"EVALUATING THE HEALTH SYSTEM OF INDIA: BEFORE & AFTER IMPLEMENTATION OF NRHM"

A dissertation submitted in partial fulfillment of the requirements for the award of

Post Graduate Diploma in Health and Hospital Management

By

Neha Agarwal

Roll No: PG/08/032



International Institute of Health Management Research
New Delhi
30th April, 2010

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Under the guidance of

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International Institute of Health Management Research
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30th April, 2010

CERTIFICATE OF INTERNSHIP COMPLETION

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Dated 30th April 2010

To whomsoever it may concern

This is to certify that Ms Neha Agarwal has successfully completed her internship from February 24, 2010 to April 30, 2010 in the National Rural Health Mission division, which is a flagship programme of the Ministry of Health and Family Welfare, Government of India. She has worked under my supervision.

National Rural Health Mission was launched by the Government of India in 2005 to improve the availability of and access to quality health care to rural population, especially the vulnerable by carrying out necessary architectural correction in the basic health care delivery system by communitization, improved management of the service delivery, improved human resource management, guaranteeing standards for all facilities and flexible financing.

During this internship she has worked on the project titled "Evaluating the 5 years progress under NRHM through various indicators". Apart from the project the managerial task performed by her is Collection and compilation of the information in NRHM status report which received from the states, UTs and other program division on regular basis, clarification of the information from the states, UTs or division if large disparity found.

Her work was found to be satisfactory and her contribution was meaningful and thoughtful for the National Rural Health Mission Directorate (Ministry of Health and Family Welfare, Government of India).

We wish her good luck for her future assignments.

(Ganga Kumar)

Healthy Village, Healthy Nation



जीवन को चुनो, तम्बाकू को नहीं
Choose Life, Not Tobacco

Certificate from Dissertation Advisory Committee

This is to certify that Ms. Neha Agarwal, participant of the **Post-Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled "Evaluating the 5 years progress under NRHM through various indicators" in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Advisor	Organizational Advisor
Designation	Designation
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Date	Date

ACKNOWLEDGEMENT

This Ministry is regularly compiling and disseminating information on rural health care services through a bulletin on rural health statistics in India based on the data received from the State Governments in the form of progress report on rural health services. The relevance of reliable and up-to-date statistics for rural health care system has increased manifolds for proper formulation and effective implementation of various schemes and programs for strengthening of the rural health care infrastructure and manpower, as envisaged in National Rural Health Mission (NRHM).

As the outset, I put on the record the continuous support and cooperation received from various States/Union territories in providing the updated information. I acknowledged the efforts put in by all the concerned members of department.

The overall supervision and guidance of Dr. Tarun Seem, Director (NRHM-2) along with the efforts of Mr. Ganga Kumar, Deputy Director with valuable support from Mr. Divya Prakash,(MIS Manager) and Last but not the least I would like to express sincere gratitude to my mentor, Dr. Pawan Taneja in the presentation and preparation of write up and report.

Ms. Neha Agarwal

Consultant (MIS)

Ministry of Health and Family Welfare

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LIST OF ABBREVIATIONS

ANM- Auxiliary Nurse Midwife

CBR-Crude Birth Rate

CDR-Crude Death Rate

CHC-Community Health Center

IMR- Infant Mortality rate

MMR-Maternal Mortality Rate

NRHM-National Rural Health Mission

GDP- Gross Domestic Product

PHC-Primary Health Center

TFR- Total Fertility Rate

RCH-Reproductive Child Health

ANC-Antenatal Care

PNC- Postnatal Care

SRS-Sample Registration Survey

EAG-Empowered Action Group

UTs-Union Territories

JSY- Janani Suraksha Yojana

MDG-Millennium Developments Goals

FRU-First Referral Unit

VHND-Village Health Nutrition Day

ASHA-Accredited Social Health Activist

UAHFWS- Uttaranchal Health and Family Welfare Society

SHM-State health Mission

SCOVA- Special Committee for Voluntary Action

DHM- District Health Mission

CMO- Chief Medical Officer

HMIS-Health Management Information System

MIS-Management Information System

NVBDCP- National Vector Borne Disease Control Program

NIIDCP-National Iodine Deficiency Control Program

NLEP-National Leprosy Eradication Program

INTERNSHIP REPORT

ORGANISATIONAL PROFILE OF NRHM

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The Mission is an articulation of the commitment of the Government to rise public spending on health from 0.9% of GDP to 2-3% of GDP.

It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

The key features in order to achieve the goals of the mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring and evaluation against standards, convergence of health and related programs from village level upwards, innovations and flexible financing and also interventions for improving the health indicators.

GOALS OF NRHM

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as women's health, child health, water, sanitation & hygiene, immunization, and nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

THE OBJECTIVE OF THE MISSION

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

THE EFFORTS SO FAR

- State and district mission has been setup in all states and UTs except Delhi.
- The mission document; guidelines on Indian public health standards; guideline for ASHA; training modules for ASHA; guidelines for state health mission, district health mission and merger of societies have been shared with the states.
- Reproductive and child health progreamme II (RCH-II) and Janani Suraksha Yojana has been launched.
- Sterilization compensation scheme was launched.
- Auto disabled syringes introduced throughout the country.
- Facility survey was introduced.
- Repair and renovation of Sub Centers under RCH-II.
- Untied funds of Rs. 10,000 to SCs
- Up gradation of CHCs as first referral units and primary health centers to 24x7 units taken up.
- Selection of ASHAs is still in progress in EAG states.
- Training of skilled birth attendants.

MAIN APPROACHES UNDER NRHM

Communitization – For ensuring better community participation; committees / organizations have been formed at various level viz. Village Health & Sanitation Committee at village level, Panchayati Raj Institutions at village/block level, Rogi Kalyan Samitis at PHC and CHC and the ASHA , a community volunteer for every village.

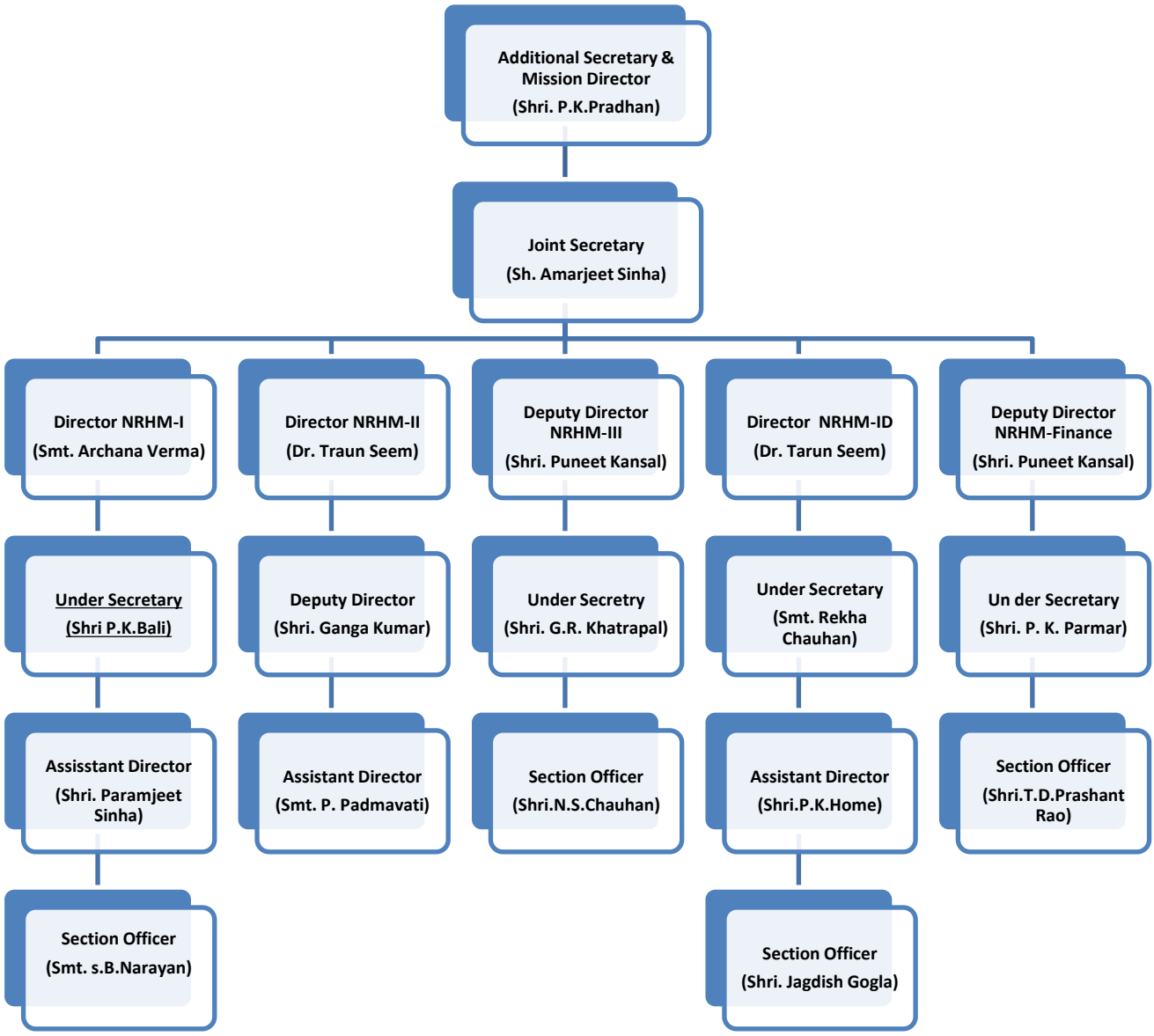
Flexible Financing – For improved finance, the mission has brought all the schemes of health & family welfare within the overarching umbrella of NRHM. Financing through the NRHM budget head provide the much needed funds to the districts to facilitate better functioning of health programme. Based on needs of the district, funds are allocated to states. The untied funds are also available under NRHM at various levels. The expenditure on public health has been raised from 0.9% to nearly 3% of GDP.

Improved management through capacity building– Management skill at block, district & state levels have been increased under NRHM. Post of public health managers has been created at district level and accountant at block level for accounts work. Various NGOs are involved in capacity building and continuous skill development of health functionaries at various levels is being carried out.

Monitor progress against standards – Progress of activities is being monitored according to the Indian Public Health Standard. Health facility surveys are conducted at regular intervals to monitor facilities available at sub-centers, PHCs and CHCs. Independent monitoring committees are also being formed to monitor progress.

Innovation in human resource management – To increase the pool of human resource, additional manpower like nurses, MO are being provided at PHC and CHC. Local residents of remote areas are trained and developed for providing basic health services. Multiskilling of health functionaries especially of doctors and paramedics is being carried out so that a person could carry out multiple tasks.

ORGNAOGRAM OF NRHM



MANAGERIAL TASK THAT HAS BEEN PERFORMED

The Health Statistics Information data sheet facilitates the flow of physical and financial performance from the District level to the State level and the state uses MIS format to provide status on the progress of states on each indicator. The portal will provide periodic reports on the status of the health sector

- I have been allotted NRHM MIS (Facility department) where I have been assigned to look after the MIS data sheet of 35 states. The MIS was launched on 18th May 2009. For improving the quality of obtaining data from states.MIS data sheet contains all the status of the states progress on each indicators of NRHM. The MIS data sheet is published monthly and is distributed to Ministry of health and family welfare, Health Ministers and NHSRC and to all departments of ministry.
- Preparing of the output reports based on the pre-defined formats.
- Analysis of reports/data and making background notes for each states.
- Regular interaction and coordination with state governments relating to progress of various activities of NRHM.
- Preparing report on the progress of the programmes in the status report of NRHM.
- Analysis of states and UTs performance on each indicators of NRHM.
- Compare the information derived from NRHM MIS report and HMIS and was reported to states and statistics department of the ministry
- Data entry in NRHM MIS monthly status report, which received from states and various division of the ministry.
- Collection and compilation of the information in NRHM status reports which was received from the states, UTs and other division on regular basis also clarification of the information from the states, UTs or division if large disparity found
- Maintaining the record which is received from states and various divisions of the ministry regarding progress.
- Logistics management of various publications, reports and IEC materials for NRHM programme.

- Preparing demographic profile of each state.

GENERAL FINDINGS

During the orientation of the departments at NRHM following findings has been observed:-

- There is **decentralized** system in each department.
- The organization has adopted **departmentalization** and division of work principle where in the employees are given job according to their skills and qualifications.
- The flow of information order is streamlined and is in structured way.
- Regular meetings of Executive director are held with each member of different department to know and converse about the update of the ongoing projects.
- The project is headed by a single person who is responsible for the same till its completion.
- The web based MIS has been launched to facilitate the data capturing at the states level.
- Many workshops and meetings are being organized for the state program officer's members to discuss the problem they are facing in the field(**grievances redressal system**)
- The main work of NRHM is to provide accessible, affordable and quality health care to the rural populations, especially the vulnerable sections.
- The NRHM also provide management support to strengthen the capacity for decentralized management of health**.(capacity building**)
- NRHM covers all programs like National Vector Borne Disease Control Program (NVBDCP), National Iodine Deficiency Disorder Control Program (NIIDCP), National Leprosy Eradication Program, Revised National TB Program (RNTCP) except HIV/AIDS, mental health and cancer.
- Regular **training** is also being organized by NRHM for Doctors, Nurses and specialist and paramedical members so that they can provide education and counseling to the community members.
- Many **IEC materials, videos and bulletin** and NRHM newsletters on various issues like antenatal care, immunization and institutional deliveries have been developed for spreading awareness among them.
- Various meetings are being organized by NRHM for awarding the states on their performance and progress.

- Published NRHM MIS status report on monthly or quarterly basis. This report contained all **physical and financial aspects** of NRHM program. This report used for report writing, documentation, presentation and analysis of state performance. This is uploaded on website as well as hard copy circulated to all division of the ministry.
- Collection and compilation of the information in NRHM status report which received from the states, UTs and other division on regular basis also clarification of the information from the states, UTs or division if large disparity found.
- NRHM has created new **website** which linked with Ministry main websites. The websites contains every aspects of NRHM programs
- It has an efficient **resource center** which provides a great source to the information on any topic

DISSERTATION REPORT

CHAPTER-1

BACKGROUND

National Rural Health Mission is not a first program on rural health in independent India. The attempts to improve rural health through various programs were started as early as in 1940 when, government in India set up 'Bhore Committee' (This committee also known as Health Survey and planning committee was set up by government of India in 1943 to understand the health situation in the country. The committee was headed by Sir Joseph Bhore and it got this name of Bhore Committee. The committee submitted its recommendations in 1946 with elaborated planning for health service delivery in India) to find out the ways to improve the health of the people. This was followed by a number of other committees and programs i.e. Balawant rai Mehta Committee (After the initial developments followed by Bhore Committee report, this committee was set up to know the progress since Bhore committee recommendations and, to give further suggestions to improve the health scenario in the country), Community Development program and Basic need programs etc. These attempts were only partially successful in changing prevailing health scenario. The successive governments started its own program and strategy to change the health conditions of the people without understanding or fully investigating the reasons for the failure of the previous programs. To improve the quality of life of our citizens, the government of India has resolved to launch the National Rural Health Mission to carry put the necessary architectural correction in the basic health care delivery system. The Hon'ble Prime Minister launched the NRHM on 12th April, 2005 throughout the country with special focus on 18 states, including 8 Empowered Action Group (EAG) states, the north eastern states, (Jammu and Kashmir and Himachal Pradesh). The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. The plan of action includes increasing public expenditure on health, reducing regional imbalances in health infrastructure, pooling resources, integration of organizational structure.

Indicator	Year 2005	Year 2010	Year 2015
Maternal Mortality Ratio (Per 100,000 live births)	**407**	**254**	**100**
Infant Mortality Rate (IMR) (Per 1000 live births)	**60**	**53**	**30**
TFR (Total Fertility Rate)	**3.0**	**2.6**	**2.1**

The above indicators highlights the progress that has been achieved under NRHM through various program like JSY, increasing manpower in PHC, CHC and SC, also strengthening the PHC, CHC and SC by providing the untied grants to them for up gradation and reconstruction.

It is clearly a gigantic task to bring about major changes in outcomes by simultaneous action on a wide range of determinants of health. The NRHM has based its interventions on the evidence from the studies and surveys; it has identified communitization, flexible financing, innovations in human resource management, monitoring against IPH Standards, and building capacities at all levels as the principal approaches to ensure quality service delivery, efficient utilization of scarce resources, and most of all, to ensure service guarantees to local households.

Health is a state subject and the NRHM is an effort at building a partnership with the States to ensure meaningful reforms with more resources. Ultimately, the success of NRHM will depend on the ability of the Mission interventions to galvanize State Governments into action, pursuing innovations and flexibility in all spheres of public health action. Ensuring availability of fully trained and equipped resident health functionaries at all levels and large scale demand side financing under initiatives like the Janani Suraksha Yojana for institutional deliveries are a few priorities for action. Partnerships with nongovernmental providers to strengthen public health delivery are also an important need given the distribution of Specialist doctors in India. While we have 30,000 MBBS graduates coming out of our Colleges every

year, the entire rural health system for more than 750 million people never has more than 26000 doctors.

PUBLIC HEALTH INFRASTRUCTURE

The central government has so far supported only the construction of sub centers. Due to the lack of financial resources the state has usually not provided funds for constructing PHC/CHC. Due to these reason the health infrastructure in most of the states is poor. NRHM allows the expenditure for construction but on the condition that it should not exceed more than 33% of the total NRHM outlay in the high focus states and 25% in case of high non focus states. It is proposed to improve outreach activities in un-served and underserved areas specially inhabited by vulnerable sections through provision of medical mobile units (MMU) in every district. The medical mobile units will cover Anganwadi center.

The initiative undertaken by NRHM in strengthening the infrastructure has shown great progress

Table No.-1(Public Health Infrastructure)

		2005	2009
Sub centre	-	142655	146036
PHC	-	23109	23458
CHC	-	3222	4276

(For each state the progress can be seen in Annexure)

IMPROVING CRITICAL MANPOWER

The issue of availability of critical manpower in the rural areas is proposed to be addressed through introducing ASHA in every village of the 18 high focus states, additional ANM at sub centre, 3 staff nurses at the primary health Centre and additional specialists and paramedical staff at the community health centers. It is also proposed to supplement the availability of critical manpower across the states through contractual appointment.

Similarly in the critical manpower has also shown great progress-

ASHA

- The No. of ASHA s selected in 5 years -791069
- The percentage of ASHAs trained up to 4th module in 5 years- 75%
- The percentage of ASHAs having drug kit in 5 years – 70%

ANM

- ANM as per RHS 2005-1389065
- ANM recruited under NRHM in 5 Years-46690

Staff Nurses

- Staff Nurse as per RHS 2005-29139
- Staff nurse recruited under NRHM in 5 years-26793

Specialist Doctors

- Specialist doctors as per RHS 2005-25927
- Specialist doctors recruited under NRHM in 5 Years-11084
- AYUSH Doctors recruited under NRHM in 5 Years-7692

CAPACITY BUILDING

In order to provide managerial support for tracking funds and monitoring activities under the mission, provision has been made for setting up program management units at state/district level. Over 500 professionals have already been recruited. In order to provide technical support to the mission for achieving the objectives, it is proposed to set up national health system resource centre (NHSRC) at the centre level and state level (SHSRC) with an annual support of Rs.15 crores and Rs.1 crores at the centre and state level.

The sub centers are proposed to be placed under the control of the Panchayat. The PHC and CHC are also to be managed by the Panchayat Block Samitis (PBS) and Rogi Kalyan Samitis (RKS)

DECENTRALIZATION

As the indicators of health depend as much on drinking water, nutrition, sanitation, female literacy, women's empowerment. NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. NRHM recognizes that delegation of financial and administrative powers at various levels would be necessary for the successful implementation of the decentralized plans.

MONITORING ANS ACCOUNTABILITY FRAMEWORK

The framework proposes accountability at every level through a three prolonged process of community based monitoring, external surveys (**SRS, DLHS household surveys by ASHA**) and internal monitoring. For effective monitoring a strong MIS is being put in place

LITERATURE REVIEW

The introduction gives the detailed picture of performance of NRHM. It provides very useful insight into the strengthening of the health system and extent to which these efforts have translated into better services. The attempts to improve rural health through various programs were started as early as in 1940 when, then British government in India set up 'Bhore Committee' (This committee also known as Health Survey and planning committee was set up by government of India in 1943 to understand the health situation in the country. To improve the quality of life of our citizens, the government of India has resolved to launch the National Rural Health Mission to carry put the necessary architectural correction in the basic health care delivery system. The Hon'ble Prime Minister launched the NRHM on 12th April, 2005 throughout the country with special focus on 18 states, including 8 Empowered Action Group (EAG) states, the north eastern states, (Jammu and Kashmir and Himachal Pradesh). It highlights the key factor that contributes in making public health system credible and accountable**.** A deeper analysis of some of the indicators will clearly indicate the progress after implementation of NRHM. The findings of this study will draw attention to the initiative that has been undertaken by NRHM like three staff nurses under PHC, second ANM at sub center, 24x7 facilities at each level, Rogi Kalyan Samitis at each level for the up gradation at each level, to provide adequate flexibility to states to identify their key concerns and develop interventions that addresses that specific problem.

Key Findings Of study

- 7.49 lakhs AHSAs selected.
- 7.05 Lakhs ASHAs trained up to first module.
- 5.65 Lakhs ASHAs trained up to fourth module.
- 5.20 Lakhs ASHAs with drug kits in village
- 29,223 Rogi Kalyan Samitis set up under NRHM.
- 14,036 Sub Centers are functional in the country.
- 23,458 Primary Health Centers are functional.

Whereas in other studies like IAP study which is done in Rajasthan, UP, MP highlights the positive contribution of ASHA, 86% improvement in human resources after NRHM. 74% increase in institutional deliveries.97% of ASHA received training.

In the Kaveri Gill Study which is done in AP, UP, Rajasthan, Bihar finds uneven progress in the states, different states perform differently on the parameters given and NRHM has created hope for the rural infrastructure in health.

The JSY study confirms increase in institutional deliveries. It also points out quality issues at facilities and 448 hr hospital stay.JSY – changing health seeking behavior of households – habit of going to PHC.

CHAPTER-2

RESEARCH METHODOLOGY

MAIN OBJECTIVE:

- To evaluate the health care system: before and after the implementation of NRHM.

SPECIFIC OBJECTIVES:

- To analyze the progress of Indian health care system with the establishment of NRHM.
- To analyze the new initiative of NRHM.
- To found out the lacunas and suggest some recommendation to government to improve the health status.

METHODOLOGY

a) For understanding about the organization profile the **secondary data** has been collected
   - The method employed was interactions with people working for NRHM. The interaction were of the conversational type focusing on how the work is performed and the programs going within NRHM
   - Review of the reports and newsletter received from the organization.
   - Textual analysis of NRHM's documents and reports of their work.

b) For "evaluating the Indian Health System : Before and After the implementation of NRHM"s" project **secondary data** has been collected through:
   - Data that has been received from status reports (from 27 states and 8 UTs) and from RHS bulletin and NFHS.

STUDY DESIGN

- The study design is a retrospective study (here the outcome that has been delivered by NRHM is collected and analyzed)

DATA SOURCE

- MIS data sheet, data received from (27States and 7 UTs) through state monthly reports, journals, NRHM Newsletters, RHS Bulletin, Framework of Implementation of last 5 years. NFHS, DLHS, SRS, Census.
- Reports (from 27 states and 8 UTs) and from RHS bulletin and NFHS.
- Current situation –IDSP, HMIS/DHIS, NRHM quarterly reporting

FORMAT OF OUTPUT

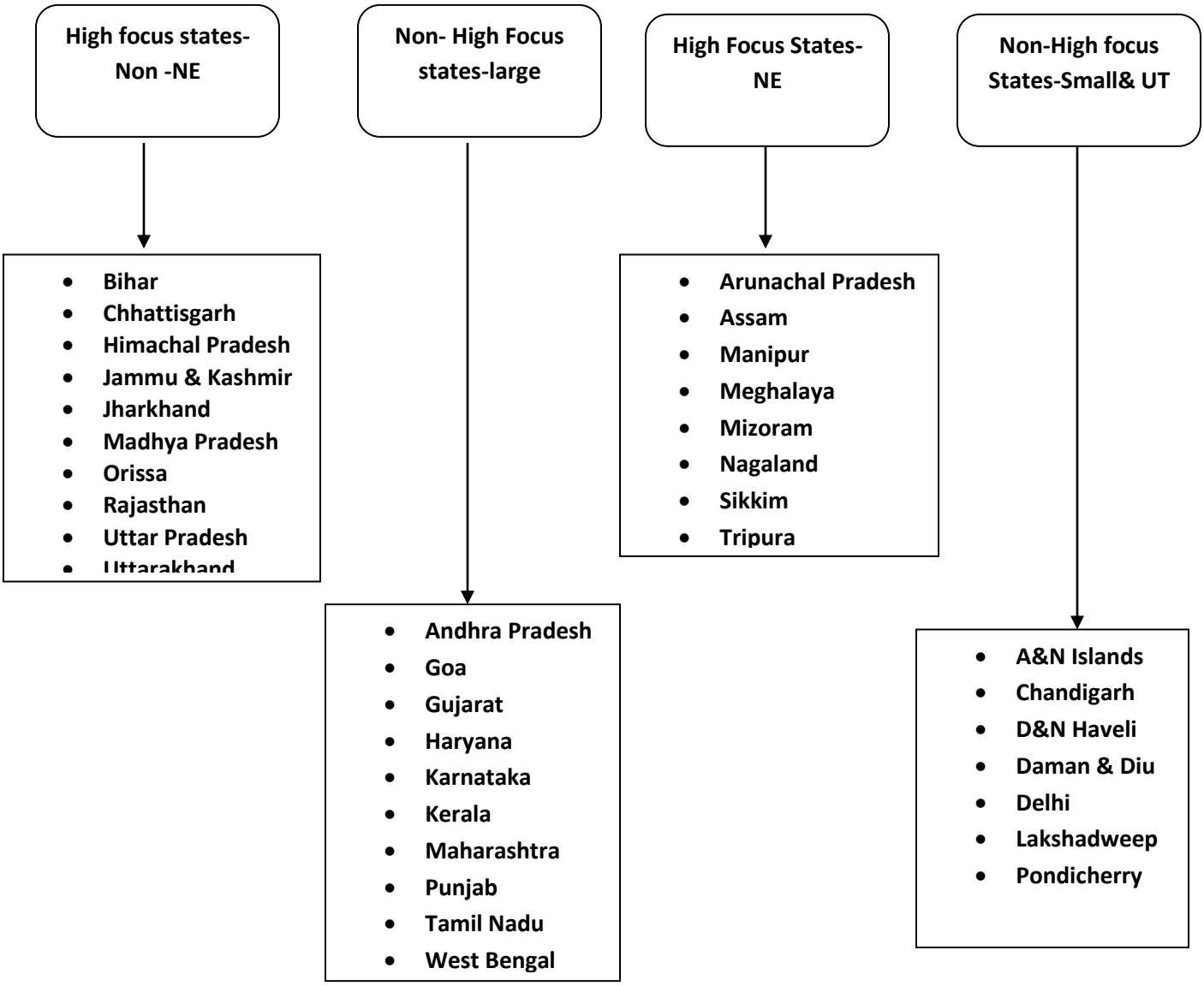
- It will be presented in the form of tables and graphs

DATA TYPE

- Secondary data for high-focus and non-high focus states, Non- High focus large and Non –high focus small and UTs for the period jan06-Jan10

SAMPLE SIZE

- There are 27 states and 7 Union Territories.



CHAPTER 3

NRHM PROGRES SO FAR IN INDIAN HEALTH SYSTEM

In its very short journey of 5 years, there are some very significant gains in the health sector, in partnership with States.

The NRHM was launched by the Hon'ble Prime minister in April 2005. In its journey of 5 years, NRHM has tried to push reforms with resources in partnership with the state and UT governments. Health is a state subject and NRHM has respected the leadership of the states and UTs in bringing about reform and improvement in health indicators.

It provided adequate flexibility to states to identify their key concerns and to develop interventions that address their specific problems. Human resources has been a priority in the planning stage itself as it was felt that a major issue in India is the non-availability of skilled health personnel around the clock in rural areas.

The NRHM framework for implementation has pushed communitization of facilities, adequate and flexible financing with community accountability, monitoring progress against Indian Public Health Standards, innovation in human resources, engagement in building of capacity at all levels for effective and efficient decentralized management of health system.

NRHM also provided an opportunity at each level from the village to the sub center, the PHC, the CHC, the sub divisional hospital, and the district hospital to create a community institution under the Panchayati Raj local governments system. Effective decentralized management is a difficult exercise as it always involves powers. It is for this reason that in a number of states the utilization of funds at the local village, Sub centers, PHC, CHC level remains slow in the initial phase.

NRHM has led to increase in outpatient cases, inpatient cases, institutional deliveries, availability of ambulances, presence of community health worker in every village, better availability of drugs. The weakness of health system in India before NRHM is public knowledge and it is also well known that India was occurring one of the lowest public expenditure on health

in the world with less than 1% GDP with NRHM these weaknesses has been conquered to some extent.

NRHM has mandate to ensure that 70% of the financial resources get spent at the block and below block level and only 20% at the district level. NRHM has successfully set up the institutions for communitization and is engaged in the process of making them even more effective government institutions. It has gone beyond the monopoly of PRI by also co-opting self help groups, women's groups or any one with motivation in the village health and sanitation committees constituted under the umbrella of PRI.

The studies of JSY have brought out the fact that institutional deliveries have increased tremendously across all states and more so in states like Madhya Pradesh, Orissa, Rajasthan Assam, Bihar and Uttar Pradesh as well. While resources are available with government facilities for improving the quality of care, it is also true that the pace of refurbishment and improvement of quality in health facilities has not kept pace with the demand for institutional delivery services in many states.

Government of India has played the role of sharing good practices through thematic workshops across states so that states can learn from each other and emulate the best practice. Efforts to set up procurement and logistics system like the Tamil Nadu Medical Services Corporation has been made in few states and a greater thrust is being placed on it to ensure availability of quality drugs and equipment at all levels .

Similarly, buildings are either renovated or constructed in over 20% sub centers and 75% CHCs and districts hospital under the NRHM.

NRHM has undertaken successful experiments in nutrition in number of states. Similarly, reduction in maternal mortality as indicated by SRS was from 301(2006) to 254(2009).

The Table below tries to capture some of the gains made during the period 2006 to 2009 in key areas and the evidence from the States in this regard. Illustrative evidence from States is indicated to convey the impact of the programme so far.

SPECIFIC GAINS TO THE HEALTH SYSTEM

Table no.-2 (Specific gains to Health System)

S.NO.	ACTIVITY/INTERVENTION	THE SPECIFIC GAIN FROM NRHM at the end of 2009
1.	Human Resources	7.96 lakhs AHSAs (community health workers) selected 7.55 lakhs ASHA trained up to 1st module and 5.65 Lakhs up to 4th Module; 5.55 lakhs ASHAs with drug kits in villages.
		8,624 MBBS Doctors , 2460 Specialist, 46,690 ANMs, 26,793 staff nurses, 7692 AYUSH Doctors , 3160 AYUSH paramedics added to the system under NRHM
2.	Physical Infrastructure	9144 new health Sub Center buildings, 8997 up-gradation of Sub Centre buildings, 1009 new PHC buildings, 2081 up-gradation of PHC buildings, 435 new CHC buildings and 1255 up gradation of CHC building , 57 new District Hospitals and 387 up-gradations of District Hospitals have been taken up under NRHM.
3.	Untied Grants for maintenance and local action.	All Health Sub Centers, PHCs, CHCs, Sub District and District Hospitals are provided untied grants to improve the facilities under th4e supervision of Panchayati Raj Institution and Rogi Kalyan Samitis at the facility levels. This has considerably improved the maintenance of facilities all over the country.
4.	Janani Suraksha Yojana	Considerable progress has been made in JSY. From 7.04 Lakhs women covered under JSY in 2005-06, the coverage in 2008-09 was 86.22 Lakhs, and 78.41 in 2009-10 so far, which is nearly one third of all deliveries in India every year
5.	Mobile Medical Units	1031 MMUs under NRHM are working to provide diagnostic and outpatient care closer to hamlets and villages in remote areas
6.	Emergency Medical transport and Ambulance systems	States have used NRHM funds to provide a variety of emergency transport systems and ambulances to improve timely attention hospital referral from households.
7.	Doctors, Drugs and Diagnostics	NRHM has added doctors and paramedics on large scale leading to more care for patients. Availability of resources for drugs and diagnostics has improved with NRHM support to states.

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As is evident from the Table on progress, a lot has been achieved in the last five years in partnership with States. The institutional platform of Village Health and Sanitation Committees, the Rogi Kalyan Samitis and the Panchayati Raj Institution committees at various levels is providing a rare opportunity for convergent action on all determinants of health.

An army of locally resident Accredited Social health Activists with strong referral links with the strengthened health system will put even greater pressure on the public sector health system to deliver quality services.

Along with need based and transparent partnerships with nongovernmental providers for public health goals, the strengthened system will have positive consequences for all interventions, whether they are for family welfare, disease surveillance, National Health Programmes, etc.

The experience of the last five years gives us the confidence that we are on the right track and that we need to deepen institutional reforms and effective decentralization through a concerted effort at capacity building. The setting up of a National Health System Resource Centre is a step in that direction. Several states have already setup state resource centers & others are also in the process of setting up their resource Centers. The North Eastern Regional Resource Centre is already playing a critical role in developing need based programmes in the eight North Eastern States.

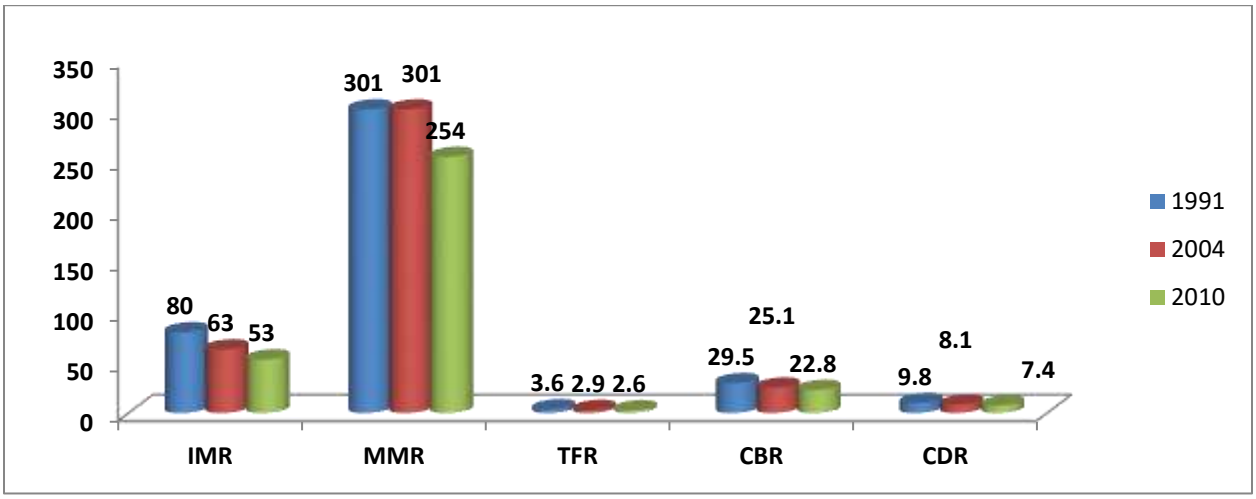
THE FOLLOWING INDICATORS SHOW THE PROGRESS OF NRHM IN 5 YEARS

Table No.-3 (Progress of the Indicators)

Indicators	1991	2004	2010
IMR	80	63	53
MMR	301	301	254
TFR	3.6	2.9	2.6
CBR	29.5	25.1	22.8
CDR	9.8	8.1	7.4

Source:-IMR, MMR, TFR, CDR, CBR-from SRS, NFHS-2, NRHM

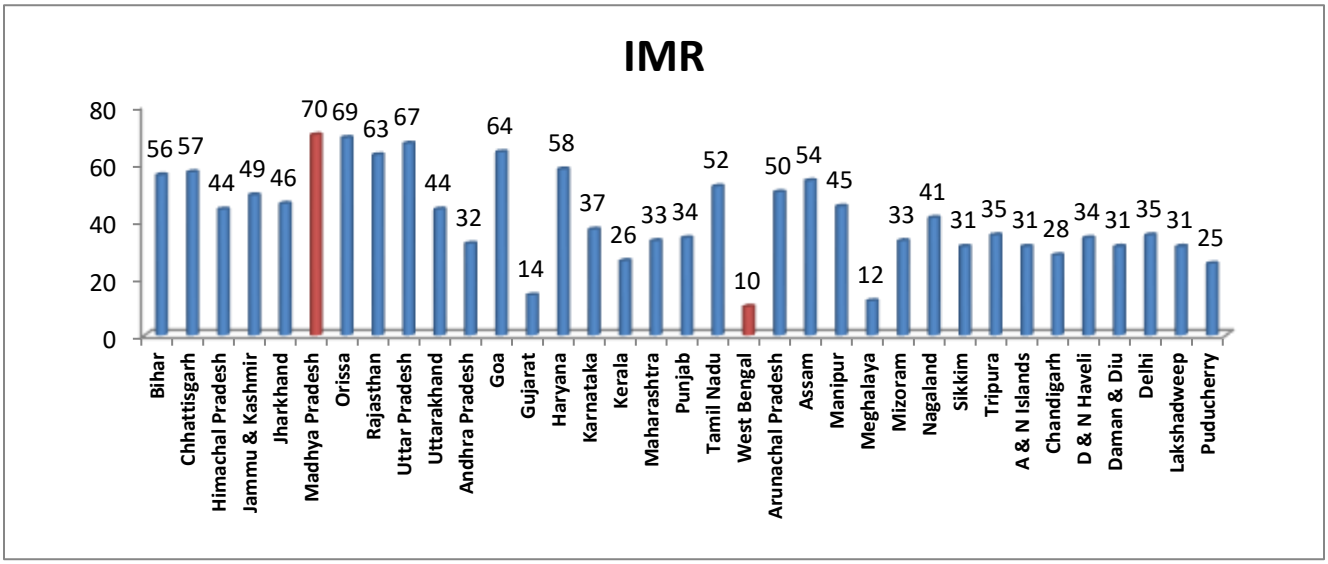
Figure-1(Progress of Indicators)



- **Infant mortality** is defined as the number of infant deaths (one year of age or younger) per 1000 live births. The most common cause worldwide has traditionally been due to dehydration from diarrhea. However, the spreading information about Oral Rehydration Solution (a mixture of salts, sugar, and water) to mothers around the world has decreased the rate of children dying from dehydration. Currently the most common cause is pneumonia. Other causes of infant mortality include malnutrition, malaria, congenital malformation, infection and SIDS.
- Infant mortality rate was80 in 1991which has reduced to 58 in 2005. It down to 55 in 2008 and now it is 53in 2009 for a country .More concerted efforts to tackle malnutrition and neo-natal mortality will facilitate a 5 point decline required for achievement of expected

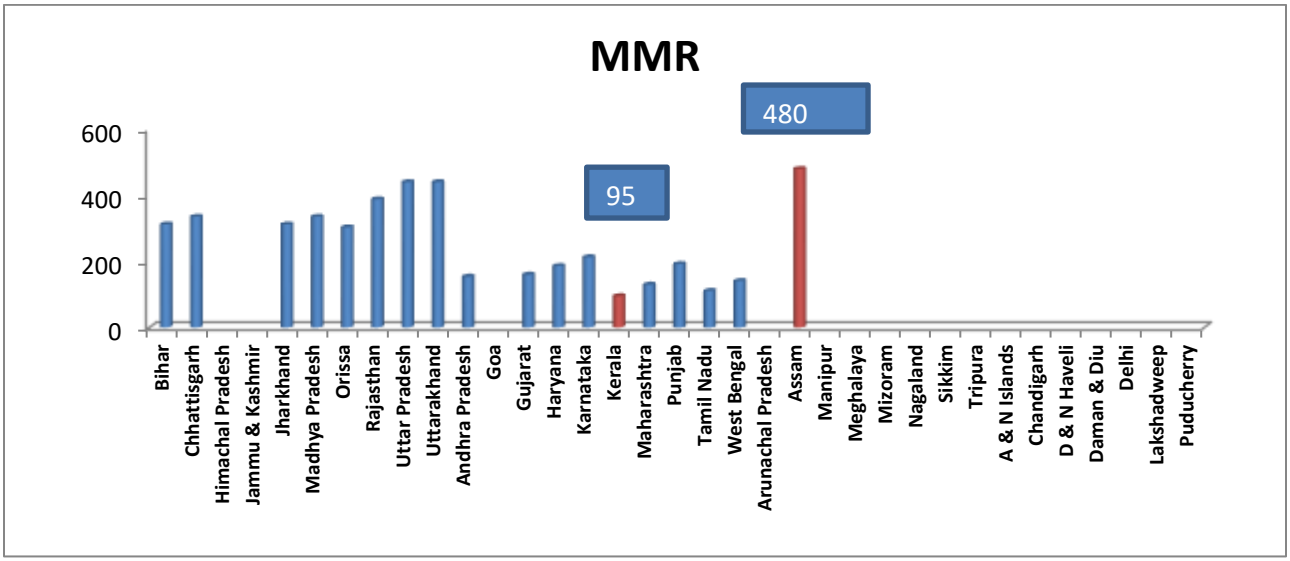
outcome. In (53 for a country with a low of 12/1000 live birth in Kerala and with a high of 78/1000 live births in Madhya Pradesh).

Figure -2 (Infant mortality rate state wise)



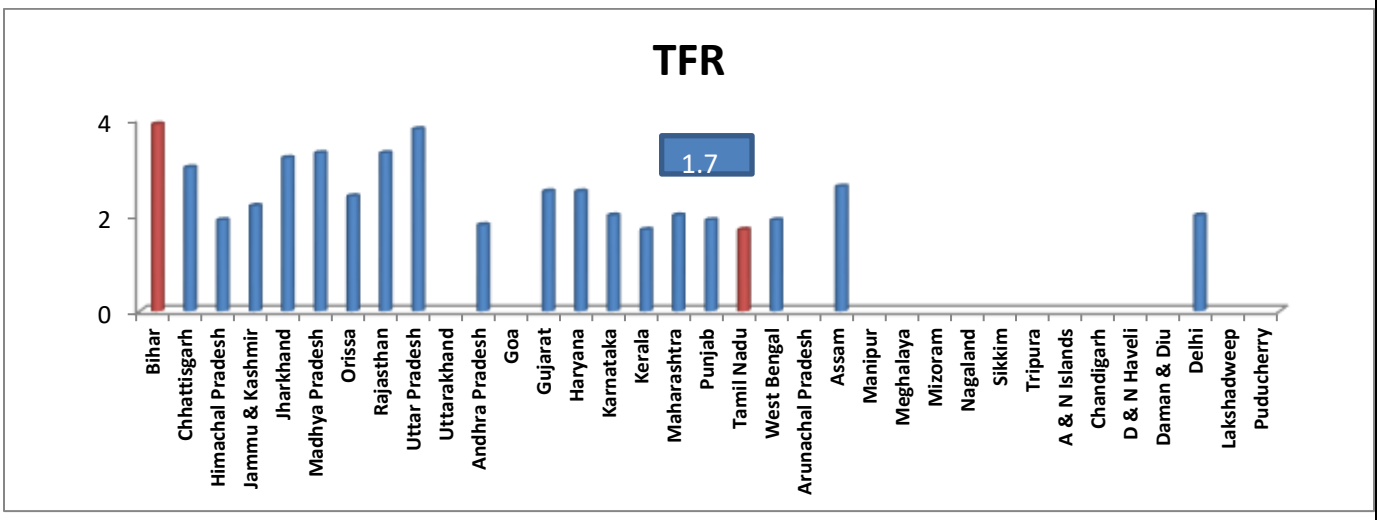
- Madhya Pradesh with high of 70/1000 live births.
- West Bengal with the low of 12/100 live births.

Figure-3(Maternal Mortality Ratio State wise)



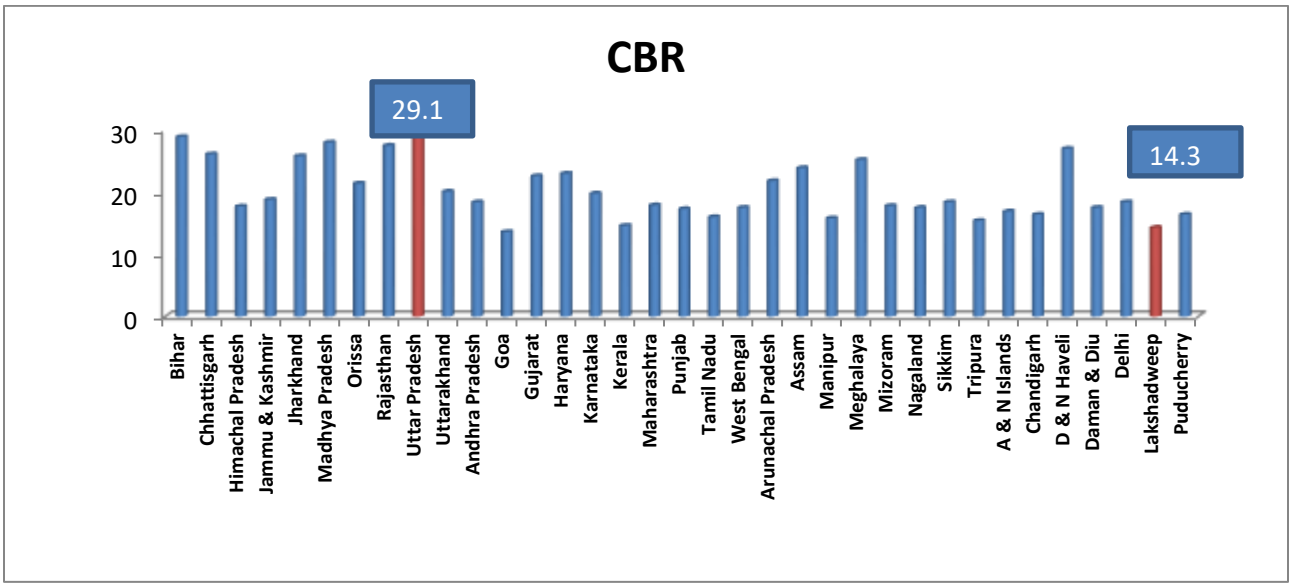
- Assam with the high of 480/100000 live birth Maternal Mortality Ratio.
- Kerala with the low of 95/100000 live births maternal mortality ratio.

Figure-4 (Total fertility Rate State wise)



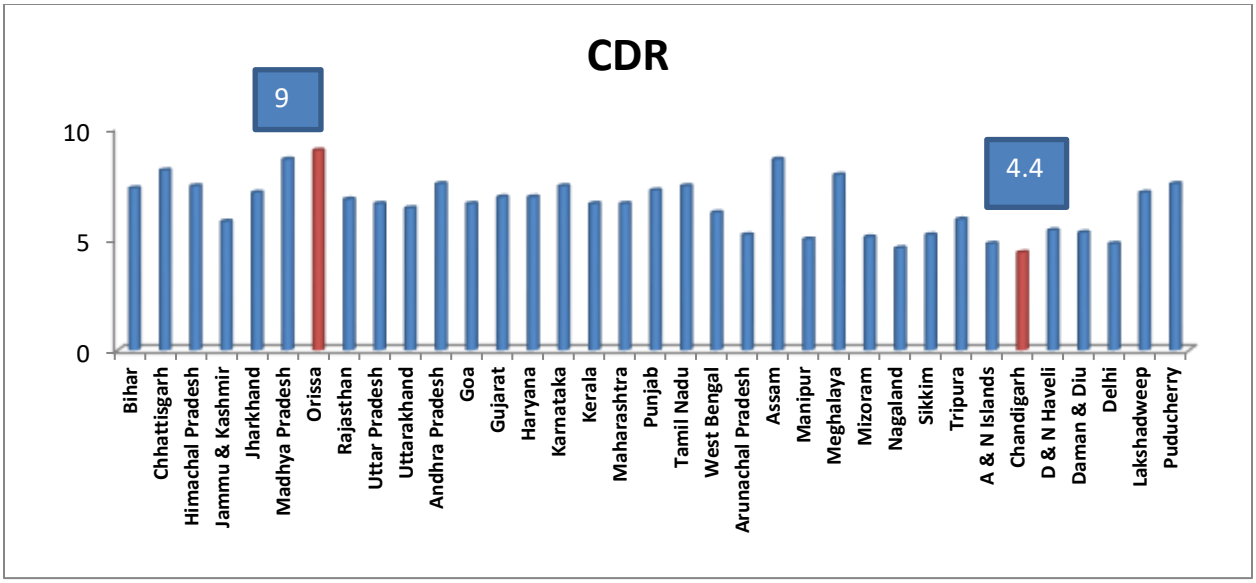
- Bihar with a high of 3.9 Total fertility rates
- Tamil Nadu and Kerala with a low of 1.7 total fertility rates

Figure-5 (Crude Birth Rate State wise)



- Uttar Pradesh with a high of 29.1 CBR.
- Lakshadweep with a low of 14.3 CBR.

Figure-6(Crude Death Rate State wise)



- Orissa with a high of 9 Crude Death Rate.
- Chandigarh with a low of 4.4 crude death rates.

General Findings

- IMR is a complex indicator where many factor plays a role like nutrition has a role in reduction of mortality and morbidity
- To reduce the infant mortality a creation of new born care unit at district hospitals, stabilization units at CHC level and newborn corners at PHC level to provide specialized care.
- Skill development of ASHA's and SBA id done to ensure home based child care.
- Around 312 districts have IMNCI facilities.
- Full immunization coverage of children up to 2 years has gone up from 45.9% (2002-04) to 58%(2007-2008)
- Recruitment of gynecologist, pediatrics, medical officers, staff nurse at PHC has led to improvement in IMR.
- The improvement in institutional delivery has lead to decrease in IMR.
- Strengthening of first referral units with CEMONC.
- Maternal mortality Ratio was 301 in 2005. It was 254 in 2009. JSY was launched in 2005 and early gains are captured in the reduction. The thrust on institutional deliveries and assured referral transport, together with efforts to improve the quality of care in facilities is likely to further increase the pace of reduction in MMR. (254 for the country with a low of 95 /100000 in Kerala with a high of 480 in Assam and uttarpradesh) One such major strategy under NRHM is to provide cash incentives to the pregnant women, who attend antenatal clinics and opt for institutional deliveries. The scheme is known as 'Janani Suraksha Yojana' (JSY). The JSY is the Hindi words which literally mean 'Pregnant Women Safety Scheme'.
- 80% of pregnant women receiving full ANC coverage.
- 80% of them are institutional birth.
- The analysis of quantum of work done by the ASHA under the JSY scheme showed that half of the deliveries took place at homes, out of the total are institutional deliveries.

- Arrangements of payment for transportation were made by the ASHA. This has facilitated and motivated pregnant women and their family members. Due to this program around 22% of the deliveries conducted at public institutions.
- JSY have brought out the fact that institutional deliveries have increased tremendously across all states and more so in states like MP, Orissa, Rajasthan, Assam, and Bihar.
- The resources are available in the government facilities for improving of quality of care
- AHSA along with AWW should mobilize women , children and vulnerable population for the monthly health days activities like immunization, careful assessment of nutrition status of pregnant /lactating mother, newborn and children, ANC/PNC health checkups has led to improvements in IMR and MMR
- The up gradation of PHC into 24x7 has proved beneficial in terms of decreasing MMR.
- Total fertility rate was 2.9 in 2006. It reduces to 2.6 in 2010. 2.6 For the country with a low of 1.9 in Kerala and with a high of 3.8 in Bihar.
- 14 State/UTs at or below Replacement level
- 7 States/UTs between 2.2 and 2.6
- UP, Bihar, Rajasthan, MP, Jharkhand, Chhattisgarh, and Assam among major States have very high TFR 2.7 – 3.9.

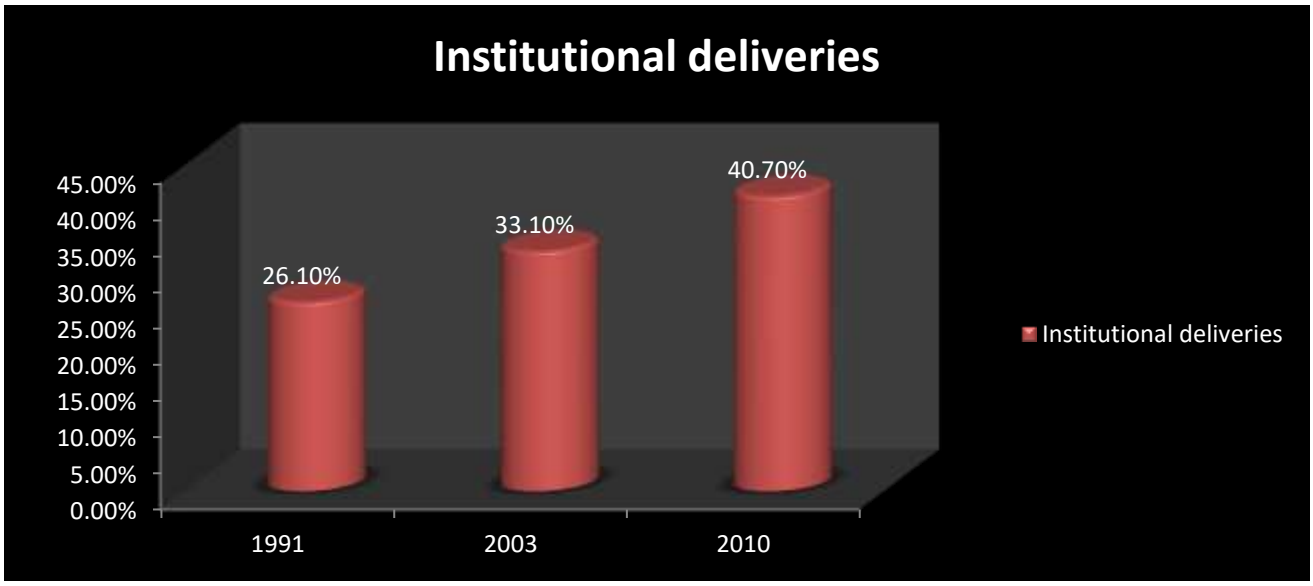
INSTITUTIONAL DELIVERIES

Table N0.-4 (Institutional Deliveries)

Indicator	1991	204	2010
Institutional Deliveries	**26.10%**	**33.10%**	**400%.**

Source:-SRS 2001-03/NFHS-2/NRHM

Figure-7 (Institutional Deliveries)



- Significant progress has been made in the year 2009-10 as compared to early years. It was 26.10% deliveries in 1991 which has increased to 33.1% which still very low as compared to 2010 which is 40.70%, which highlight the importance of JSY program.
- The NRHM has taken out new concepts such as Accreditation of hospital that is the role of JCI in India and emergence of high quality care in corporate hospitals would put additional strain on deliveries.
- The up gradation of the facilities at all level like drugs and diagnostic facilities, renovation and construction of new buildings, recruitment of additional ANM and three staff nurse under CHC, PHC has put strain in deliveries.
- Training of ASHA regarding ANC, PNC has put extra effort on institutional delivery.

- Quality of care for institutional deliveries and other RCH services like clean toilets with running water in women friendly labor rooms, good sanitation and hygiene. Maternal death audits are being conducted and recorded all these activities help in I proving the institutional deliveries.

NEW INITIATIVES TAKEN BY NRHM INTHESES 5 YEARS

1. ROGI KALYAN SAMITIS

Rogi Kalyan Samitis (Patient Welfare Committee) / Hospital Management Society is a simple yet effective management structure. This committee, which would be a registered society, acts as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs.

RKS will not function as a Government agency, but as an NGO as far as functioning is concerned. It may utilize all Government assets and services to impose user charges and shall be free to determine the quantum of charges on the basis of local circumstances. It may also raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies. Moreover, funds received by the RKS will not be deposited in the State exchequer but will be available to be spent by the Executive Committee constituted by the RKS. Private organizations offering high tech services like pathology, MRI, CAT SCAN, Sonography etc. could be permitted to set up their units within the hospital premises in return for providing their services at a rate fixed by the RKS.

The following could be the broad objectives of the RKS

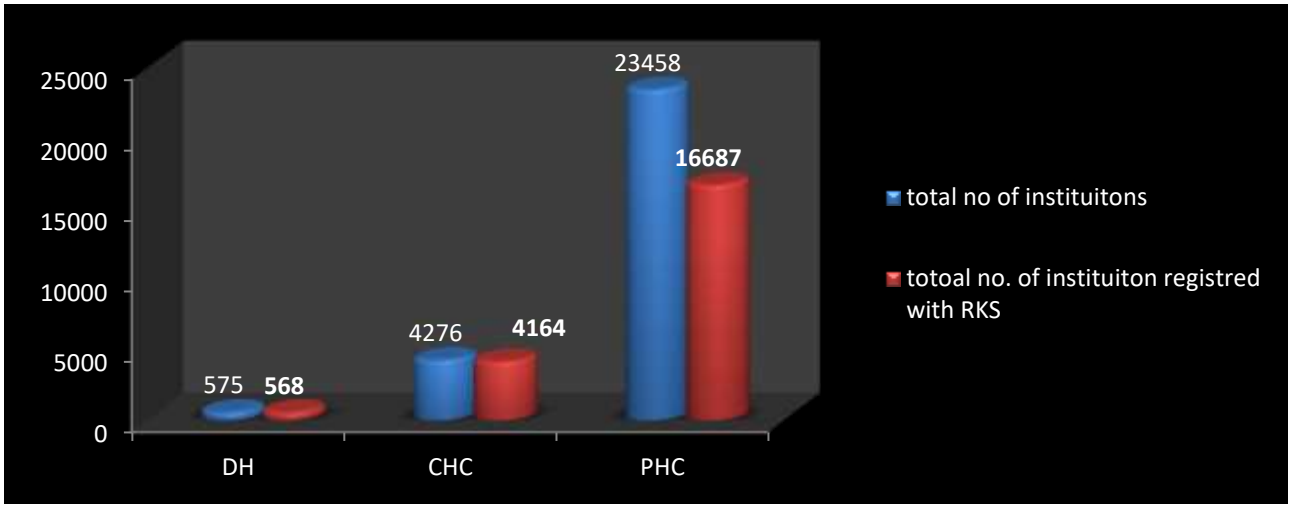
- Ensure compliance to minimal standard for facility and hospital care and protocols of treatment as issued by the Government.
- Ensure accountability of the public health providers to the community
- Introduce transparency with regard to management of funds.
- Upgrade and modernize the health services provided by the hospital and any associated outreach services.
- Supervise the implementation of National Health Programmes at the hospital and other health institutions that may be placed under its administrative jurisdiction.

- Organize outreach services / health camps at facilities under the jurisdiction of the hospital.
- Generate resources locally through donations, user fees and other means.
- Establish affiliations with private institutions to upgrade services.
- Undertake construction and expansion in the hospital building;
- Ensure optimal use of hospital land as per govt. guidelines;
- Improve participation of the Society in the running of the hospital;
- Ensure scientific disposal of hospital waste
- Ensure proper training for doctors and staff
- Ensure subsidized food, medicines and drinking water and cleanliness to the patients and their attendants;
- Ensure proper use, timely maintenance and repair of hospital building equipment and machinery

Table N0-5 (Rogi Kalyan Samiti)

']Year	Number of District Hospital	Number of Community Health Center	Number of primary Health Center
	Total no. of DH =575	Total no. of CHC=4276	Total no. of PHC =23458
2006	442	2409	5229
2007	422	2406	5234
2008	554	4098	13111
2009	563	3930	16034
2010	568	4164	16687

Figure-8 (Rogi Kalyan Samiti)



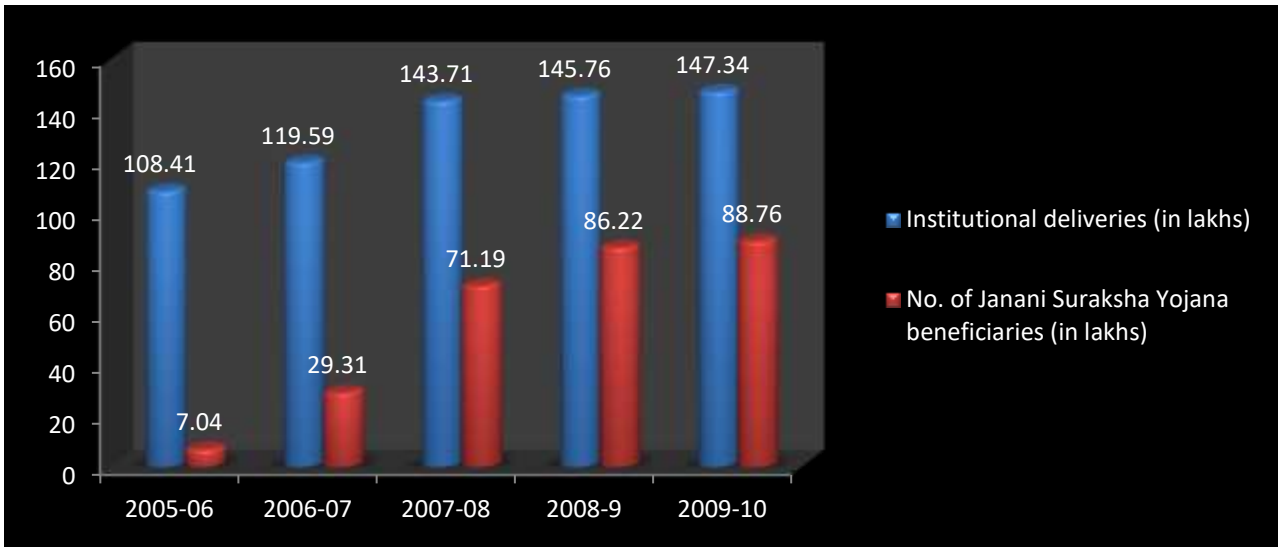
- 16687 PHCs have RHS out of the total 23458 PHCs. They have annual untied grants for improving the maintenance of the state facility for local health action. Nearly all such facilities have already formed the RKS and have received untied funds for facility improvement at CHC, Sub divisional Hospitals and district hospitals.
- Similarly out of 575 DH 568 has registered themselves with RKS which shows great improvement in DH.98% of the DH has all the facilities, adequate manpower.
- The untied grants are getting used through the RKS, some states showing a high utilization and great appreciations of the benefits. In Orissa, utilization of fund, annual maintenance grants and RKS has led to visible improvement.
- In some states RKS has proved to be an alternative financing structure than an institution for patient welfare.
- RKS is functional down to block PHC level in all states. It extends to the PHC level in the states of Andhra Pradesh, Rajasthan and Chhattisgarh.
- 50% of the user charges are deposited for the further renovation and use for patient welfare

2. JSY (to reduce institutional deliveries)

Table No.-6(Janani Suraksha Yojana)

Year	Institutional deliveries (in lakhs)	No. of Janani Suraksha Yojana beneficiaries (in lakhs)
2005-06	**108.41**	**7.04**
2006-07	**119.59**	**29.31**
2007-08	**143.71**	**71.19**
2008-9	**145.76**	**86.22**
2009-10	**147.34**	**88.76**

Figure-9(Janani Suraksha Yojana)



- The above graph showing co- relation between the institutional deliveries and number of JSY beneficiaries under NRHM. From the analysis the extent of success of the JSY programme can be judged by the proportion of all the deliveries conducted in an institution, mainly government centers and private hospitals accredited under JSY scheme. Considerable progress has been made in JSY. From 7.04 lakhs women covered under JSY in 2005-06, the coverage in 2008-09 was 86.22 lakhs and 88.76 in 2009-10 so far, which is nearly one third of all deliveries in India every year. In 2006 only 7.04 lakhs beneficiaries were there out of 108.41 lakhs which has increased to88.76 lakhs JSY

beneficiaries out of 147.34 in 2009-10. This progress has been made by the up gradation of the facilities at all level like drugs and diagnostic facilities, renovation and construction of new buildings, recruitment of additional ANM and three staff nurse under CHC, PHC which has put strain in deliveries.

- The analysis of quantum of work done by the ASHA under the JSY scheme showed that half of the deliveries took place at homes, out of the total are institutional deliveries.
- Significant progress has been made in the year 2009-10 as compared to early years. It was 108.41 lakhs deliveries in 2005-06 which has increase to 147.34 deliveries in 2009-10 which highlight the importance of JSY program.
- The NRHM has taken out new concepts such as Accreditation of hospital that is the role of JCI in India and emergence of high quality care in corporate hospitals would put additional strain on deliveries.
- The up gradation of the facilities at all level like drugs and diagnostic facilities, renovation and construction of new buildings, recruitment of additional ANM and three staff nurse under CHC, PHC has put strain in deliveries.
- Training of ASHA regarding ANC, PNC has put extra effort on institutional delivery.
- Quality of care for institutional deliveries and other RCH services like clean toilets with running water in women friendly labor rooms, good sanitation and hygiene. Maternal death audits are being conducted and recorded all these activities help in I proving the institutional deliveries.
- The extent of success of the JSY programme can be judged by the proportion of all the deliveries conducted in an institution, mainly government centers and private hospitals accredited under JSY scheme. Considerable progress has been made in JSY. From 7.04 lakhs women covered under JSY in 2005-06, the coverage in 2008-09 was 86.22 lakhs and 88.76 in 2009-10 so far, which is nearly one third of all deliveries in India every year

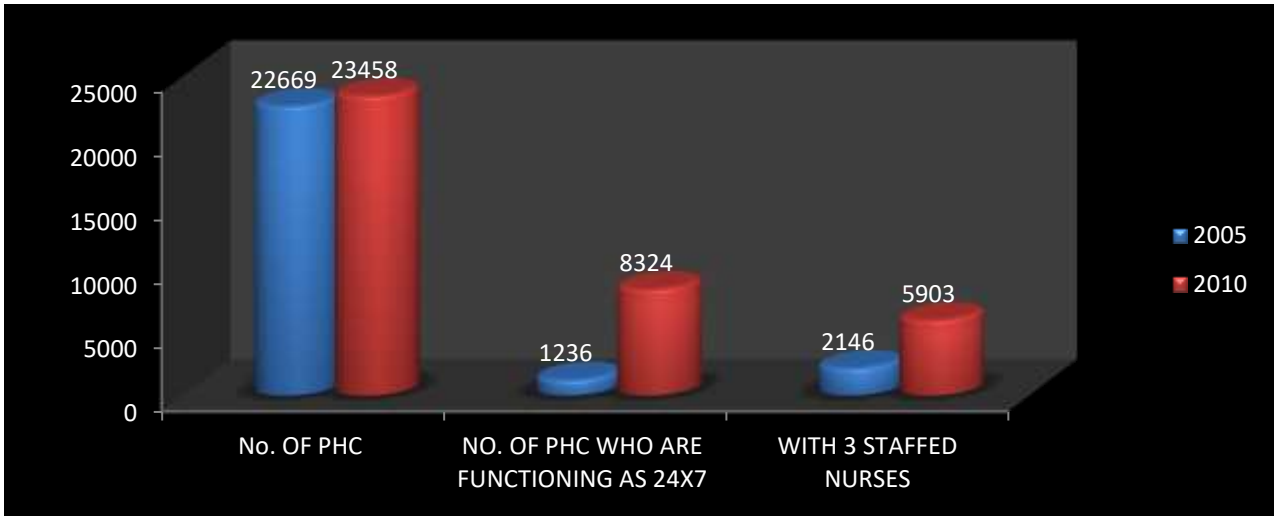
3. STRENGTHENING OF PRIMARY HEALTH CENTER (into 24x7 and appointing three staffed nurse)

The PHCs are currently provided on the population norm of 1 per 30000 populations in general areas and 1 per 20,000 populations in tribal areas. The three staff nurses under PHC would address the health needs of the rural population in a very significant manner. The staff nurses is appointed on the basis of contract.

Table No-7(Primary Health Center)

	2005	2010
No. OF PHC	22669 (Source: RHS bulletin)	23458 (Source RHS 2008)
NO. OF PHC WHO ARE FUNCTIONING AS 24X7 BASIS	1236(as on 31/3/2004)	8324(as on 31/3 2010)
WITH 3 STAFFED NURSES	2146	5903

Figure-10 (Primary Health Center)



- The above analysis shows the proposal of the NRHM in the way of introducing the PHC as 24x7 with the three staffed nurse facility.
- Out of 23458 PHC 8534 PHC are functioning as 24 x 7 with 5903 staffed nurses.
- In order to improve the quality of preventive, promotive, curative, supervisory and outreach services, the PHCs will be strengthened through:

(i) Adequate and regular supply of essential quality drugs and equipments.

(ii) Additional outlays for intensification of ongoing communicable disease control programs, new programs for control of non-communicable diseases, upgrading 100% PHCs for 24 hours referral service, and provision of second doctor at PHC level (1 male, 1 female) on felt-need basis.

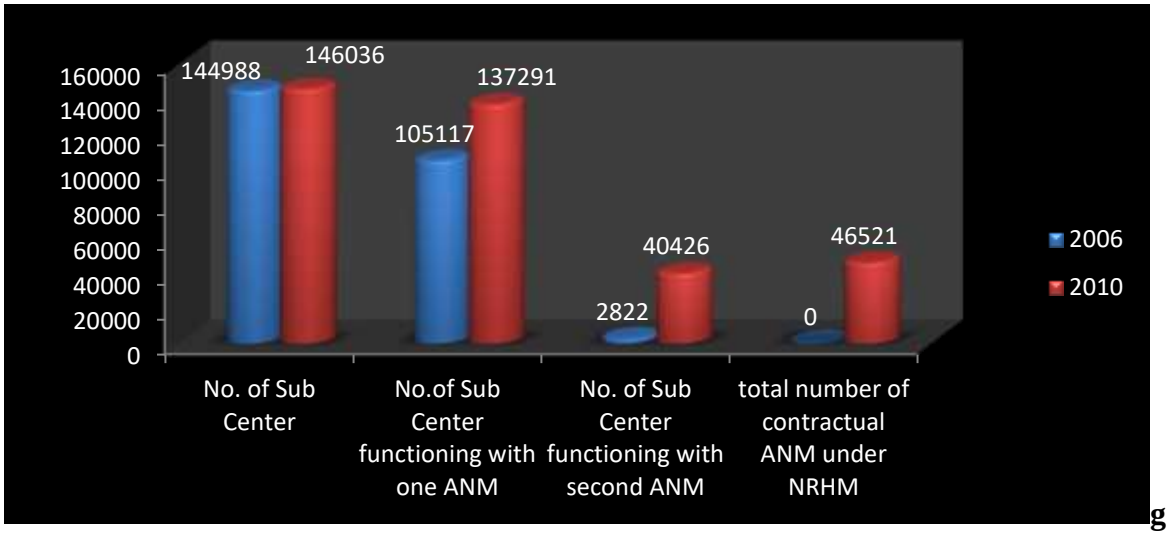
- Total number of PHC as 24x7 at the start of NRHM were 1512 whereas now it has increased to 8324 PHC which are functioning as 24x7 with all the facilities and required manpower.
- Provision for labor room and space for new born care are provided.
- Most of the PHC has registered themselves with Rogi Kalyan Samitis within the overall Panchayati Raj framework to provide better patient care.
- In order to make the PHC functional for 24 hrs, it is proposed to increase the number of staff nurses in the PHC to three.
- The availability of the three staff nurses within the PHC premises would address the health needs of the rural population in a very significant manner.
- The support under NRHM for recurring expenditure will be for the two new posts of staff nurses, on condition that the appointment is on the basis of local criteria and on contract.
- Provision of 24 hour services in 50% PHCs by addressing shortage of doctors through mainstreaming AYUSH manpower, one AYUSH doctor will be posted at PHC level

4. STRENGTHENING OF SUB CENTER
(appointing second ANM and also appointing some staff on contract basis under NRHM)

Table No.-8(Sub Center)

Year	2005	2010
No. of Sub center	144988(RHS 2005)	146036(RHS 2008)
With one ANM	105117	137291
With Second ANMs	2822	40426
Total contractual ANM recruited under NRHM	0	46521

Figure-11 (Sub Center)



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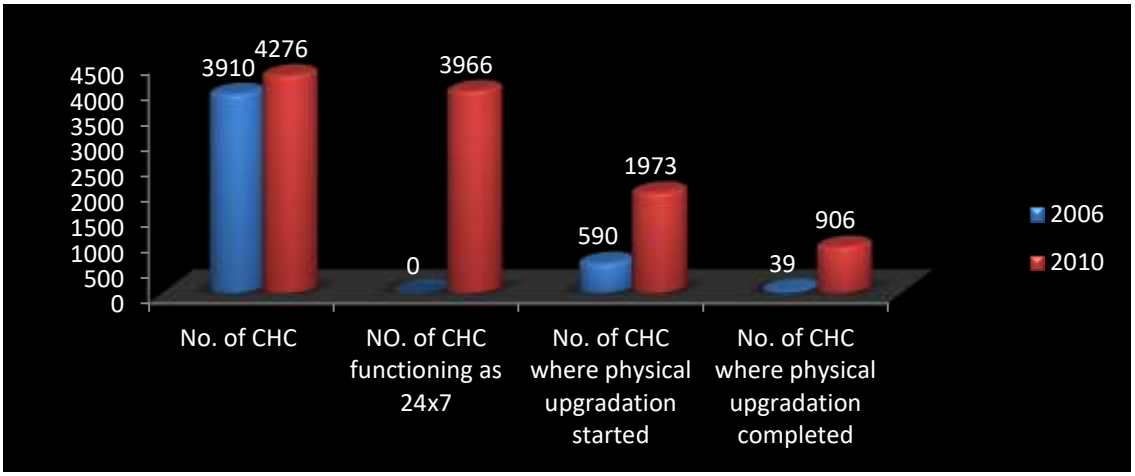
- As part of NRHM, it is proposed to provide each Sub center with Rs. 10,000 as a untied fund to facilitate meeting the urgent needs.
- To reduce workload under sub center the NRHM has taken initiative to introduce additional ANM for outreach services.
- Most of these additional ANM are recruited on contract basis under NRHM so that they can be posted in different levels o overcome from the problem of shortfall of manpower.
- All SC have ANM in position, ANM conducted VHNDs regularly through the active involvement of ASHA's. the ASHA tracked pregnant women and helped the ANM develop micro birth plan that were shared to reduce potential delays in transport

5. STRENGTHENING OF COMMUNITY HEALTH CENTER
(facility survey and physical up gradation)

Table No.-9 (Community Health Center)

Year	2005	2010
No. of community health Center	**3910(source:RHS2005)**	**4276 (source: RHS 2008)**
No. of CHC functioning as 24x7	**0(as on 31/3/2004)**	**3966 (as on 31/3/2010)**
No of CHC in which physical up gradation started	**590**	**1973**
No. of CHC in which physical up gradation completed	**39**	**906**

Figure-12(Community Health Center)



- For upgrading the facilities the need generated by increased patient load. The up gradation of CHC to 24x7 facilities has continued and offers increasing number of mothers and children access to services. It was observed that in 2006 only 39 out of 590 CHC upgraded rest of them are under construction and undergoing process.

6. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

One of the key strategies under the National Rural Health Mission (NRHM) is having a Community Health Worker i.e. ASHA (Accredited Social Health Activist) for every village with a population of 1000. Detailed guidelines have been issued by the Government of India in matter of selection and training of ASHA. The States have been given the flexibility to relax the population norms as well as the educational qualifications on a case to case basis, depending on the local conditions as far as her recruitment is concerned.

The reports received from the States indicate that over 1, 20,000 ASHAs have been selected in the year 2005-06 and that they are being provided with orientation training as envisaged in the guidelines issued on ASHA. Now, a careful strategy needs to be devised for providing the necessary management support to ASHA so that she is not left alone in the village without having any linkage with the health system.

(1) ASHA Mentoring Group:

The Government of India has set up an ASHA Mentoring Group comprising of leading NGOs and well known experts on community health. Similar mentoring groups at the State/District/Block levels could be set up by the States to provide guidance and advise on matter relating to selection, training and support for ASHA. At the District level, MNGOs and at Block level, FNGOs could be involved in the mentoring of ASHA. The State Govt. may utilize the services of Regional Resource Centre (RRC) and include them in the Mentoring Group at the State level.

(2) Selection of ASHA

As ASHA will be in the village on a permanent basis, she should be selected carefully through the process laid down in the first set of ASHA guidelines. It is possible that the selected ASHA drops out of the programme. It is, therefore, necessary to keep a record of such cases at Sub-Centre/ PHC level. In the above circumstance, a new ASHA could be selected from the panel of three names previously prepared on the recommendation of the Gram Sabah.

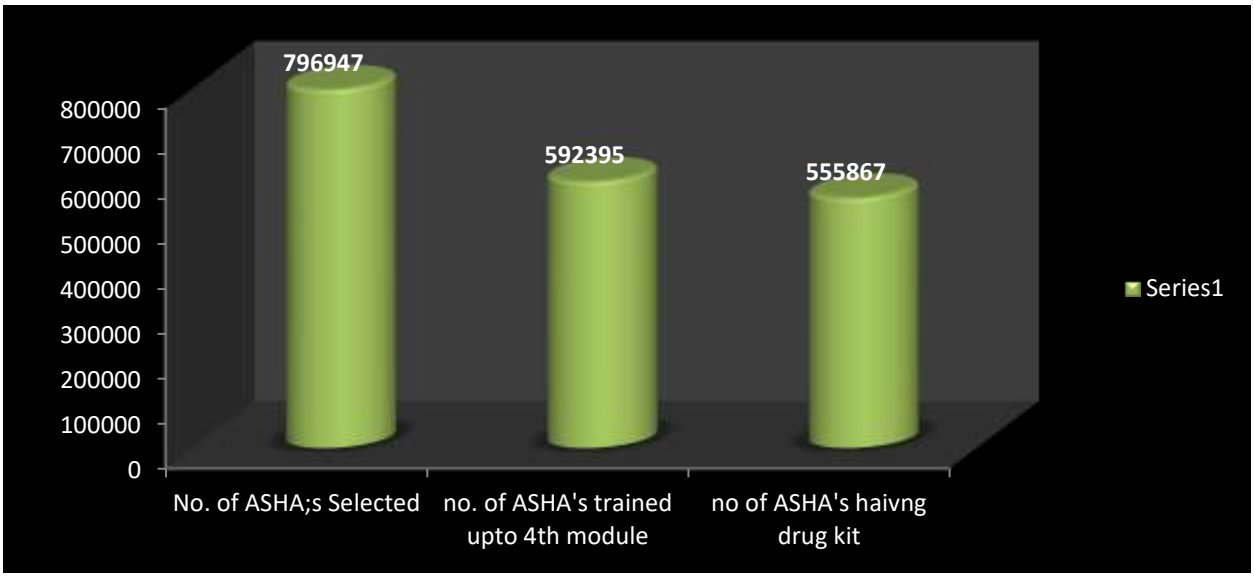
(3) Training of ASHA

The guidelines already issued on ASHA envisage a total period of 23 days training in five episodes. However, it is clarified that ASHA training is a continuous one and that she will develop the necessary skills & expertise through continuous on the job training. After a period of 6 months of her functioning in the village it is proposed that she be sensitized on HIV / AIDS issues including STI, RTI, prevention and referrals and also trained on new born care.

Table No.-10(ASHA)

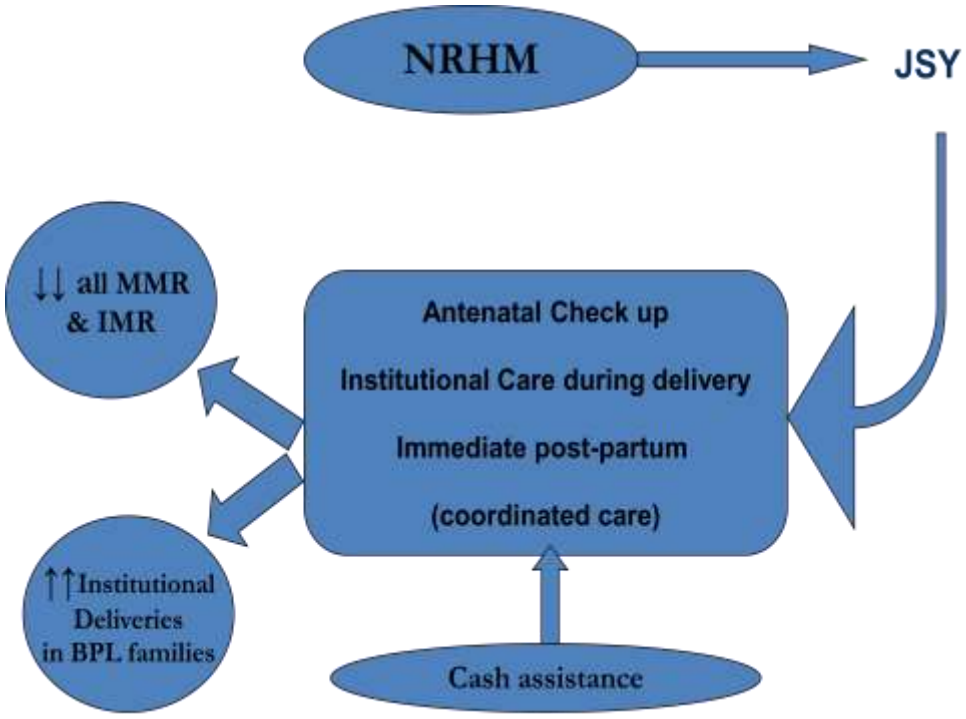
Year	ASHAs selected	ASHAs trained up to 5 module	ASHAs having drug kit
	796947	**592395**	**555867**

Figure-13(ASHA)



GENERAL FINDINGS OF THE PROJECT

- By evaluating the these indicators it was concluded that before the lunch of NRHM there were lack of various facilities and manpower like-
    - 24x7 facilities for safe deliveries.
    - Unsatisfactory access and utilization of skilled birth attendant.
    - Non –availability of doctors or specialists of Anesthesia and pediatric care.
    - Lack of transport system.
    - Lack of awareness of the hygiene and sanitation and nutrition among the rural population.
- After the launch of NRHM by our Hon'ble Prime Ministers in 2005 the progress has been made through various programs.
    - According to the Indian Public Health Standards it makes PHC into 24x7 including CHC as FRU's.
    - NRHM has developed the modules system for providing training to ASHA's. After this training they speak confidently.
    - Appointment of the second ANM as on contractual basis under the NRHM so that it can outreach the areas.
    - Expanding the workforce especially in remote areas and in large villages and also in the semi urban areas.
- The improvement in health manpower's has led to de crease in Infant mortality Rate, Maternal Mortality Ratio and increase in institutional deliveries.
- The NRHM has taken out new concepts such as Accreditation of hospital that is the role of JCI in India and emergence of high quality care in corporate hospitals would put additional strain on deliveries.



- The analysis of quantum of work done by the ASHA under the JSY scheme showed that half of the deliveries took place at homes, out of the total are institutional deliveries.
- Arrangements of payment for transportation were made by the ASHA. This has facilitated and motivated pregnant women and their family members. Due to this program around 22% of the deliveries conducted at public institutions.
    - In contract to the institutional deliveries was resulted in decrease in IMR, MMR.
    - Recruitment of gynecologist, pediatrics, medical officers, staff nurse at PHC has led to improvement in IMR, MMR.
    - Up gradation of PHC, CHC for 24x7 services and functioning as FRU's show the way of progress in IMR and MMR.
    - All state government is presently organizing monthly health and nutrition day in every village with the help of AWW/ANM. This meeting helps in providing and spreading awareness regarding the hygiene and sanitation and also about the institutional deliveries.
    - AHSA along with AWW should mobilize women , children and vulnerable population for the monthly health days activities like immunization, careful assessment of nutrition status of pregnant /lactating mother, newborn and children, ANC/PNC health checkups has led to improvements in IMR and MMR

- Strengthening of CHC as facilities for first referral care is a key mission strategy, Rogi Kalyan Samitis is constituted for each PHC/CHC and other hospital. At presently, nearly half of the facilities have constituted the hospital management society and half are in the process of getting registered.
- To overcome the shortage of manpower in management of health facilities NRHM provides additional manpower in the form of contractual staff to health facilities at various levels.
- Indian Public Health Standard has raised the nursing post in the system. The ANM is not able to handle the workload of CHC so NRHM has decided to fund 2nd ANM at Sub center
- NRHM has decided to provide untied grants to the PHC, CHC and SC for up gradation and reconstruction of the buildings.
- Increased utilization of services is reflected in increased number of outpatient cases, inpatient cases, and institutional deliveries under the supervision of Panchayati Raj Institutions and Rogi Kalyan Samitis.
- The developments of medical mobile unit in each state are providing diagnostic and outpatient cases closer to hamlets and villages in remote areas.
- Many states put special efforts into filling doctor's vacancy in PHC's. The some states have taken out a policy of using AYUSH doctors as one of the 2 doctors posted at the PHC from AYUSH stream.
- NRHM has added to doctors and paramedics on a large scale leading to more care for patients.
- The recruitment of three staffed nurse under the PHC has increased in the institutional deliveries and decrease in IMR, MMR.
- From the analysis it is evident that delivery capacity of the public health system has led to increase at each level. It is also found that outdoor patient visits have increased at three levels.
- The up gradation of block PHC to 24x7 facilities has continued and offers increasing number of mothers and children access to services.cae load of OPD also continues to increase.
- MIS is effectively managed at state and district level.

EXECUTIVE SUMMARY

NRHM

- Launched in April 2005.
- Framework for implementation approved in July 2006.
- Provides support to states strengthening system of health care in rural areas through provision of physical infrastructure, human resources, equipment, emergency, transport, drugs, diagnostic and other support.
- Covers all programs in the health sector except HIV/AIDS, mental health and sanitation committees to district hospitals.
- Provides for constitution of community institutions at health facility level.
- Provides a community worked called ASHA in every village.
- Allows states to innovate and promotes flexible financing to allow local decision making.
- 7.49 lakhs AHSAs selected.
- 7.05 Lakhs ASHAs trained up to first module.
- 5.65 Lakhs ASHAs trained up to fourth module.
- 5.20 Lakhs ASHAs with drug kits in village.
- 46,690 ANMs appointed on contract.
- 26,793 staff nurses appointed on contract.
- 8, 624 MBBS Doctors appointed on contract.
- 2,460 specialists appointed on contract.
- 7,692 AYUSH doctors appointed on contract.
- 14,490 paramedics Staff appointed on contract.
- Pressure on States to fill up existing vacancies.
- Responsibility for existing vacancy with state government.
- NRHM provides support on contract for new positions as per Indian Public Health Standards at various levels.
- NRHM provides for untied funds and maintenance grants to all government health facilities from Sub Centers, PHCs, CHCs, Sub District and District hospital.

- All District Hospitals provided Rs.20 Lakhs as initial grant for up –gradation of facilities to meet increased case load.
- District Hospitals in the North Eastern region provided rupees one crores for hospitals.
- All community health centers provided Rs. 20 Lakhs for up gradation of facilities to meet all increased case load.
- 1031 Mobile Medical Units operational under NRHM in States.
- 451,473 Village health and sanitation committees set up under NRHM.
- 29,223 Rogi Kalyan Samitis set up under NRHM.
- 14,036 Sub Centers are functional in the country.
- 23,458 Primary Health Centers are functional.
- Of these, 8,324 have been made 24X7.
- 4,276 Community Health centers in the country.
- 15,196 health Facilities are functional in rural areas.
- 2,463 First Referral Units in the country.
- In 2009-10, Rs.14050 crores was allotted and the expenditure was Rs. 100131.01 crores.
- The utilization of funds in the stated has considerably improved over the last few years. Under the RCH flexible pool the expenditure has gone up from Rs. 301.49 crores in 2005-06 to Rs.972.74 crores in 2006-07, Rs. 1527 crores in 2007-08, Rs.3256 crores in 2008-09 and Rs, 2679 crores in 2009-10.
- More financial resources are needed to provide3 quality health care in rural areas as this sector was totally neglected in the past.

RECOMMENDATIONS

- To have a bigger impact on decline of IMR, NRHM need to strengthen the home based delivery concept in the training program of ASHA.
- There is also need to look after the nutrition status. It not only ensures the safety of food for households but also the reduction of infections through effective public health measure.
- The village health sanitation committee and village Health Nutrition day needs to be further strengthened.
- NRHM needs to further decentralized management and accountability by engaging non – governmental for community monitoring at all levels.
- While NRHM has added a large number of human resources in the states, the effectiveness of such addition would be more pronounced if supervisory structures and job descriptions of every worker are well established.
- The NRHM needs to maintain the registers which track all mortality and morbidity in the rural areas.
- NRHM has started useful process of accreditation of hospital with the help of NABH, JCI. It needs to be further strengthened to ensure service guarantee for quality outcomes at every health facility
- Bringing more coordination between ASHA, ANM, and AWW would be essential to achieve much of the tasks needed at the community and sub center level.

CONCLUSION

Through the study of organization profile it was concluded that the organization has decentralized structure and it has adopted departmentalization and division of work principle. It is found that sometimes due to departmentalization, groups are formed in the organization which can affect the efficiency and functioning of the organization so it is recommended that a new employee should get orientation of all the departments and employees of the organizations at least for one month so that he/she get acquaintance with the working and management of the organization.

Though there were various programs to improve the health system which has proved too some extent beneficial in improving the health status but on the other hand found failure inn achieving the necessary improvements in other areas. NRHM successive developments have put the positive impact on reaching health care to the heights and improving the service delivery of the country.

NRHM has made these developments with the help of:

- NRHM has **Decentralized syste**m which involves the delegation of powers and authority at each level to take necessary action and innovation to improve the health status.
- NRHM recognize the integrating the determinants of health, like nutrition, water and sanitation with the health system.
- NRHM provides mechanism for **community participation and management**.
- NRHM provides training to equip them to **provide leadership** as well as plan and monitor the activities at village level.
- The NRHM also provide management support to strengthen the **capacity** for decentralized management of health.

Through the study of "Evaluating the Indian health System: Before & after the implementation of NRHM" project it confirms the positive impact that NRHM is making on reaching health care to households in remotes areas. It also brings out a few issues or lacunas with regard to provision

of human resources. Through the study it was concluded that achievements of decline in IMR, MMR and TFR has been done with great efforts and innovative approaches.

The700, 000 ASHA across the country have demonstrated their ability to link households to facilities. NRHM only needs to further put pressure for better governance and for larger civil society involvement at all levels through public hearings and community monitoring.

REFFERENCES

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- http://mohfw.nic.in
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- http://nfhsindia.org
- http://www.rchiips.org
- http://censusindia.gov.in/vital_statistics/srs/sample_registration_system.aspx

Annexure

1. **Institutional Deliveries**
2. **States report (Jan 2006-2010)**