISMS etc, in an integrated policy context. If these documents are discussed by different stakeholders and finally passed by state cabinets or state legislators, then the agenda for action is protected against changes of government, changes of personnel and moves from 'interesting whims and fancies' of a few to serious state level commitment.

Raising an Army of Community Health Volunteers: It is unfortunate that the paper only mentions CRHP, Jamkhed, Tribhuvandas' Foundation -- rather old experience of the 1980s and early 1990s. It would be useful to look at much larger schemes launched by the Government, and learn from their experiences.

The Janata Government's experiment with the VHW scheme in the late Seventies was a thorough failure. Men were selected instead of women. The honorarium became like a salary without adequate community preparation and social control. Thousands of health workers are still drawing this amount because of a legal case, which the government lost.

For example, the Madhya Pradesh Government in 1994, launched a state level Jana Swasthya Rakshak Programe with the ambitious goal of one JSR per village of MP (50,000 including the present state of Chattisgarh). Fairly detailed review of this scheme are available – some conducted by JSA partner organisations. The main concern of the review was to prevent such schemes from losing focus and quality and long term perspectives and succumbing to the exigencies of populism and red tape and bureaucratization.

These findings were discussed in the top leadership of state, but were ignored because by that time 'populism' had overtaken 'serious policy reform'. However, they made an impact on the "Mitanin" Scheme of Chattisgarh and some policy checks have been included in the now evolving Chattisgarh Scheme.

Many of the salient features of the proposal in the agenda of action are fraught with certain inherent dangers, which would have long term backlash. We believe that any such scheme needs a much wider discussion and needs to take into account a large body of experience that is available today in launching such schemes. The scheme outlined in the paper, in our opinion, is too idealistic and does not show adequate sensitivity to ground level realities.

Reproductive Health services and Control Measures: The Agenda for action fails to locate the challenge of women's Health in the context of women's empowerment. Further, it is unfortunately that it does not address issues such as Female Foeticide, Domestic Violence, Dowry Deaths?

The Discussion Paper, as it stands today, is a collation of very good innovative ideas form diverse sources. Unfortunately, these are not linked into any cogent, coherent or experience derived process of evolution. It, therefore, appears to be ahistorical and ad-hoc, and not adequately reflective of the

phenomenal amount of grass root experiences not only of alternative models, but alternative training, alternative policy generation, that abounds in the country.

We believe that the best of ideas have failed in the country because they have been transplanted from micro level innovation to state and national level experimentation without fully grasping the socio-economic - cultural - political context in which they are being scaled up. In the absence of this understanding, the Jamkhed experiment taken up by Janata Government in 1977 was a collosal failure and there are many such ruins - along the way. We believe the NAC has a great opportunity to prevent this from happening by being in close touch with those who are trying experimentation and preventing too much populism.

We appreciate the openness and the opportunity provided to dialogue. But we suggest a more inclusive referencing paper. It was quite a surprise that none of these well known alternatives were even noted and the paper was too full of selective primary health care strategies advocated by the world Bank, and bio-medical techno-managerialism that need to be confronted and contextualized.

We hope these points will help to expand the discussion on health policy. Rich experience and research is available within JSA to further elucidate this brief response to proposals that have already been circulated within the NAC. Jan Swasthya Abhiyan would be happy to share perspectives and frameworks for addressing issues such as a National Community Health Worker (CHW) scheme, accountability of Primary Healthcare Delivery System and operationalising health rights, Health insurance, Population policy, Communicable disease control, regulation of the private medical sector and other issues with members of the NAC as and when required.

Common Minimum Programme
Priorities in Health

Shri. J.V.R.Prasada Rao,

Secretary, Health
Govemment of India

Common Minimum Program Goals

1. INCREASE PUBLIC HEALTH SPENDING FROM 0.9% TO 2-3% GDP;

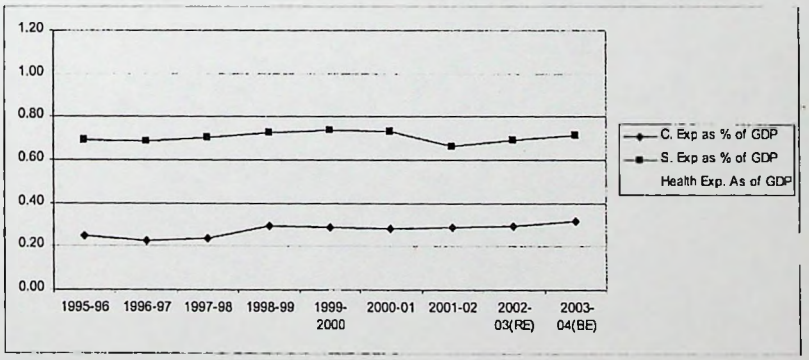
2. CONTROL OF COMMUNICABLE DISEASES

3. PROVIDE LEADERSHIP FOR CONTROL OF HIV/AIDS

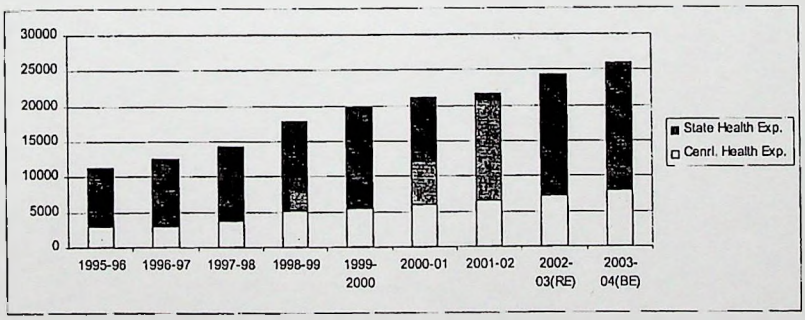
National Health Policy - 2002

- 3 Goals Related to Financing of Health:
- A. Increase Public Health Spending to 2% of GDP
- B. Increase Share of Central Government to 25% of State expenditure -
- C. Increase State Spending to from current level of 5.5% to 7% of Revenue Expenditure

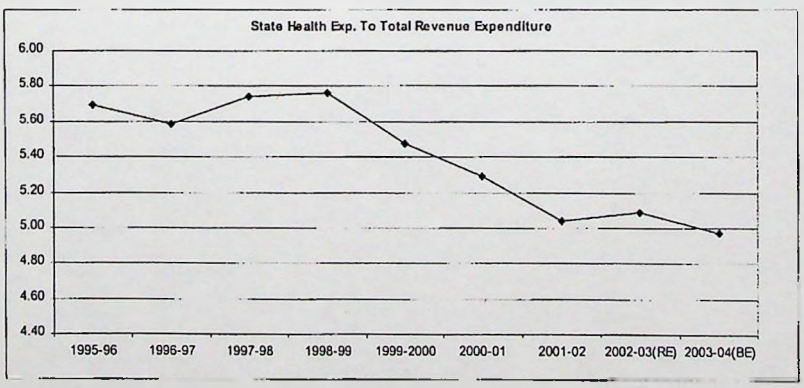
Percentage of Central & State Expenditure to GDP



Share of Central to Total Expenditure



Share of State Expenditure to Total Revenue Expenditure



Estimated Availability of Funds in 2001

Total At 2% of GDP Rs. 1 12 000 cr.
Total At 25% of Central Share Rs. 28,000cr.
Total States Share = Rs. 84,000cr.
Current Level of Health Expenditure 20032004 = Rs. 22,505cr.
States Share = Rs. 14,535 cr.
Central Share = Rs 7,970cr.

Key Priorities for Additional Resources

Strengthening of the Primary Health System

1. Direct Central financing of Multipurpose Workers (M)
Amounts Required: Rs.828 er./yr.

Of the total 1.38 Sub Centers, there are no Male Workers in almost **80,600** - largely on account of the State's poor financial position.

Largest number of Male Workers Vacancies in the States of Bihar, **UP,** Orissa etc.which have highest disease burden

Strengthening Primary Care .. Contd..

- 2. Honororium for Village Health Workers of Rs. 1000 per month: 500,000 workers

- Total Budget Required : Rs. 600 cr. Per year

Strengthening of the Primary Health Care System .. Contd...

3. Provisioning of 35 Drugs Listed in the EDL to all PHC's

Bridging this gap will improve the utilization of the PHCs' from current level of 19%

4. Health Posts in Urban Areas

Strengthening of the Primary Health Care System .. Contd...

Upscaling Community Disease Control Programs that disproportionately affect the poor by upscaling, intensification and sustaining the ongoing programs for the Control of Malaria, TB and HIV/AIDS

An Estimated amount of Rs.2000 crores will b e required in addition to the current provision of Rs. 5850 cr.

Increase Focus on Non Communicable Diseases

- NCD - mainly Cancer, Vascular Diseases, including Diabetes, Respiratory and chronic diseases, Mental health, injuries and accidents etc.entailing high disease burden - high contributors of impoverishment

- NCDs' entail high burden of morbidity and mortality

- Need to Design Programs for Emerging Diseases, namely, diabetes, CVD, Stroke etc.

Increase Central assistance for Coping with NCD

At present GOI has 5 CSS programs for NCD
National Health Programs for:

1. Control of Blindness (Rs. 590 cr), 2. Cancer(Rs.3 80cr.), 3. Mental Health(Rs. 215cr.), 4. Drug Addiction(Rs. 5 0.4 cr) and 5. IDD (Rs. 10cr) Total allocation of Rs. 1285.90cr.for Tenth Plan

Need to **substantially increase** funding to cope with emerging diseases such as diabetes and CVD, injuries and chronic diseases, and Trauma Care along National Highways

Expand Access to Hospital care for Underserved States

Since 1958 when AIIMS was constituted as an Institute of Excellence no such Initiative taken to establish similar institutes for research and medical excellence

Absence of skilled manpower and tertiary care facilities in most states driving patients to Delhi Hospitals - overcrowding and affecting quality and heavy economic burden on the poor

Expand Access ... contd ...

- To expand access to high quality care :

- Establish 6 Institutes of Excellence like AIIMS in underserved states and provide financial support to 6 others to upgrade existing facilities.

  Outlay for next five years is Rs. 4500 cr.

Improve Quality

- Quality of Medical Education, NursingSchools a serious concern : worsened due to the rapid and unplanned expansion and commercialization of education

- Migration and attrition of senior faculty

- Near absence of any investment by states for upgrading the infrastructure in medical and nursing schools

- Problems of Approvals from Medical Council of India

Improve Quality .. contd...

- Three Initiatives required for improved quality in medical education and nursing schools:
- Constitute a Medical Grants Commission with a corpus fund to provide assistance to medical schools for improving infrastructure
- Establish mechanisms for Accreditation
- Provide Incentives and improved working conditions for retention of faculty
- **Total Amount Required Rs. 1000 cr.**

Increase Resources at State Level

- States resource position likely to continue to be adverse in the near term. 3 recommendations for improving their resource base :

1. Earmark a percentage of total Additional Central Assistance for Health;

2. Reduce Interest on External funding provided to States;

3.Earmark a proportion of PMGY grants for Health

4.Constitution of a Health Cess to finance State Health Plans

Key Concerns Regarding State Health Financing

There are two key concerns that need to be addressed by Central Government :

1. Developing a mechanism to push resources into underdeveloped and special category states like Bihar, J&K, Assam etc. to which external donors are not prepared to lend; (State Health Systems Proj ects)

2. Establish monitoring systems in the Planning Commission to ensure progressive increases in the Health Budgets of the states while approving their Annual Plans

Summing Up – Central

Additional Expenditures : Rs/crores by 2010

Intensification of ongoing Communciable disease programs **Rs. 2000cr.**

New **Initiatives :**

1. New programs for NCD's: **Rs. 1285 cr**.
2. Medical Grants Commission - **Rs. 1000cr**.
3. Central Financing of MPW (M)&VHW **Rs. 1428cr**. per year
4. Drugs for PHC's = **Rs. 500cr**. per year
5. Institutions of Excellence = **Rs. 4800cr**.
6. Urban Health Posts = **Rs. 1000cr. for 5 years.**

Summing Up - States

Increased Resource Transfers

I ACA
2. PMGY
3. Reduction of interest on loans
4. Health Cess
5. Increased Commitment of State resources to Health through the Plan process
6. External funding through Health Systems Projects for infrastructure Development.

Mission for Rural Health Care Delivery in Selected States
(Draft Document for Discussion)

Preamble:

This Mission seeks to improve rural health care delivery in states where it is weakest at present by ensuring a provider in each village, effective hospital care to rural population and converged action on health and the determinants of health for maximum impact. The Mission will be the instrument to integrate multiple vertical programmes at the District level along with their funds. The Mission will ensure right to every child in these states in India to basic health services.

Current Situation:

- Health Status of the people in the extremely poor in rural areas of the 10 states of Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajsathan, Uttar Pradesh, Uttaranchal, Assam, Jammu and Kashmir and the states of North East
- Poverty and ill-health are mutually reinforcing
- Status of public provisioning of health care weak where it is needed most
- These states also contain the 150 population-focus districts: New national response required
- Health Sector has not utilised opportunity for inter-sectoral action provided by Panchayat Raj
- Health output dependent on action for health combined with action on key determinants of health like safe water, sanitation, nutrition etc., Panchayat Raj has mandate also over these determinants
- Opportunity to redesign ineffective national programmes mandate in NCMP/PM's directive to revamp delivery

Rural Health through a Citizen Lens

- "Burden of disease high on account of poverty and illiteracy"
- "There is no official health provider in the village" (in most villages in these states)
- "There is a designated ANM (MPW). Located elsewhere so visits, at best, twice a month"
- "Most deliveries take place at home – Nearest PHC (20Kms) anyway cant provide institutional care"
- "The nearest effective unit for hospital care is the CHC, about 40 Kms away
- "There are private providers close by whose services are paid for"

Rural Health through Government Lens

- There is a Multi-purpose Worker (Male and Female) for population of 3000-5000 at the Sub Centre as First Unit

- The next Unit is the one for Hospital Care – Sector PHC for a population of 30,000 – 1,00,000 (About 40 villages) with one doctor, one nursing assistant, one ward boy, dresser, 2 sector supervisors and 2 MPW. It also has 6 beds
- There is a Community Health Centre for a population of over 1 Lakh. With over 10 doctors, nursing staff, lab technicians, radiologists etc., and about 40 plus beds. High Occupancy rate

Rural Health and Government Provisioning: Why does it fail?

- First Unit of MPW (ANM) fails because not a resident of the village
- Second Unit of PHC a planning failure of serious proportions. Utilisation of beds 0 to 2%. A mixed-up model combining inpatient care and outreach function not doing either
- Means citizen gets effective referral care only at CHC-about 40 kms away
- Though private providers exist, there is no link with them for Public health
- MPW (ANM) is an extension of the government into the village – not a "finger of the community going up" therefore comes with government's health agenda and not structured to respond to people's health needs
- Government does not simultaneously act on the causes of ill-health (preventive action on determinants)
- Private providers are not accredited and therefore do an entrepreneurial function, not a public health one
- Government has "programmes for individual diseases" and not a plan for comprehensive health care
- Health Care delivery is completely top-down with priorities set in Delhi and flowing down

Some serious planning errors/need for correction

- ANM (MPW) conceived on population – norm and needs to be based on habitation-norm
- Sub Centre has no autonomy
- Sector PHC cannot do impatient care and so needs to be reconfigured as outreach unit only
- CHC can be strengthened to become first effective referral unit only
- District has no space to plan for itself – therefore cant link effectively with determinants
- No collective platform for health at district-level which includes private providers, other non allopathic providers
- State level budgets being spent mostly on salaries and medicines, GOI has become the real player in programme design – more so for poorer states
- Resource constraints and importance of health goals have brought in large number of donors: in absence of an integrating framework donor-catalysed programmes further fragment comprehensive health care into "selective" goals
- Within States, areas are carved out for different donor agencies
- Each programme operates as a vertical silo

- Too many vertical programmes with no horizontal connections
- Every programme exhorts "intersectorality" but in practice fragment resources and dissipate energies
- In short health sector which needs "extra-sector action" to be effective, is internally fragmented

What could be done?

- **Step 1: Simple horizontal integration at the district level of all vertical programmes under the format of Rural Health Care Delivery Mission**
- A "funnel" approach to doing this: May be many on top but flow into one common pool at district level
- GOI will create on Omnibus Centrally Sponsored Programmed called "District Rural Health Care Delivery Mission" and put under it the following programmes
- **Programmes for integration of funds at district level under the common head of the Mission:**
    a) **Strengthening of Rural Health Infrastructure**
    b) **Population control**
    c) **Reproductive and Child Health**
    d) **National Malaria Programme**
    e) **National Leprosy Eradication Programme**
    f) **National Kala Azar Programme**
    g) **National Programmed for Control of Blindness**
    h) **National Iodine Deficiency Disorders programme**
    i) **National Filaria Programme**
    j) **Revised National Tuberculosis Programme**

  National AIDS Programme and National Cancer Programme may be separately considered

- These different programmes will be budgeted under the common head and resources passed on to districts through states
- Monitoring would be done by the centre and states for which separate streams for monitoring will be retained at Centre/State levels
- This will mean dissolving the multiple societies that now exist for managing these programmes into one common Health Society at the District level. Could be chaired by the Chairperson ZP, with collector as Co-Chair and CMHO as secretary. Operation of cheque by any two
- All of the above to be done by GOI

Step 2: District Health Plan as Programme Instrument and following components

a) **Provider in Each Village: Government provider mapping and filling up gaps by training one person in each village as a barefoot doctor (in those villages where none exist)**

- **Government to provide training, kit, link with the sub Health Centre/PHC. She/He entitled to practice as government certified community health activist**

b) **Facility: Government will try and provide a health room in each village (if resources permit: this is not considered essential, especially in low -density population villages)**

- **Every untrained dai will be trained in each village (many have already been trained)**

c) **Organisation**

A Frontline team for health in each village with elected Panchayat, ANM/Community health Activist, Dai/teacher/anganwadi worker

d) **Support from Private providers**

District to identify and register all private providers and link them effectively with public health provisioning

e) **Strengthening Facilities at Sub Centre, PHC, CHC**

- Untied fund of Rs. 5000 per year as Community Health Action Fund to ANM/MPW to catalyse frontline team for action on health and determinants
- Sector PHC given territorial responsibility and its medical staff deployed with CHC, if state so wishes
- CHC strengthened with community monitoring through Patients Welfare Committee
- CHC allowed to levy user charges, more for accountability (poor can be exempted to avoid any such criticism that poor are being charged)

f) **District Health Plan**

- This plan should detail action under components (a) to (e) and suggest collaborative action for determinants through sectors like safe water, sanitation, nutrition etc.,
- It could contain ideally an (g) untied fund for supporting local action
- The District Health Society will have on it intersectoral functionaries who can operationalise such a plan

g) **What could be done: Supportive Action**

- District Health Society will pool existing personnel under different societies for managerial support: Gaps here will be provided for (example, accounts staff)
- Private Sector, NGO Collaboration would be enabled at district level through district health plans
- District Public Health report will be presented each year on status under key components
- Concurrent review will be done by non government organisations

Mission Output

- At the village level, every village gets a provider – either MPW or Community Health Activist
- At the Village level, if possible, a health room
- At the Village level, a trained dai in each village
- At the Village level, a sensitised frontline team of panchayat, MPW, Anganwadi, etc.,
- At the Village level, action on determinants of health
- At Village (cluster) level, a better functioning sub health centre with untied funds for community health action
- A better functioning CHC for hospital care
- Each CHC working under community control, with local resource mobilisation
- At district level, a coordinated plan that links with private providers
- At district level, a coordinated plan with action on determinants
- At District level, integration of resources internal to health sector and combining with outside sector funds
- At district level, effective support staff
- At District level, effective programme review and public accountability
- Impact on IMR, MMR, Universal Immunisation, Reduction in Communicable diseases in 4 years, mainstreaming AIDS prevention, leading to population stabilisation.

Everybody Wins

- Citizens get improved health services
- Local bodies / District gets leadership roles in planning for their area
- State Governments/State managers get freedom from Vertical programmes that dissipate energies
- Government of India is able to target its resources better and ensure better outcomes
- Private Sector, NGOs get space to collaborate
- Development partners get value for money

Mission Implementation:

Structure (For all Missions)

- Mission Coordinating Group headed by the Prime Minister with Deputy Chairman Planning Commission, Ministers of Mission areas, Cabinet Secretary and Principal Secretary to PM
- National Mission for Rural Health Care Delivery located in the Ministry of Health (Family Welfare)
- Mission Steering Group headed by the Minister of Health, Secretaries of the three wings of Health, Member Planning Commission, Secretaries of WCD, Elementary education and Literacy, Experts. Mission located in Department of Family welfare with a Mission Director (at JS level)
- State level Missions headed by the Chief Minister with similar composition
- State level Steering Group headed by the Chief Secretary
- District level Mission with ZP as chairperson, Collector as Co-chairperson and CMHO as Secretary and heads of Committees for health, education, WCD in ZP etc., as members along with district heads of Departments, representatives of private providers, NGOs, Experts on public health etc.,

Next Steps:

- Circulation of the draft Mission outline to a selected group of experts and representatives of states taken up under the Mission: 15-18 September
- Meeting to finalise Mission and setting deadlines for state-level documents: 1st week of October
- Finalisation of the National Mission Document : 15 October
- Cabinet Clearances etc.: 15-30 October
- Mission to commence : 14 November

PHM-Secretariat

From: "sushama rath" <sushamarath@yahoo.co.in>
To: <secretariat@phmovement.org>
Sent: Tuesday, October 05, 2004 3:12 PM
Subject: Rural Health Mission

Dear Sir,

As already informed in the invitation letter TA/DA will paid to you including air travel by economy class.

Overview of Rural Health Care Mission is hereby sent.

Sushama Rath
Under Secretary (ID/EAG)

OVERVIEW OF RURAL HEALTHCARE MISSION

STRATEGIC INPUTS

INSTITUTIONAL:

- Expanding the EAG mechanism to Rural Healthcare Mission (RHM) for focused attention on 17 States- 8 EAG States (U.P., M.P., Bihar, Rajasthan, Orissa, Jharkhand, Uttaranchal and Chhattisgarh), 7 North Eastern States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura), Jammu & Kashmir and Sikkim
- 5 States to be covered under Common Minimum Programme (CMP) Strategy for focus on population stabilization
- 8 States to be covered under North East Health Mission (NEHM)
- Graded packages for varying needs, based on State ownership and articulation
- At national level, RHM to be presided over by PM/HFM
- At state level, RHM to be presided over by CM/State Health Minster
- RHM to include agendas of the 3 Departments of Health, FW and AYUSH — More towards integrations Functions.

INTRA & INTERSECTORAL CONVERGENCE:

- All vertical national health programmes and donor funds to converge at the State/District level
- Funds for civil works, drugs equipment, training management and IEC pooled together into a District Health Fund for which a composite District Health Plan shall be made
- Creation of a District Health Development Agency (DHDA)

Mission for Rural Health Care Delivery in Selected States

Draft Document for Discussion

Preamble

This Mission seeks to improve rural health care delivery in states where it is weakest at present by ensuring a provider in each village, effective hospital care to the rural population and converged action on health and the determinants of health for maximum impact. The Mission will be the instrument to integrate multiple vertical programmes at the District level along with their funds. The Mission will ensure the right of every child in these states in India to basic health services

Current Situation

- Health status of the people is extremely poor in the rural areas of the 10 states of Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, Assam, Jammu and Kashmir and states in the North-East
- Poverty and ill-health are mutually reinforcing
- Status of public provisioning of health care weak where it is needed most
- These states also contain the 150 population-focus districts: New national response required

Current Situation

- Health Sector has not utilised opportunity for intersectoral action provided by panchayat raj
- Health output dependent on action for health combined with action on key determinants of health like safe water, sanitation, nutrition etc. Panchayat Raj has mandate also over these determinants
- Opportunity to redesign ineffective national programmes mandate in NCMP/PM's directive to revamp delivery

Rural Health through a Citzen Lens

- **" Burden of disease high on account of poverty and illiteracy"**
- **" There is no official health provider in the village"(in most villages in these states)**
- **" There is a designated ANM(MPW). Located elsewhere so visits, at best, twice a month"**
- **"Most deliveries take place at home—the nearest PHC (20 kms) anyway cant provide institutional care"**
- **"The nearest effective unit for hospital care is the CHC, about 40 kilometers away"**
- **" There are private providers close by whose services are paid for"**

Rural Health Care through Government Lens

- There is a Multi-Purpose Worker (Male and Female) for population of 3000-5000 at the Sub Centre as First Unit
- The next unit is one for hospital care- Sector PHC for a population of 30,000-1,00,000 (about 40 villages) with one doctor, one nursing assistant, one ward boy, dresser, 2 sector supervisors and 2 MPW. It also has 6 beds
- There is a Community Health Centre for a population of over 1 lakh. With over 10 doctors, nursing staff, lab technicians, radiologists etc and about 40 plus beds. High occupancy rate

Rural Health and Government Provisioning: Why does it fail?

- First Unit of MPW (ANM) fails because not a resident of the village
- Second unit of PHC a planning failure of serious proportions. Utilisation of beds 0 to 2%. A mixed-up model combining inpatient care and outreach function not doing either
- Means citizen gets effective referral care only at CHC- about 40 Kms away
- Though private providers exist, there is no link with them for public health

Rural Health and Government Provisioning: Why does it fail?

- MPW (ANM) is an extension of the government into the village—not a "finger of the community going up" – therefore comes with government's health agenda and not structured to respond to people's health needs
- Government does not simultaneously act on the causes of ill-health (preventive action on determinants)
- Private providers are not accredited and therefore do an entrepreneurial function, not a public health one
- Government has " programmes for individual diseases" and not a plan for comprehensive health care
- Health care delivery is completely top-down with priorities set in Delhi and flowing down

Some serious planning errors/ need for correction

- ANM(MPW) conceived on population- norm and needs to be based on habitation-norm
- Sub Centre has no autonomy
- Sector PHC cannot do inpatient care and so needs to be reconfigured as outreach unit only
- CHC can be strengthened to become first effective referral unit
- District has no space to plan for itself—therefore cant link effectively with determinants

Some serious planning errors/ need for correction

- No collective platform for health at district-level which includes private providers, other non allopathic providers
- State level budgets being spent mostly on salaries and medicines, GOI has become the real player in programme design—more so for poorer states
- Resource constraints and importance of health goals have brought in large number of donors: in the absence of an integrating framework donor-catalysed programmes further fragment comprehensive health care into" selective" goals

Some serious planning errors/ need for correction

- Within states, areas are carved out for different donor agencies
- Each programme operates as a vertical silo
- Too many vertical programmes with no horizontal connections
- Every programmes exhorts "intersectorality" but in practice fragment resources and dissipate energies
- In short health sector which needs "extra-sector action" to be effective, is internally fragmented

What could be done?

- Step 1: Simple horizontal integration at the district level of all vertical programmes under the format of Rural Health Care Delivery Mission
- A " funnel" approach to doing this: May be many on top but flow into one common pool at district level
- GOI will create one omnibus Centrally Sponsored Programme called " District Rural Health Care Delivery Mission" and put under it the following programmes

What could be done?

- **Programmes for integration of funds at district level under the common head of the Mission:**

(a) **Strengthening of Rural Health Infrastructure (b) Population Control © Reproductive and Child Health (d) National Malaria Programme (e) National Leprosy Eradication Programme (f) National Kala Azar Programme (g) National Programme for Control of Blindness (h) National Iodine Deficiency Disorders programme (I) National Filaria Programme (j) Revised National Tuberculosis Programme**

(b) **National Aids Programme and National Cancer Programme may be separately considered**

What could be done?

- These different programmes will be budgeted under the common head and resources passed on to districts through states
- Monitoring would be done by the Centre and States for which separate streams for monitoring will be retained at Centre/State levels
- This will mean dissolving the multiple socities that now exist for managing these programmes into one common Health Society at the District level . Could be chaired by the Chairperson ZP, with Collector as co-Chair and CMHO as Secretary. Operation of cheque by any two
- All of the above to be done by GOI

What could be done?

Step 2: District Health Plan as Programme Instrument and following components

(a) Provider in Each Village: Government Provider mapping and filling up gaps by training one person in each village as a barefoot doctor(in those villages where none exist)

- Government to provide training, kit, link with sub Health Centre/PHC. She/He entitled to practice as government certified community health activist

(b) Facility: Government will try and provide a health room in each village (if resources permit: this is not considered essential, especially in low-density population villages)

What Could be done?

- Every untrained dai will be trained in each village (many have already been trained)

© Organisation

A frontline team for health in each village with elected panch,ANM/Community health activist.dai/teacher/anganwadi worker

(d) Support from private providers

District to identify and register all private providers and link them effectively with public health provisioning

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- ✓ **Untied fund of Rs 5000 per year as Community Health Action Fund to ANM/MPW to catalyse frontline tean for action on health and determinants**
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What could be done?

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- At village (cluster) level, a better functioning sub Health Centre with untied funds for community health action

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National Rural Health Mission

A Promise of

Better Healthcare Service for the Poor

A summary of

Community Entitlements

and

Mechanisms for Community Participation and Ownership

for

Community Leaders

Prepared for

Community Monitoring of NRHM - First Phase

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Briefing Note Compiled by: **Abhijit Das, Gitanjali Priti Bhatia**

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Contents

Preface 04

An Introduction- NRHM 05

Service Guarantees Important Schemes and Provisions under NRHM 06

- ASHA
- ANM
- JSY
- Service guarantees from Sub Health Center
- Service guarantees from Primary Health Center
- Service guarantees from Community Health Center
- AYUSH

Community Participation in NRHM 14

- Village Health and Sanitation Committee
- PHC Monitoring and Planning Committee
- Block Monitoring and Planning Committee
- District Health Monitoring and Planning Committee
- State Health Monitoring and Planning Committee
- Rogi Kalyan Samiti

Some Frameworks for Community Monitoring 20

- Indian Public Health Standards
- Charter of Citizen's Health right
- Concrete Service Guarantees

Annexure 23

- Model Citizens Charter for CHCs and PHCs

Preface

The National Rural Health Mission has been launched with the objective of improving the access to quality healthcare services for the rural poor, especially women and children. The Mission recognizes that good health is an important component of overall socio-economic development and an improved quality of life.

The most significant aspect of NRHM is that it is not a new health scheme or programme but a new approach to providing healthcare services. Some of the important components of this approach is that it

- recognizes the importance of integrating the determinants of health, like nutrition, water and sanitation with healthcare systems
- aims at decentralizing planning and management
- integrates organizational structures–i.e. the different vertical health schemes
- improves delivery of healthcare services through upgrading and standardizing health centres
- introduces standards and guarantees for service quality and triangulated monitoring systems for assuring quality
- provides mechanisms for community participation and management

This short briefing note has been prepared by pooling together all the manuals and guidelines that have been prepared to guide the implementation of NRHM and highlights its key components which relate to Entitlements, Mechanisms for Community Participation and Yardsticks for Community Monitoring. It is expected that this information will prove useful for all those involved in the Community Monitoring processes at the district, block and village levels.

This briefing note has been prepared as a part of the Community Monitoring of NRHM (first phase) being implemented by the Advisory Group on Community Action.

An Introduction to NRHM

The Government of India launched the National Rural Health Mission (NRHM) on the 12th of April 2005.The vision of the mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

NRHM is a 7 years programme ending in the year 2012. It has time bound goals and its progress will be reported publicly by the government.

Some of the goals of the Mission:

- Reduction in child and maternal mortality
- Universal access to public health care services along with public services for food and nutrition, sanitation and hygiene
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care

Some of the Core Strategies through which the mission seeks to achieve its goals:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services
- Promote access to improved healthcare at household level through (ASHA)
- Health Plan for each village through Village Health Committee
- Strengthening existing sub-centre, PHCs and CHCs
- Preparation and Implementation of an inter-sectoral District Health Plan
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels

Unlike previous health programmes, the government has clearly defined the roles of Non governmental organization (NGOs) in the Mission. NGO's are not only included in institutional arrangement at National, State and District Levels but also they are supposed to play an important role in monitoring, evaluation and social audit.

Source of Information: Mission document http://mohfw.nic.in/NRHM/Documents/NRHM%20Mission%20Document.pdf

For more Information on NRHM vision, goals, objectives, strategies and outcomes go to:

1) Framework for Implementation. http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

2) Website on NRHM by Ministry of Health and Family Welfare http://mohfw.nic.in/NRHM/NRHM.htm

Service Guarantees and Important Schemes and Provisions under NRHM

Accredited Social Health Activist (ASHA)

With the launch of NRHM, the Government of India proposed Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system.

Since Sub centers were serving much larger population than they were expected to and ANMs were heavily overworked, one of the core strategies of NRHM is to promote access to improved healthcare at household level through ASHA.

- ASHA is a Health Activist in the community
- Every village will have 1 ASHA for every 1000 persons
- She will be selected in a meeting of the Gram Sabha
- She will be chosen from women (married/widowed/ divorced between 25-45 years) residing in the village with minimum education up to VIIIth class.
- ASHA is accountable to the Panchayat
- ASHA will work from the Anganwadi Centre
- ASHA is honorary volunteer and she is entitled to receive performance based compensation. Her services to the community are Free of cost
- ASHA will receive trainings on care during pregnancy, delivery, post partum period, New born care, sanitation and hygiene

Roles and Responsibilities

ASHA is responsible for creating Awareness on Health including

- Providing information to the community on nutrition, hygiene and sanitation
- Providing information on existing health services and mobilizing and helping the community in accessing health related services available at Health Centers
- Registering pregnant women and helping poor women to get BPL certification
- Counseling women on birth preparedness, safe delivery, breast feeding, contraception RTI/STI and care of young child
- Arranging escort/accompany pregnant women and children requiring treatment/admission to the nearest health centre.
- Promoting universal immunization
- Providing primary medical care for minor ailments. Keeping a drug kit containing generic AYUSH and allopathic formulations for common ailments
- Promoting construction of household toilets
- Facilitating preparation and implementation of the Village Health Plan through AWW, ANM,SHG members under the leadership of village health committee
- Organizing Health Day once/twice a month at the anganwadi with the AWW and ANM
- ASHA is also a Depot holder for essential services like IFA, OCP, Condoms, ORS DDK etc, issued by AWW

Timeline: Fully trained ASHA for every 1000 population/large-isolated habitations in 18 Special Focus States-30% by year 2007, 60% by 2009 and 100% by 2010

Source of Information:

(1) Guidelines on ASHA- It has been envisaged that states will have flexibility to adapt these guidelines keeping their local situations in view. http://mohfw.nic.in/Guidelines%20on%20ASHA-Annex%201.pdf

(2) Framework for Implementation (*) http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20 Framework %20for%20Implementation.pdf

For more Information on ASHA go to:

1) Guidelines on JSY http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

2) Website of Ministry of Health and Family Welfare http://mohfw.nic.in/NRHM

Auxiliary Nurse Midwife (ANM)

ANM is a government paid health worker who provides free maternal and childcare services within a sub center area. The Mission seeks to provide minimum two ANMs at each Sub Health Centre to be fully supported by the Government of India.

Primary tasks of ANM

- Registration of all pregnancies (ANM along with ASHA will ensure that all BPL women get benefits under Janani Suraksha Yojna)
- Ensure Minimum 4 antenatal check ups along with 100 IFA tablets and two T.T. Injections to pregnant women
- Appropriate and prompt referral in case of high-risk pregnancies
- Provide Skilled Attendance at home deliveries, post partum care and contraceptive advice
- Newborn Care (full immunization and Vitamin A doses to children, prevention and control of childhood diseases like malnutrition, infections etc.
- Curative Services like treatment for minor ailments
- Maintenance of all relevant records concerning mother, child and eligible couples in the area
- Providing information on different family planning and Contraception methods and Provision of Contraceptives
- Counseling and correct information on safe abortion services
- Coordinates services with AWWs, ASHA, Village Health & Sanitation Committee and PRI for observance of Health Day at AWW center at least once a month
- Coordination and supervision of ASHA
- The Untied grant to the Sub Center is kept in a joint account, which is operated, by the ANM and the local Sarpanch

ANM is answerable to Village Health and Sanitation committee, which will oversee her work.

Source of Information:

Framework for Implementation http://mohfw.nic.in/NRHM/Documents/ NRHM%20-%20Framework%20for %20 Implementation.pdf

For more Information on JSY go to:

1) Guidelines on JSY http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm

2) Website of Ministry of Health and Family Welfare - http://mohfw.nic.in/NRHM

JANANI SURAKSHA YOJANA (JSY)

JSY is meant to reduce maternal mortality and neo-natal mortality by promoting deliveries at health institutions by skilled personnel like doctors and nurses.

JSY is a 100% centrally sponsored scheme. It integrates cash assistance to women from poor families for enabling them to deliver in health institutions along with anti natal and post natal care.

The scheme applies differently to LPS and HPS.While states having low institutional delivery rates have been named as Low Performing States (LPS), the remaining states have been named as High Performing States (HPS). LPS states include the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and HPS states include Maharashtra and Tamilnadu.

Eligibility for Cash Assistance:

LPS States	All pregnant women delivering in Government health centres like Sub-centre, PHC/CHC/FRU/general wards of District and state Hospitals or accredited private institutions. No age constraint
HPS States	BPL pregnant women, aged 19 years and above
LPS & HPS	All SC and ST women delivering in a government health centre like Sub-centre, PHC/CHC/FRU/general ward of District and state Hospitals or accredited private institutions. No age constraint

Limitations of Cash Assistance for Institutional Delivery:

In LPS States	All births, delivered in a health centre – Government or Accredited Private health institutions.
In HPS States	Upto 2 live births.

Scale of Cash Assistance for Institutional Delivery

Category	Rural Area		Total	Urban Area		Total
	Mother's Package	ASHA's Package	Rs.	Mother's Package	ASHA's Package	Rs.
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

Generally the ANM/ASHA should carry out the entire disbursement process.

Assistance for Home Delivery

In LPS and HPS States, BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance would be available only upto 2 live births and the disbursement would be done at the time of delivery or around 7 days before the delivery by ANM/ASHA/any other link worker. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery.

Role of ASHA or other link health worker associated with JSY

Along with fulfilling their usual duties of providing anti natal and post natal care to woman, ASHA/other health workers would be responsible for

- Identifying pregnant woman as a beneficiary of the scheme
- Assisting the pregnant woman to obtain necessary certifications
- Identifying a functional Government health centre or an accredited private health institution for referral and delivery
- Escorting the beneficiary women to the health center and stay with her till the woman is discharged

Source of Information: Website of Ministry of Health and Family Welfare

For more Information on need of BPL certification, Disbursement of Cash Assistance, flow of fund (from state district authority to ANM to ASHA), ASHA's package under JSY, Subsidizing cost of Caesarean Section , Grievance Redressal cell, display of names of JSY beneficiaries in health centers go to: http://mohfw.nic.in/dofw%20website /JSY_features_FAQ_Nov_2006.htm

Service Guarantees from Sub Health Center

(Services provided at the Sub Center are Free of Cost for a person from BPL family)

Maternal Health

Antenatal care:

- Early registration of all pregnancies
- Minimum four antenatal check-ups
- General examination such as weight, BP, anaemia, abdominal examination, height and breast examination
- Iron and Folic Acid supplementation
- T.T.Injection, treatment of anaemia, etc.
- Minimum laboratory investigations like haemoglobin, urine albumen and sugar
- Identification of high-risk pregnancies and appropriate and prompt referral

Intranatal care:

- Promotion of institutional deliveries
- Skilled attendance at home deliveries as and when called for
- Appropriate and prompt referral

Postnatal care:

- A minimum of 2 postpartum home visits
- Initiation of early breast-feeding within half-hour of birth
- Counselling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding and STI/RTI and HIV/AIDS

Child Health

- Promotion of exclusive breast-feeding for 6 months
- Full Immunization of all infants and children
- Correct doses of Vitamin A
- Prevention and control of childhood diseases like malnutrition, infections, etc.

Family Planning and contraception

- Provision of contraceptives and counseling to adopt appropriate Family planning methods
- Counselling and appropriate referral for safe abortion services (MTP) for those in need

Adolescent health care

Providing education, counselling and referral services Assistance to school health services.

Control of local endemic diseases Disease surveillance

- Disinfection of water sources
- Promotion of sanitation including use of toilets and appropriate garbage disposal

Curative Services

- Provide treatment for minor ailments including and First Aid in accidents and energencies
- Appropriate and prompt referral
- Organizing Health Day at Anganwadi centres at least once in a month

Training, Monitoring and Supervision

- Training of Traditional Birth Attendants and ASHA
- Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRI

Record of Vital events

- Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants

- Maintenance of all the relevant records concerning mother, child and eligible couples in the area

The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of Village Health and Sanitation Committee.

ANM and Multi purpose Health worker MPW works from the Subcentre and deliver the above-mentioned service with the help of ASHA.

Funds

- The Gram Panchayat SHC Committee has the mandate to undertake construction and maintenance of SHC. An annual maintenance grant of Rupees 10,000 will be available to every SHC
- Every SHC gets Rs.10,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand. The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch

Time Line:

- 2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75000 places - 30% by 2007, 60% by 2009, 100% by 2010
- Untied grants provided to each Sub Centre to promote local health action. 50% by 2007, 100% by 2008
- Annual maintenance grant provided to every Sub Centre - 50% by 2007, 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres- 50% by 2007,100% by 2008

Source of Information:

1) Framework for Implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

For more Information go to:

1) Guidelines for VHSCs, SCs, PHCs AND CHCs http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

2) IPHS for Subcenters http://mohfw.nic.in/NRHM/Documents/IPHS_for_SUBCENTRES.pdf

Services Guarantees from Primary Health Centre (PHC)

(All services provided at PHC are free of cost for BPL families)

Every PHC has to provide OPD services, Inpatient Service, referral service and 24 hours emergency service for all cases needing routine and emergency treatment including treatment of local diseases.

All services provided by Sub centers are also provided by PHC.

Some additional services provided in a PHC are as follows:

Maternal Health

- 24-hour delivery services both normal and assisted
- Appropriate and prompt referral for cases needing specialist care
- Pre-referral management (Obstetric first-aid)
- Facilities under Janani Suraksha Yojana

Family Planning

- Permanent methods of Family Planning
- Facility for Medical Termination of Pregnancies (wherever trained personnel and facility exists)

Treatment of RTI/ STIs
Basic laboratory services
Referral services

Appropriate and prompt referral of cases needing specialist care including:

- Stabilisation of patient

- Appropriate support for patient during transport
- Providing transport facilities

A Charter of Citizen's Health Rights should be prominently displayed outside all PHCs.

The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located.

The Block level PHC will have involvement of Panchayti Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

The Mission seeks to provide minimum three Staff Nurses to ensure round the clock services in every PHC.

Funds

- Each PHC is entitled to get an annual maintenance grant of Rs. 50,000 for construction and maintenance of physical infrastructure. Provision for water, toilets, their use and their maintenance, etc, has to be priorities. PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure
- Every PHC is entitled to get Rs. 25,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand

Time Line:

- 30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 60% by 2009 and 100% by 2010
- Untied grants provided to each PHC to promote local health action - 50% by 2007 and 100% by 2008
- Annual maintenance grant provided to every PHC - 50% by 2007 and 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at PHCs - 50% by 2007 and 100% by 2008

Source of Information:
Framework for Implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

For more Information go to:
Guidelines for VHSCs, SCs, PHCs AND CHCs http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

Service Guarantees from Community Health Centre (CHC)

- Care of routine and emergency cases in surgery and medicine
- 24-hour delivery services including normal and assisted deliveries
- Essential and Emergency Obstetric Care including surgical interventions
- Full range of family planning services
- Safe Abortion Services
- Newborn Care and Routine and Emergency Care of sick children
- Diagnostic services through the microscopy centers
- Blood Storage Facility
- Essential Laboratory Services
- Referral Transport Services
- All National Health Programmes should be delivered through the CHCs. e.g. HIV/AIDS Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS to provide round the clock hospital-like services. According to IPHS, it is mandatory to display Charter of Citizen's Health Rights outside all CHCs. The dissemination and display of charter is the

responsibility of Block Health Monitoring and Planning Committee.

According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.^

Mission also seeks to provide separate AYUSH set up in each CHC.

Funds

- Every CHC gets Annual maintenance grant of Rs. 1 lakh for construction and maintenance of physical infrastructure. Rogi Kalyan Samiti/Block Panchayat Samiti has a mandate to undertake construction and maintenance of CHC

- Every CHC gets Rupees 50,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand

Time Line

- 6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS-30% by 2007,50% by 2009 and 100% by 2012

- Untied grants provided to each CHC to promote local health action- 50% by 2007 and 100% by 2008

- Annual maintenance grant provided to every CHC -50% by 2007 and 100% by 2008

- Procurement and logistics streamlined to ensure availability of drugs and medicines at CHCs-50% by 2007 and 100% by 2008

Source of Information:

1) Framework for Implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

2) IPHS for CHC(^) http://mohfw.nic.in/NRHM/Documents/Draft_CHC.pdf

For more Information on Guidelines for Village Health and Sanitation Committees, Sub Centres. PHCs and CHCs go to: http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

AYUSH

The term AYUSH covers **A**yurveda, **Y**oga & Naturopathy, **U**nani, **S**iddha and **H**omeopathy. These systems are popular in a large number of States in the country. e.g. Ayurved system is popular in the States of Madhya Pradesh, Rajasthan, and Orissa, the Unani system is particularly popular in Tamil Nadu and Maharashtra.This is to imply that the AYUSH systems of medicine and its practices are well accepted by the community, particularly, in rural areas. The medicines are easily available and prepared from locally available resources, economical and comparatively safe.

One of the objectives of the mission is to revitalize local health traditions and mainstream AYUSH into the public health system.

Modalities For Integration

- For mainstreaming, the personnel of AYUSH may work under the same roof of the Health Infrastructure, i.e., PHC, CHC; However, separate space should be allocated exclusively for them in the same building

- The Doctors under the Systems of AYUSH are required to practice as per the terms & conditions laid down for them by the appropriate Regulatory Authorities

- Provision of one Doctor of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in PHC

- Provision of one Specialist of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in CHC

- Supply of appropriate medicines pertaining of AYUSH systems

- The already existing AYUSH infrastructure should be mobilized. AYUSH dispensaries that are not functioning well should be merged with the PHC or CHC barring which, displacement of AYUSH clinic is not advised

- Cross referral between allopathic and AYUSH streams should be encouraged based on the need for the same

- AYUSH Doctors shall be involved in IEC, health promotion and also supervisory activities
- The IPHS pertaining to AYUSH and also the detailed manpower and other requirements and financial projections for the same will be provided by the Department of AYUSH for further consideration

Source of Information:
Mainstreaming of AYUSH Systems in the National Health Care Delivery System- Mohfw.nic.in/ayush%2015th%20march.pdf

For more Information go to:
Website of Department of AYUSH http://indianmedicine.nic.in/

Community Participation in NRHM

Village Health and Sanitation Committee (VHSC)

Village level Health and Sanitation Committee will be responsible for the Village Health Plans.

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

Composition

The Village Health Committee would consist of:

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

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

Training

The members would be given orientation training to equip them to provide leadership as well as plan and monitor the health activities at the village level.

Grants available

- Every village with a population of upto 1500 gets an annual Untied grant of up to Rs. 10,000, after constitution and orientation of VHSC. The Untied grant to be used by this committee for household surveys, health camps, sanitation drives, revolving fund etc.
- A revolving fund for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization would also be operated by the VHSC

Some roles of the VHSC

- Create Public Awareness about the essentials of health programmes, with focus on People's knowledge of entitlements to enable their involvement in the monitoring
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha
- Participatory Rapid Assessment to ascertain the major health problems and health related issues in the village. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village
- Maintenance of a village health register and health information board/calendar: The health register and board will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW

- Get a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action

Time Line
Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them - 30% by 2007, 100% by 2010

Untied grants provided to each Village Health and Sanitation Committee to promote local health action. 50% by 2007, 100% by 2008

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

For more Information go to:
Guidelines for VHSCs, SCs, PHCs AND CHCs http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf

PHC Monitoring and Planning Committee

This Committee monitors the functioning of Sub-centres operating under jurisdiction of the PHC and developes PHC health plan after consolidating the village health plans.

Composition

- 30% members from PRI (from the PHC coverage area; 2 or more sarpanchs of which at least one is a woman)
- 20% members non-official representatives from VHSC, (under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages)
- 20% members representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the area covered by the PHC
- 30% members representatives of the Health and Nutrition Care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area
- Chairperson: Panchayat Samiti member, Executive chairperson: Medical officer of the PHC, Secretary: NGO/CBO representatives

Role & Responsibilities

- Consolidation of the village health plans and charting out the annual health action plan in order of priority
- Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC
- Ensure that the Charter of citizen's health rights is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action
- Monitoring of the physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it
- Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organizations
- Share the information about any health awareness programme organized in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.
- Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area

- Review the functioning of Sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning

- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee

Time Line:
Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

Block Monitoring and Planning Committee

This Committee monitors the progress made at the PHC level health facilities in the block, including CHC and develops annual action plan for the Block after consolidating PHS level health plans.

Composition

- 30% members representatives of the Block Panchayat Samiti (Adhyaksha/Adhyakshika or members with at least one woman)

- 20% members non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time

- 20% members representatives from NGOs/CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services

- 20% members officials such as the BMO, the BDO, selected MO's from PHCs of the block

- 10% members representatives of the CHC level Rogi Kalyan Samiti

- Chairperson: Block Panchayat Samiti representative, Executive chairperson: Block medical officer, Secretary: NGO / CBO representatives

Role & Responsibilities

- Consolidation of the PHC level health plans and charting out of the annual health action plan for the block.

- Review of the progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to be taken for further improvement of health facilities in the block, including the CHC

- Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunization and other national programmes

- Monitoring of the physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC

- Coordinate with local CBOs and NGOs to improve the health services in the block

- Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning

- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level

Time Line:
Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

District Health Monitoring and Planning Committee

This Committee contributes to the development of District Health plan.

Composition

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

Role & Responsibilities

- Discussion on the reports of the PHC health committees
- Financial reporting and solving blockages in flow of resources if any
- Infrastructure, medicine and health personnel related information and necessary steps required to correct the discrepancies
- Progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs
- Ensuring proper functioning of the Hospital Management Committees
- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal

Time Line:
Systems of community monitoring put in place- 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

State Health Monitoring and Planning Committee

This Committee reviews and contributes to the development of State Health plan.

Composition

- 30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation

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

Role & Responsibilities

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

Time Line:
Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

Source of Information:
Framework for implementation http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

Rogi Kalyan Samiti (RKS)

For efficient management of Health Institutions NRHM has proposed Rogi Kalyan Samiti (RKS)/Patient Welfare Committee/Hospital Management Committee (HMC) . This initiative is taken to bring in the community ownership in running of rural hospitals and health centres, which will in turn make them accountable and responsible.#

Broad Objectives of RKS#

- Ensure compliance to minimal standard for facility and hospital care
- Ensure accountability of the public health providers to the community

- Upgrade and modernize the health services provided by the hospital
- Supervise the implementation of National Health Programme
- Set up a Grievance Mechanism System

Apart from this, RKS at PHC and CHC will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure. RKS would also develop annual plans to reach the IPHS standards.*

RKS would be a registered society. It may consists of following members#

- Group of users i.e. people from community
- Panchayati Raj representatives
- NGOs
- Health professionals

According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.^

Grants

To motivate the states to set up RKSs, a support of Rs.5.0 lakhs per rural hospital, Rs.1.00 lakh per CHC and Rs.1.00 per PHC per annum would be given to these societies through states. The societies would be eligible for these grants only where they are authorized by the States to retain the user charges at the institution level.*

Time Line*:

- Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals - 50% by 2007, 100% by 2009
- One time support to RKSs at Sub Divisional/ District Hospitals - 50% by 2007, 100% by 2008

Source of Information:

1) Framework for implementation (*) http://mohfw.nic.in/NRHM/Documents/NRHM%20%20Framework%20for%20Implementation.pdf

2) Guidelines for IPHS for CHC(^)

3) Guidelines for Rogi Kalyan Samiti (#) http://mohfw.nic.in/NRHM/RKS.htm

Some Frameworks for Community Monitoring

Indian Public Health Standards (IPHS)

IPHS are being prescribed to provide optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care. These standards help in monitoing and improving the functioning of public health centers.#

IPHS for CHCs provides for "Assured services" that should be available in a Community health centre along with minimum requirements for delivering these services such as:

- Minimum clinical and supporting manpower requirement
- Equipments
- Drugs
- Physical Infrastructure
- Charter of Patients' rights
- Requirement of quality control
- Quality assurance in service delivery-standard treatment protocol#

Similar standards are being developed for PHCs & Sub Center.*

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs would be operationalized as first Referral Units (FRUs) with all facilities for emergency obstetric care. *

It will be for the States to decide on the configuration of PHCs to meet IPH Standards and offer 24X7 services including safe delivery. The RKS would develop annual plans to reach the IPH standards.*

Time line*
In the first six months since the launch of the mission, following work should have been completed:

- Selection of and 2 CHCs in each State for upgradation to IPHS
- Release of funds for upgradation of two CHCs per district to IPHS
- 2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75000 places- 30% by 2007, 60% by 2009 and 100% by 2010
- 30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 60% by 2009 and 100% by 2010
- 6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 50% by 2009 and 100% by 2012

Source of Information:
1) Framework for Implementation (*) http:// mohfw.nic .in/NRHM/Documents/NRHM%20-%20Framework %20for%20Implementation.pdf

2) IPHS for CHC (#) - http://mohfw.nic. in/NRHM/ Documents/Draft_CHC.pdf

For more Information go to:
Link given on Ministry of Health and Family Welfare website: http://mohfw.nic.in/NRHM/iphs.htm

Charter of Citizen's Health Rights

Charter of Citizen's Health Rights seeks to provide a framework which enables citizens to know.

- What services are available?
- The quality of services they are entitled to.

- The means through which complaints regarding denial or poor qualities of services will be addressed.#

A Charter of Citizen's Health Rights should be prominently displayed outside all District Hospitals, CHCs and PHCs. While IPHS makes the display mandatory for every CHC.*

The dissemination and display of charter is the responsibility of Health Monitoring and Planning Committee at that level. E.g. Block Health Monitoring and Planning Committee has the responsibility to ensure display of the charter at CHC.*

While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination.*

The charter seeks to increase transparency that would help the community to better monitor the health services.*

Source of Information:
1) Framework for implementation(*) http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf

2) IPHS for CHC(#)- http://mohfw.nic.in/NRHM/Documents /Draft_CHC.pdf

For more information go to:
Link given on Ministry of Health and Family Welfare website: http://mohfw.nic.in/NRHM/iphs.htm

Concrete Service Guarantees

Concrete Service Guarantees that NRHM provide are the benchmarks against which mission functioning can be monitored and its success can be measured. These guarantees are as follows:

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

Time Line:
SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HIV/AIDS, etc.-30% by 2007, 50% by 2008, 70% by 2009 and 100% by 2012

Institution-wise assessment of performance against assured service guarantees carried out-30% by 2008, 60% by 2009 and 100% by 2010.

Source of Information:
Framework for Implementation http://mohfw.nic.in /NRHM/Documents/NRHM%20-%20Framework %20for%20Implementation.pdf

For more information on:
Institution wise service guarantees go to Annex–III of Framework for Implementation.

Annexure

Model Citizens Charter for CHCs and PHCs

1. Preamble

Community Health Centres and Primary Health Centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

2. Objectives

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure you just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

3. Commitments of the Charter

- to provide access to available facilities without discrimination.
- to provide emergency care, if needed on reaching the CHC/PHC.
- to provide adequate number of notice boards detailing the location of all the facilities.
- to provide written information on diagnosis, treatment being administered.
- to record complaints and designate appropriate officer, who will respond at an appointed time, that may be same day in case of inpatients and the next day in case of out patients.

4. Component of service at CHCs

- access to CHCs and professional medical care to all.
- making provision for emergency care after main treatment hour whenever needed.

- informing users about available facilities, costs involved and requirements expected of them with regard to the treatment in clear and simple terms.
- informing users of equipment out of order.
- ensuring that users can seek clarifications and assistance in making use of medical treatment and CHC facility.
- informing users about procedures for reporting in-efficiencies in services or nonavailability of facilities.

5. Grievance redressal

- grievances that citizens have will be recorded.
- there will be a designated officer to respond to the request deemed urgent by the person recording the grievance.
- aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC.
- to have a public grievance committee outside the CHC to deal with the grievances that are not resolved within the CHC.

6. Responsibilities of the users

- users of CHC would attempt to understand the commitments made in the charter.
- user would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- instruction of the CHC's personnel would be followed sincerely, and
- in case of grievances, the redressal mechanism machinery would be addressed by users without delay.

7. Performance audit and review of the charter

- performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified.

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COMH-92.

ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಮಂತ್ರಾಲಯ, ಭಾರತ ಸರ್ಕಾರ
ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ, ಕರ್ನಾಟಕ ಸರ್ಕಾರ

ರಾಷ್ಟ್ರೀಯ ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನ

ನಗರ ಪ್ರದೇಶದ ಬಡವರಿಗೆ ಸುಲಭದಲ್ಲಿ ಆರೋಗ್ಯ ಸೇವಾ ಸೌಲಭ್ಯಗಳನ್ನು ಕಲ್ಪಿಸುವ ಮಹತ್ವಕಾಂಕ್ಷೆಯ ಯೋಜನೆ – ಎನ್.ಯು.ಹೆಚ್.ಎಂ.

ಹೆಚ್ಚುತ್ತಿರುವ ಜನಸಂಖ್ಯೆ ಮತ್ತು ನಗರೀಕರಣ

- 2011 ರ ಜನಗಣತಿ ಪ್ರಕಾರ ಭಾರತದ ಜನ ಸಂಖ್ಯೆ 121 ಕೋಟಿ ಮೀರಿದೆ.
- ವಿಶ್ವದಲ್ಲಿ ಅತಿ ಹೆಚ್ಚು ಜನಸಂಖ್ಯೆಯುಳ್ಳ ರಾಷ್ಟ್ರಗಳ ಪೈಕಿ ಭಾರತ ಎರಡನೇ ರಾಷ್ಟ್ರವಾಗಿದೆ.
- ಭಾರತದೇಶದ 32% ಜನಸಂಖ್ಯೆ ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ ವಾಸಿಸುತ್ತಿದ್ದಾರೆ. 2011 ರಜನಗಣತಿಯ ಪ್ರಕಾರ ಕರ್ನಾಟಕದ ಜನಸಂಖ್ಯೆ 6.11 ಕೋಟಿ ಮೀರಿದೆ, ಸುಮಾರು 38.7% ಜನ ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ ವಾಸಿಸುತ್ತಿದ್ದಾರೆ. ಬೆಂಗಳೂರು ನಗರದ ಜನಸಂಖ್ಯೆ 95.6 ಲಕ್ಷದಾಟಿದೆ.
- ತೀವ್ರ ನಗರೀಕರಣದಿಂದ ವಸತಿ, ಸಾರಿಗೆ, ಕುಡಿಯುವ ನೀರು ಮತ್ತು ಶೌಚಾಲಯ ಸಮಸ್ಯೆ, ವಿದ್ಯಾಭ್ಯಾಸ, ಉದ್ಯೋಗ, ಆರೋಗ್ಯ ಮುಂತಾದವುಗಳ ಸಮಸ್ಯೆ ಹೆಚ್ಚಾಗುತ್ತಿದೆ. ಈ ಸಮಸ್ಯೆಗಳು ಕೊಳಚೆ ಪ್ರದೇಶಗಳು ಮತ್ತು ಬಡವರು ವಾಸಿಸುವ ಪ್ರದೇಶಗಳಲ್ಲಿ ಹೆಚ್ಚಾಗಿವೆ.
- ನಗರ ಪ್ರದೇಶಗಳಲ್ಲಿ, ಅದರಲ್ಲೂ ವಿಶೇಷವಾಗಿ ಕೊಳಚೆ ಪ್ರದೇಶಗಳು ಹಾಗೂ ಬಡವರು ವಾಸಿಸುವ ಪ್ರದೇಶಗಳಲ್ಲಿ ಈ ಕೆಳಕಂಡ ಕೆಲವು ಆರೋಗ್ಯದ ಸಮಸ್ಯೆಗಳು ದಿನದಿಂದ ದಿನಕ್ಕೆ ಹೆಚ್ಚಾಗುತ್ತಿವೆ:
  - ತೀವ್ರತರಹದ ನಗರದ ಬೆಳವಣಿಗೆಯಿಂದ ಜನಸಂದಣಿ ಹಾಗೂ ವಸತಿ ಸಮಸ್ಯೆ
  - ಗಾಳಿ, ಬೆಳಕು ಮತ್ತು ಪರಿಸರ ಮಾಲಿನ್ಯ
  - ನೀರು ಮತ್ತು ಶೌಚಾಲಯಗಳ ಕೊರತೆಯಿಂದ ಉಂಟಾಗುವ ವಾಂತಿ, ಬೇಧಿ, ಕಾಲರಾ ಮುಂತಾದರೋಗಗಳು
  - ಡೆಂಗ್ಯೂ, ಮಲೇರಿಯಾ, ಹೆಚ್1 ಎನ್1 ಕಾಯಿಲೆಗಳು
  - ನಗರ ಪ್ರದೇಶದಿಂದ ವರದಿಯಾಗುತ್ತಿರುವ ಬಹು ಔಷಧಿಗಳಿಂದ ಗುಣಪಡಿಸಲಾಗದ ಕ್ಷಯರೋಗ
  - ನಗರ ವಾಸಿಗಳಲ್ಲಿ ಹೆಚ್ಚಾಗಿ ಕಾಣಿಸಿಕೊಳ್ಳುತ್ತಿರುವ ರಕ್ತದೊತ್ತಡ, ಅಸ್ತಮಾ ಕಾಯಿಲೆ, ಸಕ್ಕರೆ ಕಾಯಿಲೆ, ಅಯೋಡಿನ್‌ಕೊರತೆ ಮುಂತಾದವುಗಳು
  - ನಗರ ಪ್ರದೇಶದ ಮಹಿಳೆಯರಲ್ಲಿ ಹೆಚ್ಚಾಗಿ ಕಾಣಿಸಿಕೊಳ್ಳುತ್ತಿರುವ ಸ್ತನ ಮತ್ತು ಗರ್ಭಕೋಶದ ಕ್ಯಾನ್ಸರ್ ರೋಗ
  - ಮಾನಸಿಕ ಖಿನ್ನತೆ, ಒತ್ತಡ ಮುಂತಾದ ಮಾನಸಿಕ ಕಾಯಿಲೆಗಳು
  - ಮದ್ಯ ಮತ್ತುಇತರ ವಸ್ತುಗಳ ವ್ಯಸನಿಗಳ ಸಂಖ್ಯೆ ಹೆಚ್ಚಳ

ನಗರದ ಆರೋಗ್ಯ ವ್ಯವಸ್ಥೆಯ ಸಮಸ್ಯೆಗಳು:

- ಆರೋಗ್ಯ ಸೇವೆಗೆ ಸಮುದಾಯದ ಸಹಭಾಗಿತ್ವ ಇಲ್ಲದೇ ಇರುವುದು.
- ನಗರ ಪ್ರದೇಶದ ಬಡವರಿಗೆ ಲಭ್ಯವಿರುವ ಆರೋಗ್ಯ ಸೇವೆಗಳ, ಮಾಹಿತಿ ಇಲ್ಲದೇ ಇರುವುದು
- ದ್ವಿತೀಯ ಮತ್ತು ತೃತೀಯ ಮಟ್ಟದ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಸಾಮಾನ್ಯ ಕಾಯಿಲೆಗಳ ಜನ ಸಂದಣಿ ಹೆಚ್ಚಾಗಿರುವುದು
- ಖಾಸಗಿ ಆರೋಗ್ಯ ಸೇವೆ ನೀಡುವವರ ಸಂಖ್ಯೆ ಗಣನೀಯವಾಗಿ ಹೆಚ್ಚಾಗುತ್ತಿರುವುದು
- ಬಡವರಿಗೆ ಆರೋಗ್ಯ ಸೇವೆ ಪಡೆಯಲು ಉಂಟಾಗುತ್ತಿರುವ ವೈಯಕ್ತಿಕ ಹಣದ ಖರ್ಚು ಹೆಚ್ಚಾಗುತ್ತಿರುವುದು
- ಸಾರ್ವಜನಿಕ ಆರೋಗ್ಯ ಸಂಸ್ಥೆಗಳ ಬಗ್ಗೆ ಸಾರ್ವಜನಿಕರ ತಾತ್ಸಾರ
- ಪ್ರಾಥಮಿಕ ಹಂತದ ಆರೋಗ್ಯ ಸೇವೆಗೆ ಹೆಚ್ಚು ಗಮನ ಕೊಡದೇ ಇರುವುದು
- ಸರ್ಕಾರಿ ಆಸ್ಪತ್ರೆಗಳ ಸಿಬ್ಬಂದಿಗಳ ಮತ್ತು ಸಮುದಾಯದಲ್ಲಿ ಕರ್ತವ್ಯ ನಿರ್ವಹಿಸುವ ಸಿಬ್ಬಂದಿಗಳಲ್ಲಿ ಕೌಶಲ್ಯದ ಕೊರತೆ

ಇತ್ತೀಚಿನ ಕೆಲವು ಸಮೀಕ್ಷೆಗಳ ಪ್ರಕಾರ ನಗರ ಪ್ರದೇಶಗಳ, ಅದರಲ್ಲೂ ಕೊಳಚೆ ಪ್ರದೇಶದ ವಾಸಿಗಳ ಆರೋಗ್ಯದ ಸ್ಥಿತಿ ಗಂಭೀರವಾಗಿದೆ. ನಗರವಾಸಿಗಳ ಆರೋಗ್ಯದ ಮಟ್ಟವನ್ನು ಸುಧಾರಿಸಲು, ಭಾರತ ಸರ್ಕಾರ 2013–14ನೇ ಸಾಲಿನಿಂದ ರಾಷ್ಟ್ರಾದ್ಯಂತ' ರಾಷ್ಟ್ರೀಯ ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನ'ವನ್ನು ಪ್ರಾರಂಭಿಸಿದೆ. ಈ ಅಭಿಯಾನದಡಿಯಲ್ಲಿ 50,000ಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಜನಸಂಖ್ಯೆಯಿರುವ ಎಲ್ಲಾ ನಗರ ಮತ್ತು ಪಟ್ಟಣಗಳನ್ನು ತರಲಾಗುವುದು.

ರಾಷ್ಟ್ರೀಯ ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನದ ಗುರಿಗಳು ಈ ಕೆಳಕಂಡಂತಿವೆ:

- ನಗರ ಪ್ರದೇಶದ ಜನರ ಆರೋಗ್ಯ ಸ್ಥಿತಿಯನ್ನು ಉತ್ತಮ ಪಡಿಸುವುದು. ಅದರಲ್ಲೂ ಬಡವರು, ದೀನದಲಿತರು, ವಲಸಿಗರು, ಕಟ್ಟಡ ನಿರ್ಮಾಣ ಕಾರ್ಮಿಕರು, ನಿರಾಶ್ರಿತರು, ಮನೆಕೆಲಸಗಾರರು, ಲೈಂಗಿಕ ಕಾರ್ಯಕರ್ತರು, ತರಕಾರಿ ಮಾರುವವರು, ಬೀದಿ ಮಕ್ಕಳು, ಕಸ ಆಯುವವರು, ರಿಕ್ಷಾಚಾಲಕರು, ಭಿಕ್ಷುಕರು, ಅಲೆಮಾರಿಗಳು, ಸಣ್ಣ ಪುಟ್ಟ ಕೆಲಸಗಳಲ್ಲಿ ತೊಡಗಿರುವವರು ಮತ್ತು ನಿರ್ಗತಿಕರ ಆರೋಗ್ಯ ಸ್ಥಿತಿ ಉತ್ತಮಪಡಿಸುವುದು.
- ಎಲ್ಲಾ ವರ್ಗದವರಿಗೂ ಮತ್ತು ಆರೋಗ್ಯ ಸೇವೆ ವಂಚಿತ ಜನರಿಗೆ ಗುಣಮಟ್ಟದ ಆರೋಗ್ಯ ಸೇವೆ ಒದಗಿಸುವುದು.
- ಪ್ರಾಥಮಿಕ ಹಂತದ ಆರೋಗ್ಯ ಸೇವೆಯನ್ನು ಬಲಪಡಿಸುವುದು.
- ಸರ್ಕಾರಿ–ಖಾಸಗಿ ಸಹಭಾಗಿತ್ವದಿಂದ ಉತ್ತಮ ಸೇವೆ ಒದಗಿಸುವುದು.
- ಆರೋಗ್ಯ ಸೇವೆಗೆ ಸಮುದಾಯದ ಸಹಭಾಗಿತ್ವ ಹೆಚ್ಚಿಸುವುದು
- ನಗರಾಡಳಿತ ಸಂಸ್ಥೆಗಳನ್ನು ನಗರದ ಆರೋಗ್ಯ ಸಮಸ್ಯೆ ಬಗೆಹರಿಸಲು ಪಾಲುದಾರಿಕೆ ಮಾಡಿಕೊಳ್ಳುವುದು.

ನಗರದ ಆರೋಗ್ಯ ಸಮಸ್ಯೆಗಳನ್ನು ಬಗೆಹರಿಸಲು ರಾಷ್ಟ್ರೀಯ ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನದಡಿಯಲ್ಲಿ ಈ ಕೆಳಕಂಡ ಕಾರ್ಯತಂತ್ರಗಳನ್ನು ಅನುಸರಿಸಲಾಗುವುದು:

- ನಗರದ ಆರೋಗ್ಯ ಸೇವೆಯನ್ನು ಉತ್ತಮ ರೀತಿಯಲ್ಲಿ ಒದಗಿಸಲು, ಕಾರ್ಯಕ್ರಮ ಅನುಷ್ಠಾನ ವ್ಯವಸ್ಥೆ ಬಲಪಡಿಸುವುದು.
- ಆಸ್ಪತ್ರೆಗಳ ಆರೋಗ್ಯ ಸೇವೆ ಉತ್ತಮಪಡಿಸಲು, ಕಟ್ಟಡಗಳ ಸುಧಾರಣೆ/ಬಲವರ್ಧನೆ, ಸಿಬ್ಬಂದಿಗಳ ಕೊರತೆ ನೀಗಿಸುವುದು, ಆಸ್ಪತ್ರೆಗಳಿಗೆ ಅವಶ್ಯವಿರುವ ಪೀಠೋಪಕರಣಗಳು, ಔಷಧಿ ಮತ್ತು ಇತರೆ ಬಳಕೆ ಸಾಮಗ್ರಿಗಳನ್ನು ಒದಗಿಸುವುದು.
- ಸಮುದಾಯದ ಸಹಭಾಗಿತ್ವ ಮತ್ತು ಪಾಲುದಾರಿಕೆ ಹೆಚ್ಚಿಸಲು, ಸಮುದಾಯದ ಸಂಘ ಸಂಸ್ಥೆಗಳನ್ನು ಪಾಲುದಾರರನ್ನಾಗಿ ಮಾಡಿಕೊಳ್ಳಲು, 50–100 ಕುಟುಂಬಗಳಿಗೊಂದು **ಮಹಿಳಾ ಆರೋಗ್ಯ ಸಮಿತಿ**ಗಳನ್ನು ಸ್ಥಾಪಿಸುವುದು.
- 1000–2500 ಜನಸಂಖ್ಯೆಗೆ ಒಬ್ಬ ಸಾಮಾಜಿಕ ಆರೋಗ್ಯ ಕಾರ್ಯಕರ್ತೆಯರನ್ನು (**ಆಶಾ ಕಾರ್ಯಕರ್ತೆ**) ನೇಮಿಸುವುದು.
- 50,000 ಜನಸಂಖ್ಯೆಗೊಂದು ನಗರ ಆರೋಗ್ಯ ಕೇಂದ್ರವನ್ನು ಸ್ಥಾಪಿಸುವುದು.
- 10,000 ಜನಸಂಖ್ಯೆಗೊಂದು ಎಎನ್‌ಎಮ್ (ಕಿರಿಯ ಮಹಿಳಾ ಆರೋಗ್ಯ ಸಹಾಯಕಿ) ಗಳನ್ನು ನೇಮಿಸುವುದು.
- ಪ್ರತಿ ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ಪ್ರತಿ ವರ್ಷ ರೂ.12.5 ಲಕ್ಷಗಳ ಔಷಧಿ ಸರಬರಾಜು ಮಾಡುವುದು ಮತ್ತು ಈ ಕೇಂದ್ರಗಳ ಸಣ್ಣ ಪುಟ್ಟ ಖರ್ಚುಗಳಿಗೆ ಪ್ರತಿ ವರ್ಷ ರೂ.2.5 ಲಕ್ಷ ಮುಕ್ತನಿಧಿ ನೀಡುವುದು.
- ಸಮುದಾಯ ಆರೋಗ್ಯ ಕೇಂದ್ರಗಳು/ರೆಫರೆಲ್ ಆಸ್ಪತ್ರೆಗಳನ್ನು ಸಿಬ್ಬಂದಿ, ಔಷಧಿ, ರೂ.5 ಲಕ್ಷ ಮುಕ್ತ ನಿಧಿ ನೀಡಿ ಬಲಪಡಿಸುವುದು.

- ಅತೀ ಹಿಂದುಳಿದ ಕೊಳಚೆ ಪ್ರದೇಶಗಳಲ್ಲಿ **'ಆರೋಗ್ಯ ಕಿಯಾಸ್ಕ್'**ಗಳನ್ನು ಸ್ಥಾಪಿಸುವುದು.
- ದುರ್ಗಮ ಕೊಳಚೆ ಪ್ರದೇಶಗಳಲ್ಲಿ **'ಸಂಚಾರಿ ಆರೋಗ್ಯ ಆಸ್ಪತ್ರೆ'**ಗಳನ್ನು ಪ್ರಾರಂಭಿಸುವುದು.
- ರೆಫರೆಲ್ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಎಲ್ಲಾ ಉನ್ನತ ಪ್ರಯೋಗಾಲಯದ ಪರೀಕ್ಷೆಗಳನ್ನು ಉಚಿತವಾಗಿ ಮಾಡಲು **ಹೈ–ಟೆಕ್ ಲ್ಯಾಬ್**ಗಳನ್ನು ಪ್ರಾರಂಭಿಸುವುದು.
- ಆರೋಗ್ಯ ಸೇವೆ ವಂಚಿತ ಪ್ರದೇಶಗಳಲ್ಲಿ ಹೊಸ ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳನ್ನು ಪ್ರಾರಂಭಿಸುವುದು
- ಆರೋಗ್ಯ ಸಂಸ್ಥೆಗಳನ್ನು ಮೇಲ್ವಿಚಾರಣೆ ನಡೆಸಲು ಮತ್ತು ಕಾಲಕಾಲಕ್ಕೆ ವರದಿಗಳನ್ನು ಪಡೆಯಲುಗಣಕೀಕರಣ ಗೊಳಿಸುವುದು.
- ರೋಗಿಗಳು/ಫಲಾನುಭವಿಗಳು ಆರೋಗ್ಯ ಸೇವೆ ಪಡೆದುಕೊಳ್ಳಲು, ಅವರಿಗೆ ಸಹಾಯ ಮಾಡಲು ನೇಮಿಸಿರುವ ಆಶಾ ಕಾರ್ಯಕರ್ತೆಯರಿಗೆ ಗೌರವಧನ ನೀಡುವುದು.
- ನಗರ ಆಡಳಿತ ಸ್ಥಳೀಯ ಸಂಸ್ಥೆಗಳ ಮತ್ತು ಆರೋಗ್ಯ ಸಂಸ್ಥೆಗಳ ಸಿಬ್ಬಂದಿಗಳ ಸಾಮರ್ಥ್ಯ ಅಭಿವೃದ್ಧಿಪಡಿಸಲು ತರಬೇತಿ /ಕಾರ್ಯಾಗಾರ ಏರ್ಪಡಿಸುವುದು.

ಕರ್ನಾಟಕದ ನಗರ ಪದೇಶಗಳಲ್ಲಿಯೂ ಮೇಲೆ ವಿವರಿಸಿರುವ ಚಿತ್ರಣವಿದೆ.

2013–14ನೇ ಸಾಲಿನಲ್ಲಿ **'ರಾಷ್ಟ್ರೀಯ ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನ'**ದಡಿಯಲ್ಲಿ ಬೆಂಗಳೂರು, ಮೈಸೂರು, ಮಂಗಳೂರು, ಬಾಗಲಕೋಟೆ ನಗರಗಳು ಮತ್ತು ಉಳ್ಳಾಲ ಪಟ್ಟಣವನ್ನು ತರಲು ಯೋಜಿಸಲಾಗಿದೆ. ಮುಂದಿನ ವರ್ಷಗಳಲ್ಲಿ ಕರ್ನಾಟಕ ರಾಜ್ಯದ 50,000ಕ್ಕಿಂತ ಹೆಚ್ಚಿನ ಜನಸಂಖ್ಯೆಯಿರುವ ಎಲ್ಲಾ ನಗರ ಮತ್ತು ಪಟ್ಟಣಗಳನ್ನು ಈ ಅಭಿಯಾನ ದಡಿಯಲ್ಲಿ ತರಲಾಗುವುದು.

2013–14ನೇ ಸಾಲಿನಲ್ಲಿ'ರಾಷ್ಟ್ರೀಯ ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನ' ದಡಿಯಲ್ಲಿ ಬೆಂಗಳೂರು ಮಹಾನಗರಕ್ಕೆ ಈ ಕೆಳಕಂಡ ಕಾರ್ಯಕ್ರಮಗಳನ್ನು ಪ್ರಾರಂಭಿಸಲಾಗುವುದು:

- ಬೆಂಗಳೂರು ಮಹಾನಗರ ವ್ಯಾಪ್ತಿಯಲ್ಲಿ ಹಾಲಿ ಅಸ್ತಿತ್ವದಲ್ಲಿರುವ 70 ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳನ್ನು ನವೀಕರಿಸಲಾಗುವುದು /ಅಭಿವೃದ್ಧಿ ಪಡಿಸಲಾಗುವುದು.
- ಆರೋಗ್ಯ ಸೇವೆ ವಂಚಿತ ಪ್ರದೇಶಗಳಲ್ಲಿ 10 ಹೊಸ ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳನ್ನು ಸ್ಥಾಪಿಸಲಾಗುವುದು.
- ಬಿಬಿಎಂಪಿ ವ್ಯಾಪ್ತಿಯ 6 ರೆಫರಲ್ ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಸುಸಜ್ಜಿತ ಹೈ–ಟೆಕ್ ಲ್ಯಾಬ್‌ಗಳನ್ನು ತೆರೆಯಲಾಗುವುದು.
- 80 ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಲ್ಲಿ ಬೆಳಿಗ್ಗೆಯ ಹೊರರೋಗಿ ಚಿಕಿತ್ಸೆಯ ಜೊತೆ ಸಂಜೆ ವೇಳೆಯ ಒಪಿಡಿ ಪ್ರಾರಂಭಿಸಲಾಗುವುದು
- 70 ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳ ಮತ್ತು 6 ರೆಫೆರಲ್ ಆಸ್ಪತ್ರೆಗಳ ಸಿಬ್ಬಂದಿ ಕೊರತೆಯನ್ನು ಭರ್ತಿಮಾಡಲಾಗುವುದು
- ಬಿಬಿಎಂಪಿ ವ್ಯಾಪ್ತಿಯದುರ್ಗಮ ಕೊಳಚೆ ಪ್ರದೇಶಗಳಲ್ಲಿ 6 **ಸಂಚಾರಿಆರೋಗ್ಯ ಆಸ್ಪತ್ರೆಗಳನ್ನು** ಪ್ರಾರಂಭಿಸಲಾಗುವುದು.
- ಅತೀ ಹಿಂದುಳಿದ ಕೊಳಚೆ ಪ್ರದೇಶಗಳಲ್ಲಿ ಎಎನ್‌ಎಂ ನೊಂದಿಗೆ 40 ಹೆಲ್ತ್ ಕಿಯಾಸ್ಕ್‌ಗಳನ್ನು ಪ್ರಾರಂಭಿಸಲಾಗುವುದು.
- 80 ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ವರ್ಷಕ್ಕೆ 12.50 ಲಕ್ಷ ರೂಪಾಯಿಗಳ ಔಷಧಿ ಸರಬರಾಜು ಮಾಡಲಾಗುವುದು.
- 80 ನಗರಆರೋಗ್ಯ ಕೇಂದ್ರಗಳಿಗೆ ರೂ 2.50 ಲಕ್ಷ ಮತ್ತು 6 ಬಿಬಿಎಂಪಿ ರೆಫೆರಲ್ ಆಸ್ಪತ್ರೆಗಳಿಗೆ ರೂ.5.00 ಲಕ್ಷ ಮುಕ್ತನಿಧಿ ಅನುದಾನ ನೀಡಲಾಗುವುದು.
- ಸಮುದಾಯದ ಸಹಭಾಗಿತ್ವ ಬಲಪಡಿಸಲು 959 ಮಹಿಳಾ ಆರೋಗ್ಯ ಸಮಿತಿಗಳನ್ನು ರಚಿಸಿ, ಅವುಗಳ ಸಾಮರ್ಥ್ಯಅಭಿವೃದ್ಧಿ ಪಡಿಸಿ, ಪ್ರತಿಒಂದು ಸಮಿತಿಗೆ ರೂ.5000 ಮುಕ್ತನಿಧಿ ಅನುದಾನ ನೀಡಲಾಗುವುದು.
- ಬೆಂಗಳೂರು ನಗರದ ಕೊಳಚೆ ಮತ್ತು ಬಡವರು ವಾಸಿಸುವ ಪ್ರದೇಶಗಳಲ್ಲಿ 1199 ಆಶಾ ಕಾರ್ಯಕರ್ತೆಯರನ್ನು ನೇಮಿಸಿ, ಅವರ ಸಾಮರ್ಥ್ಯಅಭಿವೃದ್ಧಿ ಪಡಿಸಿ ಅವರಕಾರ್ಯ ವೈಖರಿಗೆ ಅನುಗುಣವಾಗಿಅವರಿಗೆ ತಿಂಗಳಿಗೆ ಸುಮಾರು ರೂ.2000 ಗೌರವಧನ ನೀಡಲಾಗುವುದು.
- ಕೊಳಚೆ ಪ್ರದೇಶಗಳು ಹಾಗು ಬಡವರು ವಾಸಿಸುವ ಪ್ರದೇಶಗಳಲ್ಲಿ ತಿಂಗಳಿಗೆ 3 ತಜ್ಞವೈದ್ಯರ ಶಿಬಿರಗಳನ್ನು ನಡೆಸಲಾಗುವುದು.

ಬನ್ನಿ, ಬೆಂಗಳೂರಿನ ಎಲ್ಲಾ ಸಮಸ್ತ ನಾಗರೀಕರು, ಈ ಅಭಿಯಾನದ ಯಶಸ್ಸಿಗೆ ಕೈ ಜೋಡಿಸಿ, ನಗರ ಆರೋಗ್ಯ ಅಭಿಯಾನದ ಈ ಸೇವೆಗಳನ್ನು ಸಂಬಂಧಪಟ್ಟವರು ಸಂಪೂರ್ಣವಾಗಿ ಉಪಯೋಗಿಸಿಕೊಳ್ಳಿ

ಜೈ ಹಿಂದ್! ಜೈ ಕರ್ನಾಟಕ!

ಪ್ರಕಟಣೆ: ಆರೋಗ್ಯ ನಿರ್ದೇಶನಾಲಯ, (ಎನ್.ಹೆಚ್.ಎಂ.) ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವಾ ನಿರ್ದೇಶನಾಲಯ, ಆನಂದರಾವ್ ಸರ್ಕಲ್, ಬೆಂಗಳೂರು-೫೬

NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Janani Shishu Suraksha Karyakram (JSSK)

COM H-92.

SWASTH BHARAT

– A NATIONAL INITIATIVE

सत्यमेव जयते

IEC Division
Ministry of Health and Family Welfare
Government of India

Janani Shishu Suraksha Karyakram (JSSK)

- Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011 which entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section.
- It stipulates that all expenses related to delivery in a public institution would be borne entirely by the Government and no user charges would be levied. This will also eliminate any out of pocket expenses.
- The scheme is estimated to benefit more than 12 million pregnant women & newborns that access public health institutions every year in both urban & rural areas, and also increase access to health care for the over 70 lakh women delivering at home.

ENTITLEMENTS FOR PREGNANT WOMEN:

- Free and zero expense Delivery and Caesarean Section
- Free Drugs and Consumables
- Free Essential Diagnostics (Blood, Urine tests and Ultra-sonography etc)
- Free Diet during stay in the health institutions (up to 3 days for normal delivery & 7 days for caesarean section)
- Free Provision of Blood
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Drop Back from Institutions to home after 48hrs stay
- Exemption from all kinds of User Charges

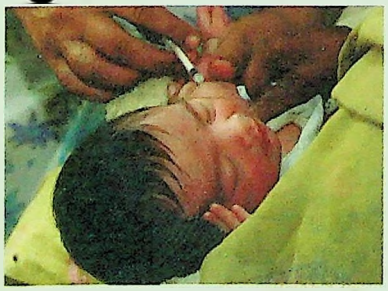
ENTITLEMENTS FOR SICK NEWBORN TILL 30 DAYS AFTER BIRTH:

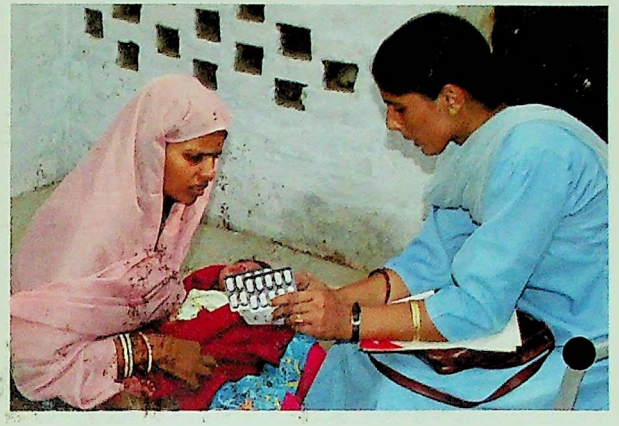
- Free and zero expense treatment
- Free Drugs and Consumables
- Free Diagnostics
- Free Provision of Blood
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Drop Back from Institutions to home
- Exemption from all kinds of User Charges

The brief details on the entitlements are:

Drugs and consumables

Drugs & consumables including supplements such as Iron Folic Acid are required to be given free of cost to the pregnant women during ANC, INC, PNC up to 6 weeks which includes management of normal delivery, C-section and any complications during the pregnancy and childbirth. The same is also needed when a neonate is sick and needs urgent and priority treatment.

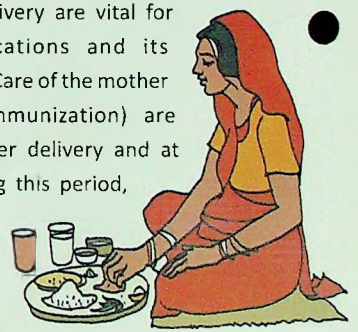




Diagnostics

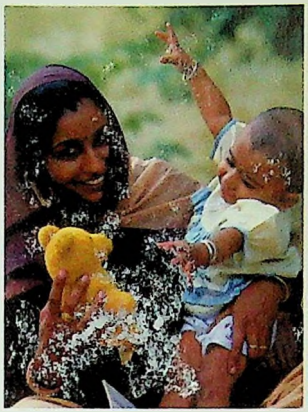
During pregnancy, childbirth and in post natal period, investigations are essential for timely diagnosis of complications and likely problems which the women can face during the process of child birth. Both essential and desirable investigations are required to be conducted free of cost for the pregnant women during ANC, INC, PNC up to 6 weeks. The same are also needed when a neonate is sick and needs urgent and priority treatment for conditions like infection, pneumonia, etc.

Diet



The first 48 hrs after delivery are vital for detecting any complications and its immediate management. Care of the mother and baby (including immunization) are essential immediately after delivery and at least up to 48 hrs. During this period, mother is guided for initiating breast feeding and advised for extra calories, fluids and adequate rest which are needed for the well being of the baby and herself. Non availability of diet at the health facilities demotivates the delivered mothers from staying at the health facilities and most of the mothers

prefer returning home immediately after delivery. This hampers adequate care of the pregnant women and neonates, which is important for quality PNC services.



Blood

Blood transfusion may be required to tackle emergencies and complication of deliveries such as management of severe anaemia, PPH and C sections, etc.

Exemption from user charges

User charges are levied by many State Governments for OPD, admissions, diagnostic tests, blood etc. These add up to the out of pocket expenses. On occasion, there are situations where these pregnant women are misguided and become vulnerable for exploitation by private diagnostic centres for unnecessary investigations.

Referral transport

It is well proven that a significant number of maternal and neonatal deaths could be saved by providing timely referral transport facility to the pregnant women for normal delivery, C-section. This also needs to be provided to a neonate up to 30 days, when the baby is sick and needs urgent and priority treatment particularly for conditions like infection, pneumonia, etc.

A drop back facility alleviates the pressure to leave the health facility earlier than desirable & obviates out of pocket expenses.

The free referral transport entitlements for pregnant women and sick neonates up to 30 days & therefore are as under:

1. Transport from home to the health facility
2. Referral to the higher facility in case of need
3. Drop back from the facility to home

Most of the States are placing 108 & 102 toll free numbers for easy access to the referral services.

Grievance Redressal

For any Grievance related to JSSK :

- The Hospital In Charge at Hospital level
- District CMO at district level
- Mission Director at State level

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