Towards Accessibility in Public Health-

A study on Progress of Infrastructure under NRHM

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

Post-Graduate Diploma in Health and Hospital Management

by

Asmita Jyoti Singh



International Institute of Health Management Research

New Delhi -110075

17 May 2010

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under the guidance of

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Certificate of Approval

The following dissertation titled "**A Study on Progress of Infrastructure under NRHM"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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ABSTRACT

ABSTRACT Introduction: Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005 throughout the India with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The NRHM was launched with a view to bring about dramatic improvement in the health system and health status of the people, especially those living in rural areas by the end of 2012. The NRHM has a clear objective of providing quality health care in the remotest rural areas by making it accessible, affordable and accountable. Given the status of Public Health infrastructure in the country, it will not be possible to provide the desired services till the infrastructure is sufficiently strengthened. The present study is a review of the improvements and progress made in infrastructure under NRHM. This particular study was designed with the overall goals of assessing the improvements in terms of construction of new facilities, manpower positioning, and provision of MMUs, Emergency Referral Transport, and Ambulances at facilities. **Methods**: This is a retrospective study; a complete literature review is done on secondary data available on NRHM. The overall study is conducted to analyse the progress of infrastructure under NRHM. For this the progress under each year is compared to the baseline data before the inception of NRHM. The progress is analysed comparatively. **Results**: On the basis of review it is revealed that growth in the CHC construction was much more remarkable than other facilities. It recorded a total of 31% increase in the number of CHC. Human resources on the other hand showed a 34.40% growth in number of ANMs at health sub-centres/PHCs, 49.73% growth in doctors at PHCs, 42.59% growth in specialists at CHCs, 62.12% growth in Nurse Midwife at PHC/CHC, 18.60% growth in number of pharmacist at PHCs/CHCs, 41.06% growth in Radiographers at CHCs. **Conclusion**: Preliminary in its first 5 years a lot of improvements has been achieved but still a lot has to be achieved further. We therefore conclude that NRHM appears to be a well designed program and lots of thought process has gone into it prior to its implementation. However, it would be too early to predict its outcome in terms of success or failure.

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List of Abbreviations

NRHM- National Rural Health Mission

MMU- Mobile Medical Unit

SC- Sub- Centre

PHC- Primary Health Centre

CHC- Tertiary Health Centre

SDH- Sub- Divisional Hospital

DH- Divisional Hospital

FRU- First Referral Unit

RHS- Rapid Household Survey

HFM- Health & Family Welfare Minister

UT- Union Territory

JS- Jeneral Secretary

US- Under Secretary

AD- Additional Secretary

PIP- Programme Implementation Planning

MDG- Millenium Development Goals

NHP- National Health Policy

ANM- Auxillary Midwife Nurse

MCI- Medical Council of India

CRM- Common Review Mission

MIS- Management Information System

SRS- Sample Registration Survey

I. Internship Report

1.1-Organization' Profile

MINISTRY OF HEALTH &FAMILY WELFARE

The Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of Health & Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines.Apart from these, the Ministry also assists States in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance.

Ministry of Health & Family Welfare incurs expenditure either directly under Central Schemes or by way of grants–in–aids to the autonomous/ statutory bodies etc. and NGOs. In addition to the 100% centrally sponsored family welfare programme, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria, Leprosy, Tuberculosis and Blindness in designated areas. Besides, State Health Systems Development Projects with World Bank assistance
are under implementation in various states. The projects are implemented by the respective State Governments and the Department of Health & Family Welfare only facilitates the States in availing
of external assistance. All these schemes aim at fulfilling the national commitment to improve access to Primary Health Care facilities keeping in view the needs of rural areas where the incidence of disease is high.

The Ministry of Health & Family Welfare comprises the following departments, each of which is headed by a Secretary to the Government of India:-

- Department of Health & Family Welfare
- Department of AYUSH.
- Department of Health Research
- Department of AIDS Control

Directorate General of Health Services (Dte.GHS) is an attached office of the Department of Health & Family Welfare and has subordinate offices spread all over the country. The DGHS

renders technical advice on all medical and public health matters and is involved in the implementation of various health schemes.

The Ministry of Health and Family Welfare is headed by Union Minister of Health and Family Welfare, Shri Ghulam Nabi Azad since 29th May 2009. He is assisted by the Ministers of State for Health and Family Welfare – Shri Dinesh Trivedi and Shri S Gandhiselvan.

VARIOUS NATIONAL HELATH PROGRAMS

- National Vector Borne Disease Control Programme (NVBDCP
- National Filaria Control Programme
- National Leprosy Eradication Programme
- Revised National TB Control Programme
- National Programme for Control of Blindness
- National Iodine Deficiency Disorders Control Programme
- National Mental Health Programme
- National Aids Control Programme
- National Cancer Control Programme
- Universal Immuization Programme
- National Programme for Prevention and Control of Deafness
- Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke
- National Tobacco Control Programme
- School Health Programme

National Rural Health Mission (NRHM)

The Hon'ble Prime Minister launched the NRHM on 12 April, 2005 throughout the country with special focus on 18 states including Eight Empowered Action(EAG)states, the North Eastern states, Jammu & Kashmir and Himachal Pradesh.

The NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It also seeks to reduce the Maternal Mortality Ratio(MMR)in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Ratio(IMR)

from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 within 7 year periods of NRHM.

The Vision of the Mission

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattissgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur , Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa , Rajasthan, Sikkim, Tripura,Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.
- Addresses inter State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

II. GOALS, STRATEGIES AND OUTCOMES OF THE MISSION

The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population

stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will:

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

The Objectives of the Mission

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

NRHM has four main divisions:

1. NRHM I

2. NRHM II

3. NRHM III

4. NRHM IV

5. NRHM Finance

1.2. Department Profile- NRHM IV- Infrastructure Division

NRHM IV/ID, previously known as RHS Section has been allocated the following work:

1. Issues pertaining to classification of Difficult, Most Difficult and Inaccessible Areas in all the States. It includes from its very beginning issuing letters from Hon'ble HFM to All States UTs, followed by another letter from JS [AS] to All States/UTs, then collecting replies from all States and UTs, making district wise list of all the areas from the available replies, making copies of replies at urgent notice, keeping everything handy all the time and other related works, submitting materials for meeting/discussions on this issue. Now a days all the files are being submitted to Hon'ble HFM with the plotted maps of all State/UT giving the information on difficult, most difficult and inaccessible areas.

2. Issues pertaining to Jammu and Kashmir. We have about five files on this issue pertaining to different subject i.e. Jammu and Kashmir Infrastructure Development Plan, Two Maternity Hospitals one each at Jammu region and Kashmir Region, Reporting on PMRP to MHA and Coordination Section, Letter from Hon'ble CM J & K to Hon'ble HFM, Monthly Report to Coordination Section on the above issues.

3. Framing and amendment/review/revision of Indian Public Health Standards[IPHS] which is a continuous process and a number of committee are constituted from various disciplines for amendment the existing IPHS i.e Clinical Standards, Lab. Standards, Building Standards , HR Standards, services standards etc. This is a continuous process which and files are kept moving all the times.
4. Various VIP References which includes sending the letter to concerned state/UT Government, collecting reports in some cases, replying to Hon'ble MPs maintaining records etc.

5. RTI Cases which is the most important work and urgent as well. This includes examining the whole issue, collecting information where-ever required, drafting reply, getting approval, amendments if any, maintaining records etc.

6. Parliament Notices and Question. It is submitted that Parliament Session is normally for a period of five months which is spread out over the complete year. During the session, the work increases manifolds. It includes collection of material from all concerned, making letters, getting those issued, faxing, running /rushing to various sections for collecting material, giving soft copies to Parliament Section of the approved replies, tracking the questions. Although the work is equally distributed to all the dealing hands we have to work as a whole team. During the session, it becomes almost impossible to have a look at our normal routine work.

7. Various Parliament Assurances, Issues raised in Parliament under different rules i.e rule 377, spl mentions etc.
8. This section is also dealing with Programme Implementation Plan which is examined by all the Dealing Hands, US [ID], AD [ID] and SO [ID]. Apart from PIP appraisal, AD is also looking after the PG Courses work. Since he has no secretariat assistance, the same is provided by ID/NRHM IV Section.
9. Other miscellaneous work which is marked Section from time to time.

The NRHM IV division looks after the issues related to infrastructure under NRHM. Physical infrastructure, Human resources, Referral transport services under NRHM, JSY, and ambulatory services in facilities. Given the status of public health infrastructure in the country, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning as well as infrastructure strengthening. The mission provide priority to both these aspects so is the work involved in NRHM IV. The department is continuously working and trying to make it possible for the mission to achieve the foresaid as far as infrastructure is concerned.

1.3. Responsibilities allotted –

I was allotted responsibility of collection and analysis of data regarding the construction of new buildings under NRHM. To analyze the status of completion of task was the major challenge. The exercise was required to complete the 5 yearly report of progress of NRHM. The states were asked to indicate the existing situation of their facilities. Since the states have received ample amount of money for the same the focus was more on number of facilities that could be made more functional till now after the starting of NRHM. I was involved in the development of the format required for the same and was in continuous communication with the states for the same. The data received from states was analyzed to derive the information regarding the number of new facilities taken up for construction, number of facilities that have been completed or the construction work is over & the number of facilities where work is under progress.
To upgrade facilities to IPHS is also one amongst many objectives of NRHM. All the facilities are receiving grants for up gradation, renovation if required to achieve IPHS norms. The format was developed for the same, the states, union territories were asked to respond for the same.
Another responsibility was to collect the data for the number of Mobile Medical Units functional in the states & Union territories. MMUs have been envisaged to provide preventive, promotive and curative health care in inaccessible areas & difficult terrains which are underserved or unserved areas under usual circumstances. Factors that negatively influence the existing public

health system and call for the exigency are distance of the remote villages from the public health institutions, geographical barriers to reach the pockets, lack of mobility support for field visits by the staff assigned to do the job, lack of medicines/ equipment/manpower, lack of awareness & health consciousness in the community particularly among disadvantaged people who are socio economically backward. Analysis of MMUs, their current numbers, mode of functioning etc was looked after as a part of job responsibility. The referral transport services were started to strengthens the public health care delivery system of our country. The states have launched services such as 102, 108 etc. different states have different arrangement for this service. Referral transport is also involved in JSY scheme and also states are encouraged to have ambulances at various facilities, this is also essential for achieving the IPHS standards. I was involved in this exercise and assisted in this programme which was also very important as these statistics were the base to rank states for their performance in last 5 years of NRHM.

A very important exercise was being done in ministry as an issue in 100 day agenda of the ministry. I helped ministry in identification of facilities which are difficult, most difficult and Inaccessible. This is essential to post human resource their by giving extra monetary and non-monetary incentives. I was involved in identification of such facilities and areas. Also my responsibility included helping states in developing an objective criterion to identify such facilities so that they could propose proper incentives. Also I have been working on mapping these facilities as these would help in proper identification of these facilities. Control sheets prepared in 3 months are attached as Annexures.

1.4-Learning in three months -

1. Developed a detailed learning about NRHM and its functioning
2. More aware of issues related to functioning and governance issues of implementation of a mission
3. A better knowledge of Soft- excels.
4. Learned mapping of facilities

II. Dissertation Report

Chapter 2.1 Introduction
Infrastructure under NRHM

Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005 throughout the India with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The NRHM was launched with a view to bring about dramatic improvement in the health system and health status of the people, especially those living in rural areas by the end of 2012. The NRHM has a clear objective of providing quality health care in the remotest rural areas by making it accessible, affordable and accountable. Given the status of Public Health infrastructure in the country, it will not be possible to provide the desired services till the infrastructure is sufficiently strengthened. The present study is a review of the improvements and progress made in infrastructure under NRHM. This particular study was designed with the overall goals of assessing the improvements in terms of construction of new facilities, manpower positioning, and provision of MMUs, Emergency Referral Transport, and Ambulances at facilities. The study attempts to collate data.

Objectives of study: To study the Progress of Infrastructure under NRHM

The National Rural Health Mission has identified provision of appropriate physical infrastructure as an important intervention in the strengthening of the Rural health System. High focus states under NRHM can spend to 1/3rd of their financial envelope under NRHM on development of appropriate physical infrastructure. This includes new construction as well as renovation of Sub Centres, Primary Health Centres, Community Health Centres, Sub District and District Hospitals. Realizing the need to up-grade facilities on a priority NRHM provided for detailed facility survey of all Government Health Institutions to identify the gaps that needed to be bridged. Rs.20 lakhs was provided under NRHM for the renovation of each and every Community Health Centre in the country. Rs. 20 lakh was also provided to all District Hospitals for an initial repair and renovation of the maternity ward etc. in the North Eastern Region considering the gaps at the level of District Hospital Rs.1. crore was provided to each District for renovation as an initial grant.

Besides these resources annual Maintenance Grants for Sub-centres, primary Health centres, community Health centres, sub-divisional and district hospitals are also provided to the Rogi Kalian Samitis established at facility level. Sub-centres are eligible for the maintenance grants only if they have a building of their own. As per the Rural health Statistics 2008, of the 146036 sub-centres, 78803 are in government buildings,49035 in rented buildings and 18198 in rent free Panchayat buildings. The rural health statistics 2008 also recorded that another 9434 buildings were under construction and that left a total of 57812 buildings to be taken up for construction. Under the NRHM a total of 9144 sub-centre buildings have been taken up for new construction and another 8997 for renovation. State Government have been taken up a large number of Sub-centre constructions from Finance Commission grants or State Government Plan funds. NRHM's

efforts is to ensure that all Sub-Centres have a building of their own, or, are located in a Panchayat building before the Governments are also being taken up for construction. The State wise progress and construction is indicated in the table form at the end of this section.

As regards Primary Health Centres, the rural Health statistics 2008 had pointed out that of the 23458 functioning PHCs, 19706 were in the government buildings, 1856 in rented buildings and 1896 in rent free Panchayat buildings. It also pointed out that 2547 PHC buildings were under construction and there was still a gap of 1212 buildings required to be constructed. One has to bear in mind that construction of Staff Quarters; Medical Officer Quarters etc. are also part of the physical infrastructure of primary health Centres. Under the NRHM, 1009 Primary Health Centre buildings have been taken up under construction and another 2081 for renovation. It may also be pointed out that State Government have also taken up PHC construction through Finance Commission and State Plan resources.

As regards Community Health Centres, the Rural Health Statistics 2008 had indicated that of the 4276 CHCs, 3882 were in government buildings, 34 in rented buildings and 360 in rent free panchayat buildings. It had also listed that 628 buildings were under construction and that 148 buildings needed to be constructed. Here also it must be pointed out that Community Health centre complexes comprise not only of hospital but also quarters for doctors, nurses and other paramedic staff. Under the NRHM so far 435 Community Health Centre buildings have been taken for construction and another 1255 for renovation. States have been also used Finance Commission funds and State plan funds for construction of Community Health Centres.

In some states like Bihar and Jharkhand the gaps in Physical infrastructure are large and they require a speeder filling up this critical gap. States like Rajasthan and Orissa have had the Health System Project under which large number of buildings has been constructed.

NRHM has similarly undertaken the strengthening of District Hospital through construction and renovation. States like Gujarat and Rajasthan have managed to set up speedy implementation arrangements for Civil Works through an earmarked Engineering Cell. The pace of construction in a few States needs speeding up. One problem has been that state had large Finance Commission grants to spend and in many of them arrangements for large construction works from the Health department was not in place. Most State Governments have now resolved these issues. All State Mission teams have been sent to Gujrat to study the Infrastructure Implementation Unit that the State has set up for quality Civil Works. The resources for repair and maintenance of government health facilities are looking much better maintained, cleaner and with more resources to meet their physical infrastructure needs. NRHM is also supporting the sates for creation of new bed strengths in health facilities where case load is very high and where there is a requirement for creation of additional infrastructure. The State wise position with regard to physical infrastructure under NRHM is placed in the tables below.

Physical Infrastructure and its upkeep

1. NRHM provides for untied funds and maintenance grants to all government health facilities from Sub-centres, PHCs, CHCs, Sub District Hospitals.

2. All District Hospitals provided Rs.20 lakhs as initial grant for up-gradation of facilities to meet increased case load.

3. District Hospitals in the North Eastern region provided rupees one crore for hospital up-gradation of hospitals

4. All Community Health Centres provided Rs.20 lakhs for upgradation of facilities to meet increased case load.

5.9144 Sub-Centres for new construction and 8997 for renovation taken up under NRHM

6.1009 Primary Health Centre taken up for new construction and 2081 for renovation under NRHM.

7. 435 Community Health Centres for construction and 1255 for renovation taken up under NRHM, over and above the Rs.20 lakhs provided to all CHCs for initial renovation

8. besides initial grants to all District Hospitals, Rs. 5 lakhs every year to the Rogi Kalyan Samitis of District Hospitals have been provided. A total of 57 new District hospitals for renovation have been taken under NRHM.

Construction and renovation includes hospital buildings, quarters for doctors, nurses and paramedics etc.

S.No	**Name of the State/UTs under NRHM**	**Works taken up under NRHM**	**Works completed**
1	Andhra Pradesh	1004	279
2	Arunachal Pradesh	72	55
3	Assam	4951	1959
4	Bihar	890	75
5	Chhattisgarh	359	NA
6	Goa	-	-
7	Gujarat	463	170
8	Haryana	248	34

9	Himachal Pradesh	220	0
10	Jammu & Kashmir	127	68
11	Jharkhand	728	128
12	Karnataka	348	110
13	Kerala	284	188
14	Madhya Pradesh	1386	744
15	Maharashtra	5648	3793
16	Manipur	386	275
17	Meghalaya	121	81
18	Mizoram	179	173
19	Nagaland	31	18
20	Orissa	1940	338
21	Punjab	747	252
22	Rajasthan	766	314
23	Sikkim	15	8
24	Tamil Nadu	686	172
25	Tripura	280	91
26	Uttar Pradesh	4633	350
27	Uttarakhand	153	53
28	West Bengal	862	339

Table 2.1.1- Status of Physical Infrastructure construction work under NRHM.

The central government has so far supported only the construction/ upgradation of sub-centres. Because of their difficult financial conditions, the states have usually not provided sufficient funds for the construction/ upgradation of Primary Health Centre/ community Health Centre (CHC)/ District Hospitals etc. As a result, health infrastructure is in poor condition in most of the states. NRHM allows the expenditure for construction subject to the condition that it should not be more than 33% of the total NRHM outlay in the case of high focus states. NRHM also provides for up gradation of District Hospitals.

In the first cabinet approval, provision had been made for setting up of Indian Public health Standards (IPHS) only for Community Health Centres. The mission now provides for IPHS at all levels i.e., sub-Centres PHC/CHC and district hospitals.

As per original cabinet approval, untied grants were to be made available only to sub-centres. However, the Mission now proposes provisions for untied funds at PHC/CHC/District levels. A provision for taking up innovative schemes at district/state/central level has also been made. Having Rogi Kalyan Samitis for managing health facilities has already been approved by the cabinet. Now funds would be released as untied funds to these samitis as 100% grant by GOI during 2006-07, while it would be in the ratio 2:2:6 with regard to State/Internal/GOI from 11th Plan onwards.

The Mission also seeks to ensure the availability of requisite equipments and drugs at all the Public Health care facilities procurement of equipments/ drugs would be progressively decentralized and a road map prepared.

Infrastructure Development under NRHM

S.No.	Name of State/UT	
1	Andhra Pradesh	Andhra Pradesh has taken up 169 activities for infrastructure up-gradation in 2005-09 and 699 in 2009-10. A total of 279 civil works activities have been completed. It has proposed another 542 activities for 2010-11. This includes construction of Sub Centres, PHCs, up-gradation and extension of buildings in First Referral Units. 32 Birth Waiting Homes, strengthening of Maternity and Pediatric Centre and 8 Training Hostels for RCH Trainees, 88 FRUs and 144 Health Sub Centre buildings have been completed.
2	Arunachal Pradesh	Arunachal Pradesh has completed 50 of the 67 Sub Centres that it took up for construction under NRHM. It has also completed 5 PHCs under NRHM.
3	Assam	Assam has a large programme for construction. This includes construction of 1500 new Sub Centres, 100 new PHCs and 5 new District Hospitals. 538 new Labour Rooms for up-gradation to 24X7 deliveries has also been taken up. 122 units of six Bedded Wards in health facilities have also been taken up. 153 Doctors and Nurses quarters and 77 Rural Health Block pooling complexes have also been taken up. The construction of 236 Sub Centres and renovation of 998 Sub Centres has been completed in Assam. Similarly, construction of 4 PHCs and 622 renovation activities at PHCs has been completed. Renovation in 99 CHCs has also been completed. Renovation of GNM/ANM Schools, repair of quarters and up-gradation of District Hospitals have also been taken up on a large scale in Assam.
4	Bihar	Bihar has combined Civil Works under NRHM with State Plan and Finance Commission resources. A total of 749 new Sub Centres are being constructed. 75 Primary Health Centres work has been

		completed out of the 138 taken up. Construction of PHCs is in progress at 31 places. Renovation of 598 Sub Centres has also been completed. Progress in Bihar is unsatisfactory as the Medical Services Corporation which will also undertake construction activities is yet to receive approval of the State Cabinet.
5	Chhattisgarh	Chhattisgarh has taken up construction works very systematically. As per its assessment, 1365 Sub Centres, 57 Primary Health Centres, 10 Community Health Centres and 2 District Hospitals were without buildings at the beginning of 2010-11. Against this, the State is taking up 300 Sub Centres construction, all PHCs and 50% of the CHCs. Construction of 208 Labour Rooms, 26 Blood Storage Units and 25 Labour Rooms in CHCs have also been taken up in the State. The pace of construction need speeding up.
6	Goa	While the situation of infrastructure in Goa is satisfactory, renovation of 64 Sub Centres, 7 PHCs and 2 CHCs have been approved.
7	Gujarat	Gujarat has done very well on Civil construction under NRHM. Out of the 725 works taken up, 170 have already been completed. This includes 98 CHCs as per Indian Public Health Standards and 35 new Primary Health Centres.
8	Haryana	165 Sub Centres, 65 Primary Health Centres and 14 Community Health Centres have been taken up for new construction under NRHM in Haryana. A total of 22 Sub Centres, 11 PHCs and one CHC have been completed. Another 98 new buildings are likely to be completed by 30.06.2010.
9	Himachal Pradesh	The Himachal Government has taken up 117 Sub Centres and 103 Primary Health Centres for new construction.
10	Jammu & Kashmir	Jammu & Kashmir focused on the construction of 8 new District Hospitals. It has also taken up major renovation and construction of 39 Sub Divisional Hospitals and 12 District Hospitals. Besides this, by providing for Blood Banks in Community Health Centres/SDH, 68 CHCs/SDHs have been up-graded to IPH Standards. A number of District and Sub District Hospital building construction has also been completed.
11	Jharkhand	408 Sub Centre buildings, 172 PHCs and 148 CHC buildings have

		been sanctioned for new construction in Jharkhand so far. Of these, 127 Sub Centres and one CHC building has been completed. Many more buildings are nearing completion.
12	Karnataka	Karnataka took up a total of 348 new construction and renovation of Sub Centres, PHCs, CHCs, District Hospitals etc. Of these, 26 Sub Centre buildings and 84 up-gradation of District Hospitals and CHCs to IPH Standards has been completed. A large number of construction works are nearing completion. Besides this, Civil Works construction in Karnataka has also been taken up from the World Bank funded project. 133 Sub Centres, 16 PHC complexes, one ANM Training Centre and 22 renovation and repair of PHCs, CHCs have also been completed.
13	Kerala	New construction of buildings was taken up in 82 CHCs, 18 PHCs and 2 Sub Centres and major renovation was taken up in 54 CHCs and one PHC. 188 works have been completed so far.
14	Madhya Pradesh	A total of 772 Sub Centres, 99 PHCs and 49 CHCs have been taken up for construction under NRHM in the State budget in Madhya Pradesh to bridge the infrastructure gap. A total of 744 worksout of 1386 have been completed.
15	Maharashtra	Maharashtra took up a total of 5648 works for construction and major renovation. A total of 3793 works taken up for construction and renovation have been completed. These include 661 new Sub Centres, many PHCs, CHCs, SDHs and DHs.
16	Manipur	All 138 Health Sub Centres taken up for construction has been completed, 20 PHCs construction is under progress. Manipur has also completed the renovation of 137 Sub Centres.
17	Meghalaya	A total of 41 Sub Centres are under progress. 15 PHCs and 4 CHCs have been taken up for major renovation. 81 of the total of 121 works taken up in Meghalaya has been completed.
18	Mizoram	158 Sub Centre construction, 12 PHCs and 3 CHCs are under progress. Renovation of 6 CHCs has been completed.
19	Nagaland	25 Sub Centres, 5 PHCs and one CHC have been taken up for construction in Nagaland.

20	Orissa	Orissa has completed new construction of 39 Labour Rooms and renovation of another 133 Labour Rooms. 40 Staff Quarters, 116 renovations of Sub Centres, 7 SNCUs and one District level Drug Warehouse has been completed. The pace of Civil Work construction was slow in the beginning but has now picked up.
21	Punjab	Punjab has taken new construction of 216 Sub Centres, 4 PHCs and one CHC. It has also renovated 227 Sub Centres, 188 PHCs and 111 CHCs.
22	Rajasthan	Rajasthan has taken up new construction of 541 Sub Centres, Residential Quarters in 105 PHCs and Residential Quarters in 336 Community Health Centres. It also took up renovation in 1021 Sub Centres, 495 PHCs and 178 CHCs. It has completed construction in 73 CHCs, 138 PHCs and 103 Sub Centres.
23	Sikkim	Sikkim has completed construction of 3 Sub Centres, 3 PHCs and 2 CHCs.
24	Tamil Nadu	Tamil Nadu has used NRHM infrastructure funds for up-gradation of PHCs. A total of 110 Primary Health Centres have been completed out of the 125 taken up. Similarly, 10 new PHC buildings have been completed out of the 110 taken up. Of the works taken up in 2009-10, 12 new PHCs, 12 FRUs, 8 renovation of Sub District Hospitals and 20 Pay and Use Toilets have already been completed.
25	Tripura	43 Sub Centre buildings out of 120 have been completed. 12 out of 77 PHC constructions are complete and one out of 7 CHC constructions has been completed. Other works are at an advance stage of completion.
26	Uttar Pradesh	Uttar Pradesh took up construction of 2908 Sub Centre buildings and 33 new CHCs. It has also taken up up-gradation of 50 CHCs. 350 works have been completed so far.
27	Uttarakhand	Uttarakhand has used NRHM funds to renovate 4 ANM Training Schools which had closed down. It has also renovated 149 Sub Centres to IPH Standards.
28	West Bengal	West Bengal took up physical infrastructure up-gradation in a systematic manner using NRHM and other external funds. A total of 60 Block PHCs have been up-graded. Similarly, 108 PHCs have also

		been up-graded and another 117 have been taken up for up-gradation. A total of 1654 Sub Centre buildings have also been taken up for construction. Besides this, renovation and construction of Staff Quarters at Block PHCs have been taken up. Gram Panchayat headquarter Sub Centres in 2003 places have also been taken up in various phases for construction and completed. 315 Health Sub Centre buildings out of 803 taken up under NRHM have been completed.

Table 2.1.2- Infrastructure in 28 States as on April 2010

(B) HUMAN RESOURCE

Since the launch of the Community Development Programme in 1951, India has gradually developed a vast public health infrastructure, which currently includes 142 655 sub-centres, 23 109 primary health centres (PHCs) and 3222 community health centres (CHCs), providing services to 742.49 million rural people (72.2% of the country's population). Besides, over 5479 subdivisional and district hospitals and other specialized hospitals are also in the public sector. The population coverage norms are 3000/5000 per sub-centre, 20 000/30 000 per PHC and 80 000/120 000 per CHC respectively, depending on whether the centre is in a hilly, tribal, difficult area or in the plains. The private sector plays a big role in the delivery of health care, catering to 46% of hospital inpatients and 81% of outpatients. There also are large numbers of practitioners of AYUSH (ayurveda, yoga and naturopathy, unani, siddha and homoeopathy – acronym for the Indian systems of medicine and homoeopathy) in the country.

Despite the well-developed administrative system, good technical skills in many fields and an extensive network of public health institutions for training, research, diagnostics and other services, the health outcome is still behind the set goals. There has been increasing recognition of the powerful influence that health care providers have on health care provision and use of health care resources. The existence and quality of services to promote health, prevent illness or to cure and rehabilitate depend on the knowledge, skills and motivation of human resources for health. The only route to attaining any health goal: Millennium Development Goal (MDG); National Health Policy (NHP) 2002, and 10th Plan goals) is through the worker and there is no shortcut. The health system requires getting the right number of service providers with the right skills to the right place at the right time5. Despite the vast institutional network and diverse human resource, that includes physicians, AYUSH practitioners, dentists, nurses, midwives, pharmacists, technicians, and community health workers, the public health system in India suffers from shortages, imbalances, mal-distribution, poor work environments, low productivity of personnel, vacant posts, high staff turnover, loss of personnel to private sector, and migration of health personnel to urban areas or overseas. Information on health workforce is sparse, available data are fragmentary and the research is limited.

Human Resource under NRHM

Human Resource under NRHM (after 5 years)

Sl. No.	State / UTs	Contractual Manpower					
		Specialist	Doctor	AYUSH Doctor	Staff Nurses	ANM	Para medical
High Focus Non - NE States							
1	Bihar	381	1763	0	3000	6000	0
2	Chhattisgarh	0	369	325	208	0	
3	Himachal Pradesh	21	315	0	239		237
4	Jammu & Kashmir	44	228	388	346	375	508
5	Jharkhand	19	1710	50	407	3204	880
6	Madhya Pradesh	55	161	0	0	1497	
7	Orissa		18	1283	760	703	36
8	Rajasthan	43	120	1042	3704	2429	7423
9	Uttar Pradesh	189	0	428	2250	1411	138
10	Uttarakhand	0		140	175	177	
High Focus NE States							
11	Arunachal Pradesh		57	21	196	158	0
12	Assam	117	986	232	2112	4575	687
13	Manipur	0	37	73	81	420	621
14	Meghalaya	3	12	49	44	141	24
15	Mizoram	0	36	15	178	373	53
16	Nagaland	1	80	22	143	302	41
17	Sikkim	0	43	2	41	71	15
18	Tripura	0	38	69	0	55	31
Non High Focus States - Large							
19	Andhra Pradesh	0		689	121	9505	118
20	Goa	2	0	19	0	47	0
21	Gujarat	865	554	773	271		283
22	Haryana	26	0	137	1145	2294	260
23	Karnataka	59	514	723	3670	1126	98
24	Kerala	19	673	225	1862	0	2448
25	Maharashtra	502	0	426	830	6476	36
26	Punjab	44	148	207	912	1569	44
27	Tamil Nadu	0	385	299	3932	0	0
28	West Bengal	29	54			2871	51
Non High Focus Smalls & UTs							
29	A & N Island	3	23	19	21	81	112
30	igarh	0	9	4	19	75	94
31	D & N Haveli	0	5	7	6	34	34
32	Daman & Diu	4	1	1	0	0	3
33	Delhi	29	266	0	73	630	200
34	Lakshadweep	0	13	0	14	14	13
35	Puducherry	5	6	24	33	77	2
	Total	2460	8624	7692	26793	46690	14490

Table 2.1.3- Human resource under NRHM (after 5 years)

Human resource reforms in States with unsatisfactory indicators

	State	Key human resource reforms after NRHM
	Assam	- Compulsory rural posting of doctors in rural areas - 768 doctors posted in rural areas on a single day. - 4575 ANMs recruited on contract. - 2112 Staff Nurses recruited on contract. - 986 Medical Officers recruited on contract. - 687 Paramedics recruited on contract. - 117 Specialists recruited on contract. - 232 AYUSH doctors recruited on contract. - 14 MOs trained for emergency Anaesthesia.
	Bihar	- New cadre rules providing for Specialists' cadre and timely promotion of doctors after 6, 12 and 18 years framed and approved. - 6000 ANMs recruited on contract after 15 years. - ANM Training Schools re-started after many years. - 3000 Staff Nurses recruited on contract after 15 years. - Doctors pooled together at Block PHCs to provide guaranteed services. APHCs being re-operationalized now. - 56 MBBS doctors trained for emergency Anaesthesia and 40 trained for emergency obstetric care.
	Chhattisgarh	- Mitanins (Community Health Workers) being admitted to ANM Training Schools. - 790 Rural Medical Assistants (RMAs) have been recruited on contract. They work under the supervision of an MBBS doctor. - 44 MBBS doctors trained for emergency anaesthesia. - Chhattisgarh Rural Medical Corps launched to provide incentives (monetary and non-monetary) for serving in naxalite affected areas.
	Jharkhand	- Over 900 MBBS doctors selected for regular appointment through Public Service Commission after 18 years. - 3204 ANMs on contract. - 407 Staff Nurses on contract. - Doctors with PG degrees brought o functional DH, SDH and Block hospital.
	Madhya Pradesh	- Compulsory rural posting of Specialists enforced. - SC/ST women supported in nursing education in private institutions. - 7 MBBS doctors trained for emergency anaesthesia and 40 trained for emergency obstetric care. - 1497 ANMs on contract. - 161 Medical Officers recruited on contract.
	Orissa	- 1406 AYUSH doctors posted to PHCs to meet shortage of MBBS doctors –trained to manage National Health Programmes.

		- ANM school in-take enhanced by 50 percent. - 703 ANMs on contract. - 89 MBBS doctors trained for emergency anesthesia and 39 trained for emergency obstetric care. - 760 Staff Nurses appointed on contract. - Monetary incentives for working in KBK region.
	Rajasthan	- 2429 ANMs recruited on contract. - Rajasthan Rural Health Service constituted for rural doctors. - Desert and tribal area allowance in postings. - 3704 Staff Nurses on contract. - 120 MBBS doctors on contract. - 7423 paramedics on contract.

2.1.4- Human Resource Reforms in states with unsatisfactory indicators

While it is true that human resource is one of the biggest challenges in NRHM, it must be acknowledged that after many years, NRHM has brought the thrust on human resources centre stage. This has involved large scale adoption of good practice and efforts at attracting doctors, nurses and para medics for government work. Major changes have been effected in performance based payment systems to ensure that health workers receive higher amounts of blended payments – fixed and performance based. The failure of the World Bank funded Health Systems projects on account of lack of attention to human resources has shaped the structure of NRHM. A separate thematic workshop on human resources in health was organized in November 2008 at Puducherry to discuss the HR issues. Regular systems of reviews and pressure on States for reform in the management of human resource for health have led to significant measures being taken. Post graduate admission preference after serving in rural areas has been incorporated in the rules of a large number of States. PG seat seems to be a very effective method of attracting doctors to rural areas for a fixed period as PG admission seems to be a priority for many of them. New courses like the LSAS and EmOC training programmes to skill MBBS doctors are innovative solutions to find Specialists. Recognizing PG students as Specialists in States where there are no cadre of Specialists has been another effort under the NRHM. Higher gross emoluments on contract to doctors willing to serve in rural areas has also been a principle that has been followed in many States with good results. Haryana has introduced the innovative system of recruitment of doctors in districts every month and confirmation by the Public Service Commission after district level recruitment. This cuts down the selection time through the public service commissions. It is reform of this kind that holds hope.

The pressure of human resource under NRHM has also now led to amendments in MCI regulation allowing for a larger number of PG seats and for simplification of procedures for opening new Medical Colleges in deficient States. These efforts will take a little while but hold the promise of meeting human resource challenges of rural India.

The thrust on nursing institutions and studies to understand the critical constraints in states like Bihar and Orissa are some other meaningful efforts under the NRHM for human resources. The

three year Rural Health Practitioner course in Assam and the Rural Medical Assistants in Chhattisgarh are also experiments that will address the human resource challenges. West Bengal's novel system of letting the Gram Panchayat select a local woman to become the 2nd ANM and sending her for 18 month training is also a good one as it ensures a resident ANM in remote areas. The continuous efforts at skill development among the ASHAs and systems of getting them priority admission to ANM and nursing schools will be able to secure resident health workers in remote areas.

(C) REACHING OUT TO REMOTE AREAS, MOBILE MEDICAL UNITS AND REFERRAL TRANSPORT SYSTEMS UNDER NRHM

Access to health care and equitable distribution of health services are the fundamental requirements for achieving the Millennium Development Goals and the goals set under the National Rural Health Mission (NRHM) launched by the Government of India in April 2005. Many areas in the Country, predominantly tribal and hilly areas, even in well-developed States, lack basic health care infrastructure limiting access to health services at present. Over the years, various initiatives have been taken to overcome this difficulty with varied results. Many States/NGOs have successfully tried out operationalizing Mobile Medical Units. Taking health care to the doorsteps is the principle behind this initiative and is intended to reach underserved areas. Under the NRHM, provision of Mobile Medical Unit (MMU) in each District is one of the strategies to improve access. For North Eastern States, Himachal Pradesh and J&K, due to their difficult hilly terrain, non-approachability by public transport, and long distances for reaching the health centres necessitate the need of MMU with specialised facilities for the patients requiring basic specialist examination. Otherwise, the basic purpose of taking the health care to the door step of the needy people in rural areas would be defeated due to non-possibility of diagnostic examination to be conducted. The States are expected to address the diversity and ensure the adoption of the most suitable and sustainable model for the MMU to suit their local requirements\. States are also required to plan for long term sustainability of the intervention. The objective is to operationalize MMUs in every district across the country for improved access to health care services & to make health care's services available in underserved areas. Every MMU has to provide Curative (Referral of complicated cases, early detection of TB, Malaria, Leprosy, Kala-Azar, and other locally endemic communicable diseases and non-communicable diseases such as hypertension, diabetes and cataract cases etc, Minor surgical procedures and suturing, Specialist Services such as O&G Specialist, Paediatrician and Physician. Reproductive & Child), Curative (Referral of complicated cases, Early detection of TB, Malaria, Leprosy, Kala-Azar, and other locally endemic communicable diseases and non-communicable diseases such as hypertension, diabetes and cataract cases etc, Minor surgical procedures and suturing, Specialist Services such as O&G Specialist, Paediatrician and Physician. Reproductive & Child Health Services, Ante-natal check up and related services e.g. injection - tetanus toxoid, iron and folic acid tablets, basic laboratory tests such as haemoglobin, urine for sugar and albumin and referral for other tests as required, Referral for complicated pregnancies, Promotion of institutional delivery, Post-natal check up, Immunization clinics (to be coordinated with local Sub-centres/PHCs, Treatment of common childhood illness such as diarrhea, ARI/Pneumonia, complication of measles etc, Treatment of RTI/STI, Adolescents care such as lifestyle education,

counseling, treatment of minor ailments and anemia etc), Family Planning Services (Counselling for spacing and permanent method, Distribution of Nirodh, oral contraceptives, emergency contraceptives, IUD insertion), Diagnostic(Investigation facilities like haemoglobin, urine examination for sugar and albumin, Smear for malaria and vaginal smear for trichomonas, Clinical detection of leprosy, tuberculosis and locally endemic diseases, Screening of breast cancer, cervical cancer etc), Specialised facilities and services (X-ray, ECG, Ultrasound test, Emergency services and care in times of disaster/epidemic/ public health emergency/ accidents etc, IEC Material on health including personal hygiene, proper nutrition, use of tobacco, diseases, PNDT Act etc., RT/STI, HIV/AIDS).

MOBILE MEDICAL UNITS (after 5 years of NRHM)

	STATE / UT	MMUs UNDER NRHM	MMU UNDER OTHER PROGRAMMES
A	HIGH FOCUS STATES		
1.	BIHAR	25	0
2.	CHHATISGARH	-	-
3.	JHARKHAND	90	0
4.	MADHYA PRADESH	91	0
5.	RAJASTHAN	25	7
6.	ORISSA	171	-
7.	UTTAR PRADESH	0	0
8.	UTTARAKHAND	17	13
9.	JAMMU & KASHMIR	0	0
10.	HIMACHAL PRADESH	0	0
11.	ASSAM	27	0
12.	ARUNACHAL PRADESH	16	0
13.	MANIPUR	9	0
14.	MEGHALAYA	7	0
15.	MIZORAM	9	0
16.	NAGALAND	11	0
17.	TRIPURA	4	0
18.	SIKKIM	4	0
B.	NON HIGH FOCUS STATES		
1.	ANDHRA PRADESH	30	475
2.	GOA	2	0
3.	GUJARAT	85	0
4.	HARYANA	6	0
5.	KARNATAKA	12	19
6.	KERALA	0	7
7.	MAHARASHTRA	2	0
8.	PUNJAB	24	15
9.	TAMIL NADU	385	6
10.	WEST BENGAL	0	6
11.	ANDAMAN & NICOBAR	0	0
12.	CHANDIGARH	2	0
13.	D & N HAVELI	1	0

14.	DELHI		
15.	DAMAN AND DIU		
16.	LAKSHADWEEP		
17.	PUDUCHERRY		
	HIGH FOCUS STATES	506	20
	NON HIGH FOCUS STATES	525	528
	TOTAL (A+B)	1031	548

2.1.5- MMUs after 5 years of NRHM

NATIONAL RURAL HEALTH MISSION
EMERGENCY TRANSPORT SYSTEM AND AMBULANCES

	STATE / UT	EMERGENCY TRANSPORT SYSTEM – 102, 108, Janani Express, other systems of referral transport.	PROVISION OF AMBULANCES AT PHC/CHC/SDH/DH
A	HIGH FOCUS STATES		
1.	BIHAR	10 PLUS OVER 500 PRIVATE AMBULANCES ON CHARGE BASIS	
2.	CHHATISGARH		166
3.	JHARKHAND		359
4.	MADHYA PRADESH	100	
5.	RAJASTHAN	164	
6.	ORISSA	234	162
7.	UTTAR PRADESH		
8.	UTTARAKHAND	105	
9.	JAMMU & KASHMIR		125
10.	HIMACHAL PRADESH		
11.	ASSAM	280	650
12.	ARUNACHAL PRADESH		34
13.	MANIPUR		
14.	MEGHALAYA	30	28
15.	MIZORAM		50
16.	NAGALAND		55
17.	TRIPURA		
18.	SIKKIM		31
B.	NON HIGH FOCUS STATES	EMERGENCY TRANSPORT SYSTEM – 102, 108	PROVISION OF AMBULANCES
1.	ANDHRA PRADESH	752	
2.	GOA	18	
3.	GUJARAT	400	
4.	HARYANA	319	
5.	KARNATAKA	517	
6.	KERALA		
7.	MAHARASHTRA		
8.	PUNJAB		
9.	TAMIL NADU		
10.	WEST BENGAL		
11.	ANDAMAN & NICOBAR		7+7
12.	CHANDIGARH		
13.	DADRA AND NAGAR		

14.	DELHI		
15.	DAMAN AND DIU		
16.	LAKSHADWEEP		
17.	PUDUCHERRY		
	HIGH FOCUS STATES	913	1660
	NON HIGH FOCUS STATES	2006	7+7
	TOTAL (A+B)	2919	1674

2.1.6- Emergency Transport System & Ambulances under NRHM

2.2 Methodology:

Type of study- A Retrospective study (Literature Review)

Strategy- The approach is to compile the data, literature available, reviews, various studies to analyse the improvement in issues related to infrastructure after inception of NRHM as it has completed 5 years. NRHM has also invested in improvement of physical infrastructure, provision of equipment and putting in place emergency and referral transport to reach every village of the country. For, any system infrastructure functions as a backbone. I am analyzing the progress made in this issue after the inception of NRHM.

Methods- The overall study is conducted to analyse the progress of Infrastructure under NRHM. For this the progress under each year is compared to the baseline data before the inception of NRHM. The progress is analysed comparatively.

Data collection
The study is based on secondary data; the sources are Ministry of Health & Family Website, published data CRM 1, CRM 2, CRM 3, RHS surveys (statistics division) for various years, Annual Progress Reports, MIS for NRHM, Data Bulletins for NRHM, Desk Review information, and various articles.

Data analysis
Data entry and analysis of quantitative data was conducted in soft form of excel sheets

2.3: Results & Finding of Project

PRIMARY HEALTH CARE INFRASTRUCTURE

AND HUMAN RESOURCES IN HEALTH SUB CENTRES, PHCs, CHCs

COMPARISON OF RHS 2005 WITH PRELIMINARY RESULTS OF RHS 2009

	INFRASTRUCTURE/HUMAN RESOURCE	2005	2009
1.	NUMBER OF HEALTH SUB CENTRES	1,46,026	1,46,378

2.	HEALTH SUB CENTRES IN GOVERNMENT BUILDINGS	63901	78846
3.	ANMs AT HEALTH SUB CENTRES/PHCs	1,39,798	1,87,902
4.	PHCs IN GOVERNMENT BUILDINGS	16023 OUT OF 23236	20236 OUT OF 23474
5.	DOCTORS AT PHCs	20308	24085 PLUS 6323 AYUSH DOCTORS
6.	NUMBER OF CHCs	3346	4385 (31% INCREASE)
7.	SPECIALISTS AT CHCs	3550	5062
8.	GDMOs OTHER DOCTORS AT CHC	NA	5368 MBBS GDMOs PLUS 1569 AYUSH DOCTORS
9.	NURSE MIDWIFE AT PHC/CHC	28930	46903
10.	LAB TECHNICIANS AT PHCs/CHCs	12284	12941 (OUTSOURCING IN STATES LIKE BIHAR, WB)
11.	PHARMACISTSATPHCs/CHCs	17708	21003
12.	RADIOGRAPHERS AT CHCs	1337	1886

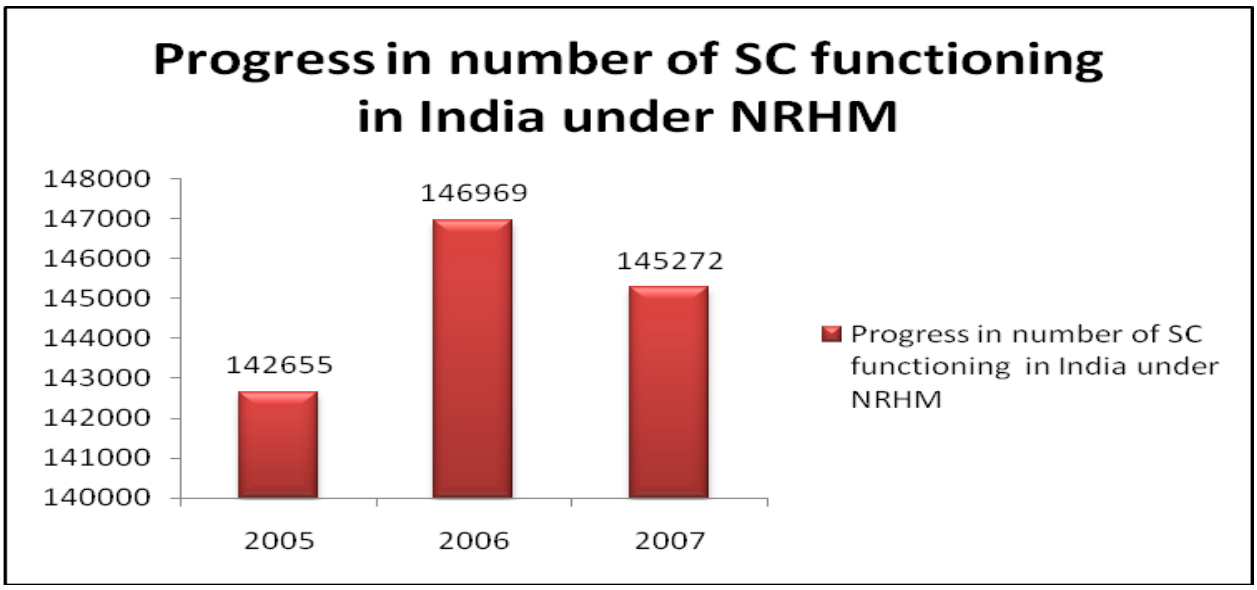
2.3.1- Comparative Infrastructure (RHS 2005 & RHS 2009)

An Analysis of Progress in Physical Infrastructure-

Health sub-centre is the first contact point between the community and the Public health care delivery system of our country. There are norms in our system for these sub-centers such as for population coverage, human resource & health services provided. The Sub-center has to cover 3000/5000 depending on whether the area is hilly, tribal, difficult area or in plane. There were 142655 SC in our India which gradually increased to 146969 in 2006 and as on the time RHS 2007 was declared the number reported was 145272. The number decreased from 2006 to 2007 as many SC were converted to PHC. The SC in India is both in government and rented buildings. The centres which are in government building are receiving annual maintenance grants for the maintenance so that the health services are provided as per standards. Before the inception of

2.3.1- Graph- Progress in number of SC functioning in India under NRHM

NRHM that is in beginning of 2005 the number of SC was 146026 which have now reached to 14678(as per RHS 2009). This increase is only due to the unique strategies of NRHM, though the



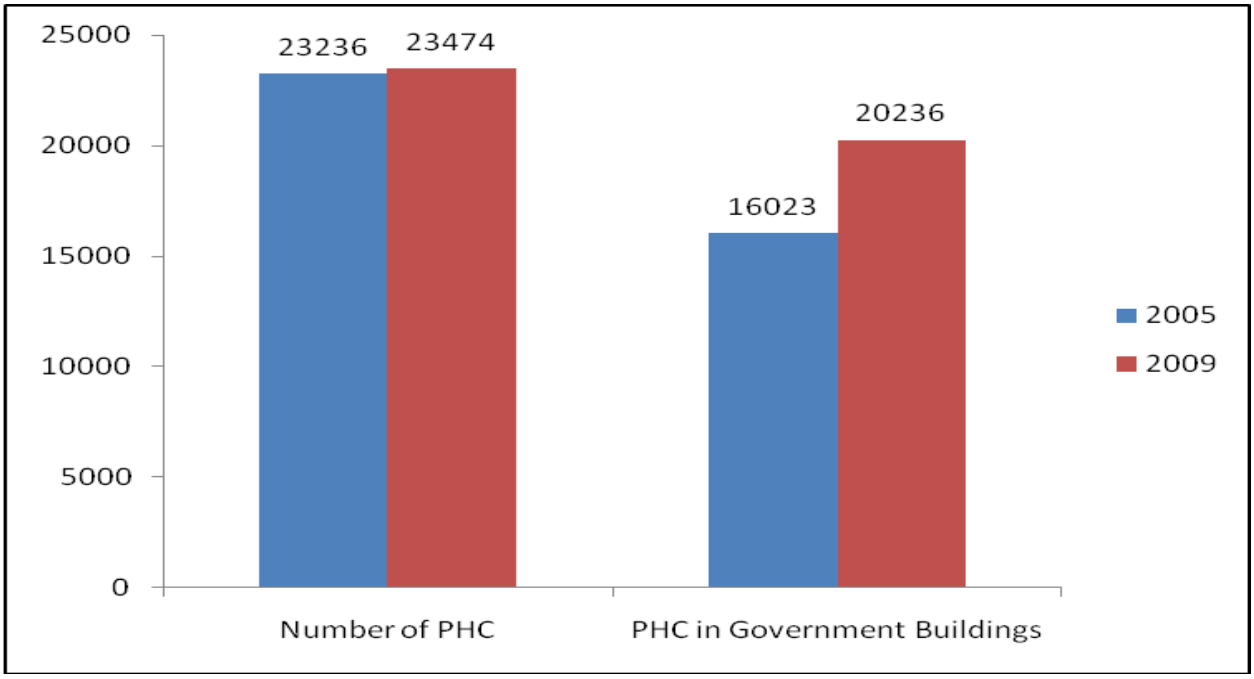
increase is not very much but still it gives some hope to our health care system. Among them 63901 were running in government buildings in 2005 and in 2009 a total of 78846 were providing health services in government building.

If we look at the increase year wise we can see the increase though very meager is very uniform. The government could provide enough buildings for establishing these sub-centers in government buildings.

Number of Sub-Centre functional under NRHM	
2005 (as on September 2004)	142655
2006 (as on March 2005)	146969
2007 (as on March 2006)	145272

2.3.2- Number of SC functional under NRHM

The norms for PHC says that it should provide health care services to 20000/30000 people depending on whether it lie in hilly, tribal, difficult area or in plane. At present there are 23474 PHC out of which 20236 are in government building. In 2005 there were 16023 PHC who were running in government building out of 23474.

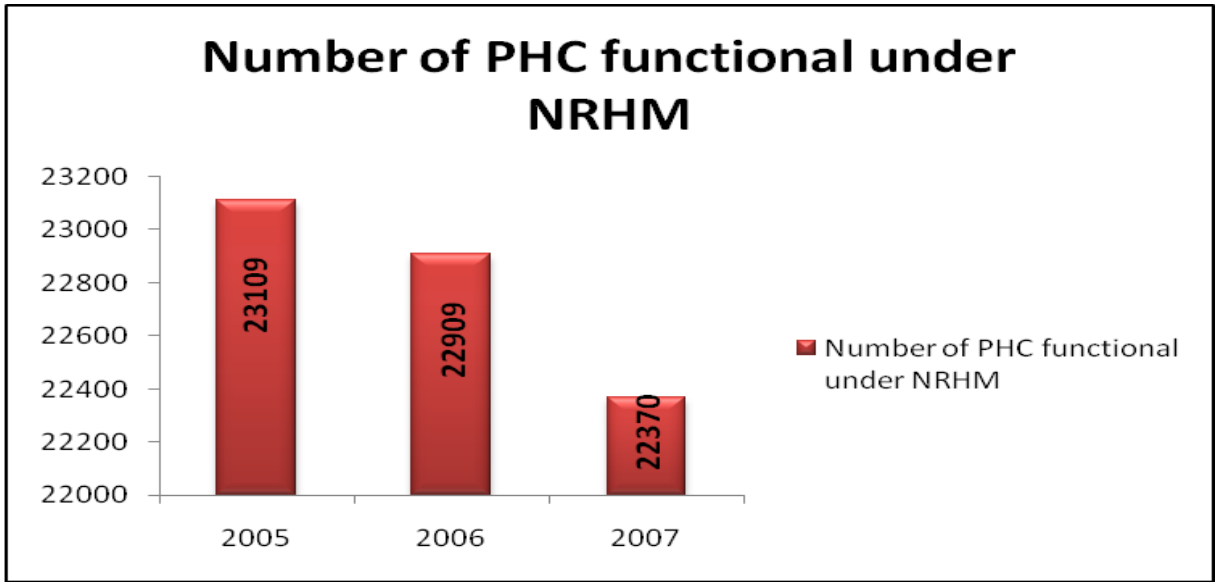


2.3.2- Graph- Comparative analysis of PHC(RHS 2005 & RHS 2009)

The data is very different in RHS, as it can be seen from the graph below the number of these facilities actually decreased and this decrease is quiet steep.

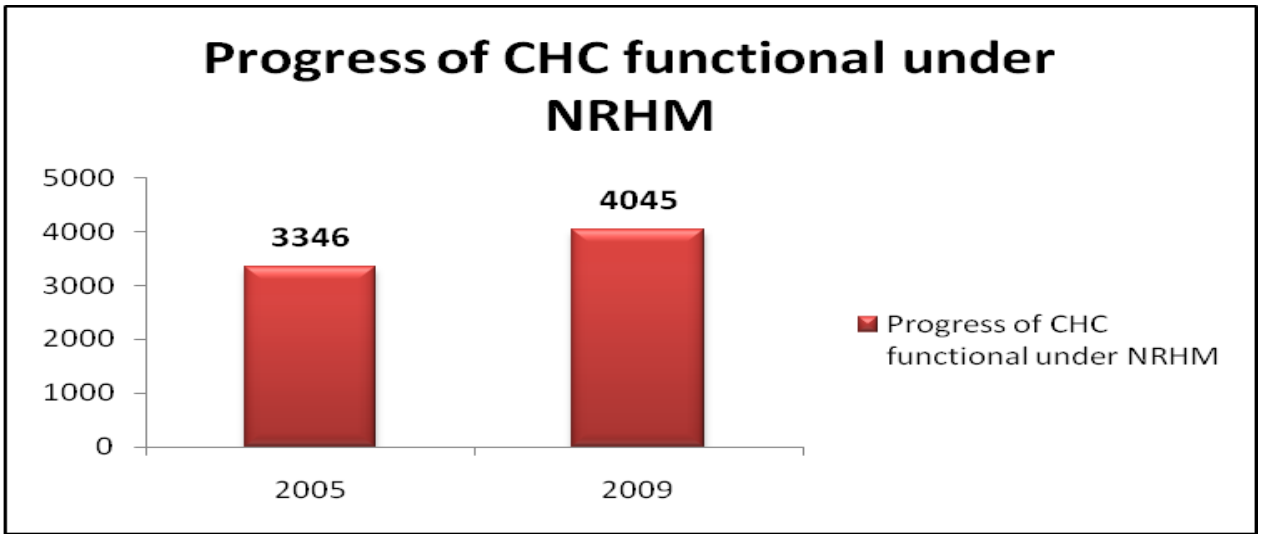
Number of PHC functional under NRHM	
2005 (as on September 2004)	23109
2006 (as on March 2005)	22909
2007 (as on March 2006)	22370

2.3.3- Comparative Analysis of PHC across years



2.3.3- Comparative Analysis of PHC across years)

The growth of CHC is quiet remarkable, there is a total of 31% increase in the number of CHC, there were 3346 CHC in 2005 and the number increased to 4385 in 2009 all due to the efforts of NRHM.

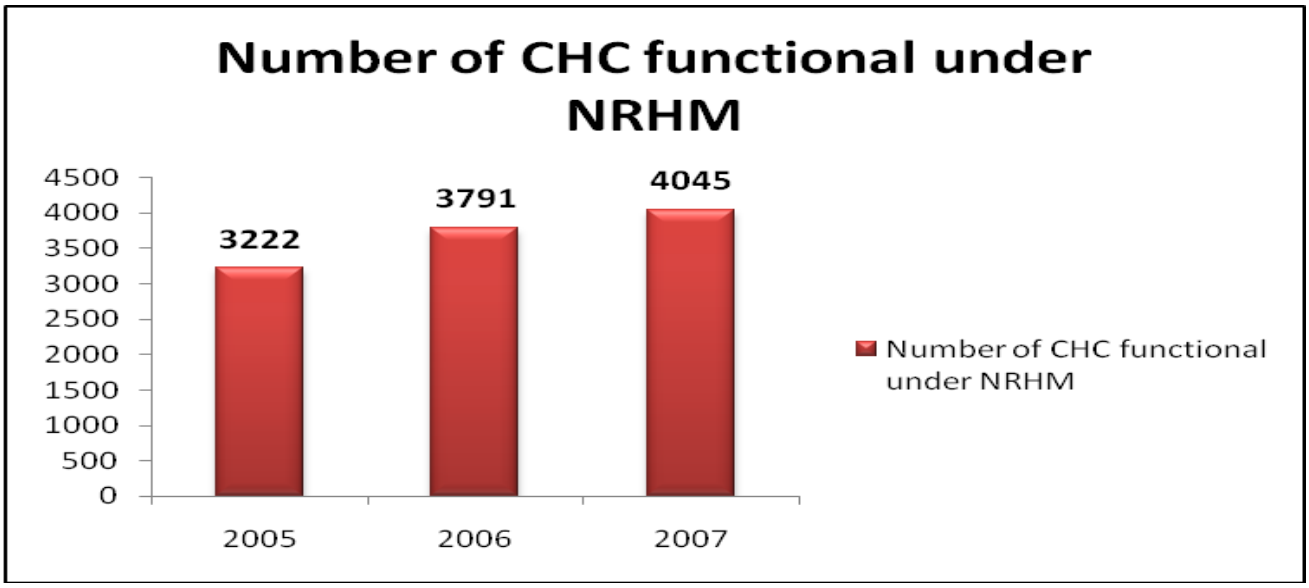


2.3.4- Progress of CHC functional under NRHM

The growth was visible even after the initial few years of the mission, within initial 1 year the number was increased by 15% followed by a growth of 6.09% in 2nd year of the mission. The efforts were to provide the blocks with fully functional CHC so that they could work as complete referral centres to all below health facilities. A lot of work is also been done on upgradation of these facilities to enable them to provide health care services. The facilities have also received enormous funds to achieve IPHS standards for the same a lot of renovation has also been done in these facilities.

Number of CHC functional under NRHM	
2005 (as on September 2004)	3222
2006 (as on March 2005)	3791
2007 (as on March 2006)	4045

2.3.4- number of CHC functional across years



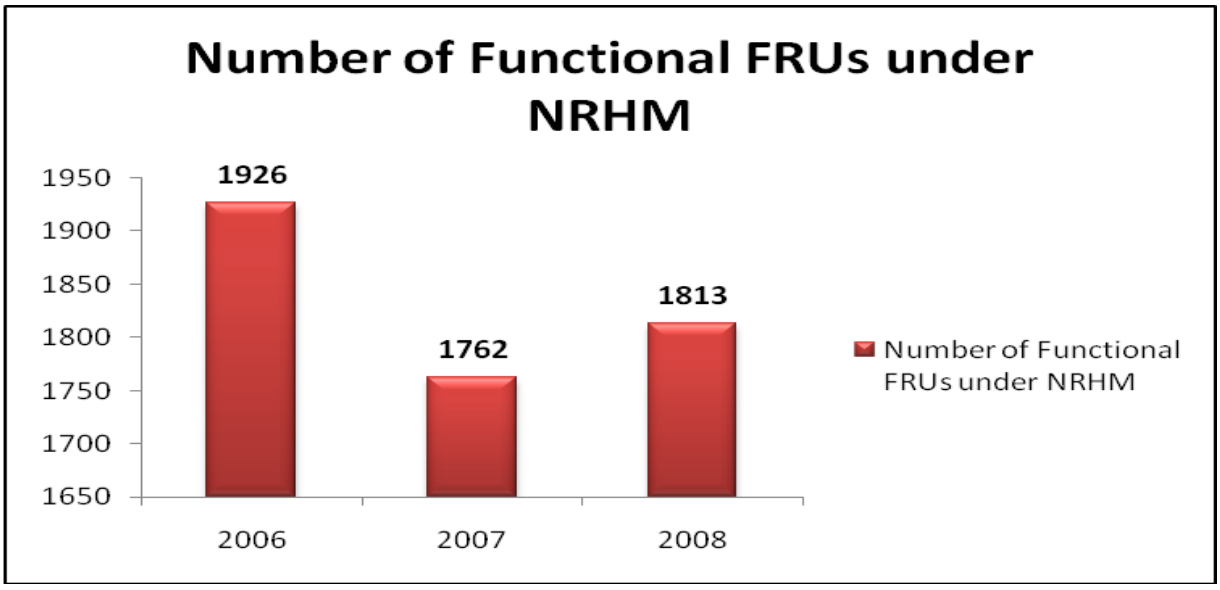
2.3.5- Number of CHC functional across years

Number of frus developed

Number of Functional FRUs under NRHM	
2006	1926
2007	1762
2008	1813

2.3.5- number of FRUs developed across times

As per RHS the number of FRUs have decreased in years



2.3.6- Number of functional FRUs under NRHM

As clearly visible the FRU increased from 2007 to 2008, the concept of FRU was to establish First referral units for each facility so that the patients who are referred could avail health care

services as required. The exact number of FRU available now could not be known. So it could be concluded that maximum positive results is achieved in terms of construction of CHC across the country. The progress is also in terms of other facilities but the comparative picture is quiet in favour of CHC.

An Analysis of Progress in Human Resource-

Human Resource under NRHM	2005	2009
ANMs at Health Sub-centres/PHC	139798	187902
Doctors at PHCs	20308	24085
Specialists at CHCs	3550	5062
GDMOs other doctors at CHC	NA	5368 MBBS GDMOs Plus 1569 Ayush Doctor
Nurse Midwife at PHC/CHC	28930	46903
Lab-Technicians at PHCs/CHCs	12284	12941 (out sourcing in states like Bihar, WB)
Pharmacist at PHCs/CHCs	17708	21003
Radiographers at CHCs	1337	1886

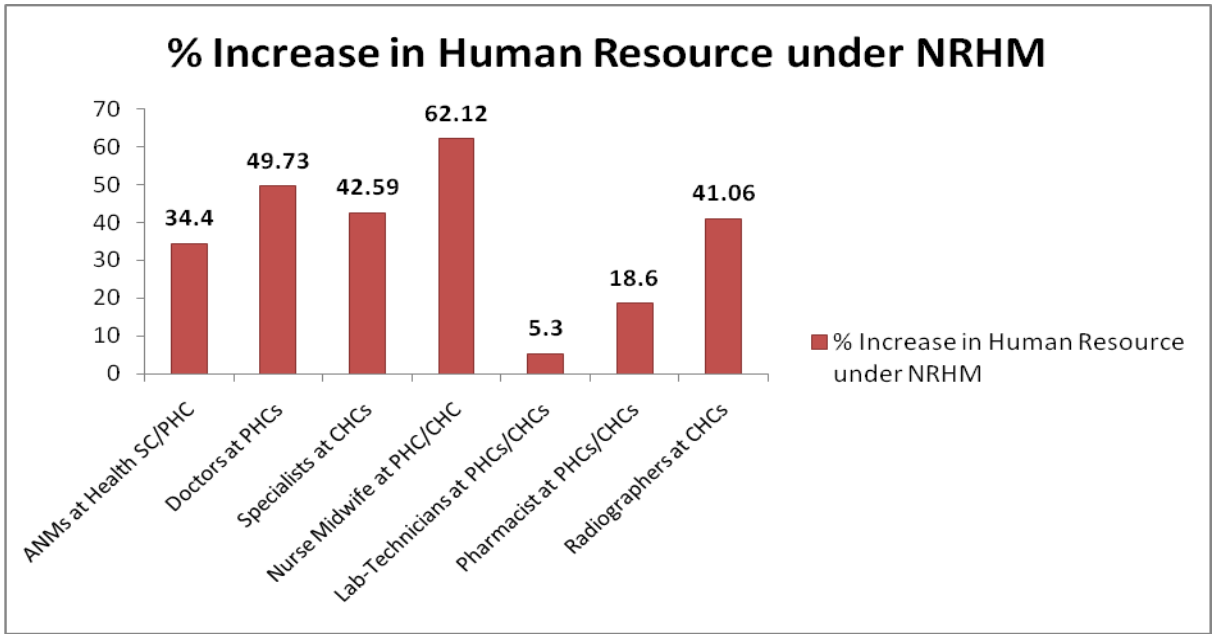
2.3.6- analysis of Progress in Human Resource

The table above clearly throws light on the focus of policy makers on the importance of well trained staff. There was and still a darth of well qualified and skilled manpower in health sector specially in public health care delivery system in our country. To fulfill these shortfall special posts, training modules, promotion schemes, monetary, non-monetary incentives are been developed to encourage people to work in rural areas. In last 5 years the mission put its best foot forward by realizing that human resource and its management is the most important and difficult aspect which is essential for the success of any organization. Till now a lot has been achieved in this regard and a lot has still to be achieved.

S.no	Human resource issue	% change
1	ANMs AT HEALTH SUB CENTRES/PHCs	34.40
2	DOCTORS AT PHCs	49.73
3	Specialist at CHCs	42.59
4	Nurse Midwife at PHC/CHC	62.12
5	Lab-Technicians at PHCs/CHCs	5.3
6	Pharmacist at PHCs/CHCs	18.60
	Radiographers at CHCs	41.06

2.3.7- % change in Human Resource

The maximum recruitment is done in the case of Nurse Midwife at PHC/CHC showing a progress of 62.12 %, followed by posting a doctor at CHCs, on analysis it is observed that the number of specialist in CHCs have increased by 42.59 %. Improvement in the number of Radiographers at CHCs, specialist at CHCCs, ANMs at health sub-centre, Pharmacists at PHCs/CHCs, is 41.06%, 43.59%, 34.40%, 5.3% respectively.



2.3.7- % Increase in Human Resource under NRHM

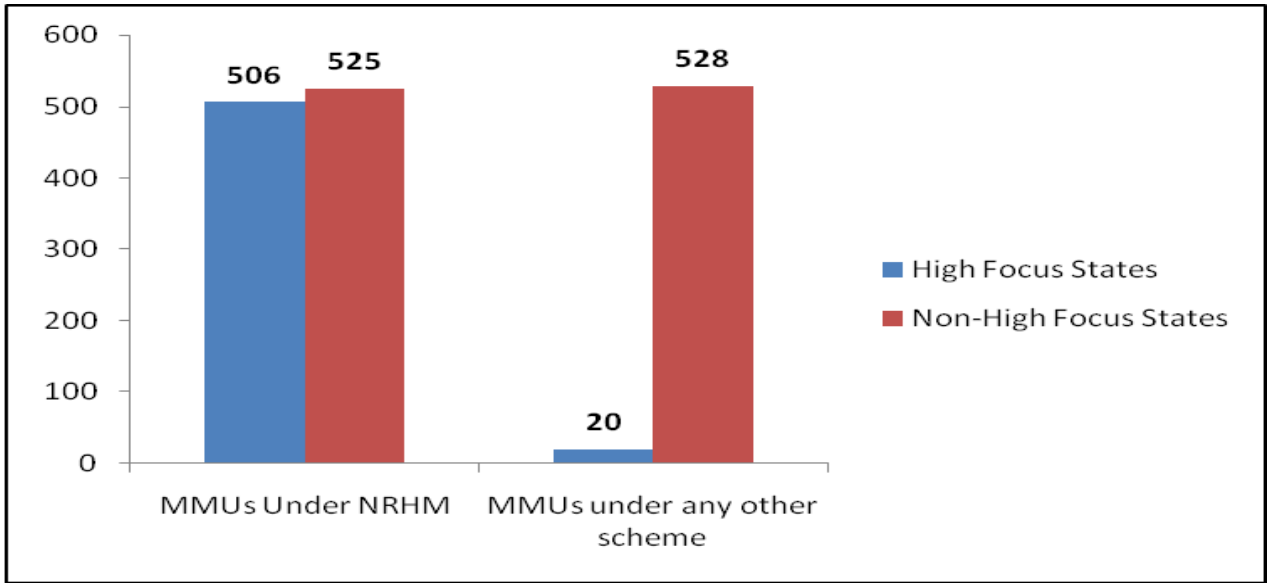
A Novel concept- MMU

Category of state/UT	MMUs under NRHM	MMUs under any other scheme
High focus states	506	20
Non-High focus states	525	528

2.3.8- MMUs in High Focus states & Non-high focus states

Many areas in the Country, predominantly tribal and hilly areas, even in well-developed States, lack basic health care infrastructure limiting access to health services at present. Over the years, various initiatives have been taken to overcome this difficulty with varied results. Many States/NGOs have successfully tried out operationalizing Mobile Medical Units. Taking health care to the doorsteps is the principle behind this initiative and is intended to reach underserved areas. Under the NRHM, provision of Mobile Medical Unit (MMU) in each District is one of the strategies to improve access. The states have arranged MMUs under NRHM as well as under other schemes whichever possible and feasible.

If we look at this progress in states under the terms of high focus and non high focus states we could make out that the number is far higher in non-high focus state, though our major resource junk and concentration goes on high focus states. Also to mention that in non-high focus state the majority of MMUs have been arranged in schemes which are other than NRHM.
This is quiet visible in the graph below:



2.3.8- MMUs in high focus states & Non-high focus states

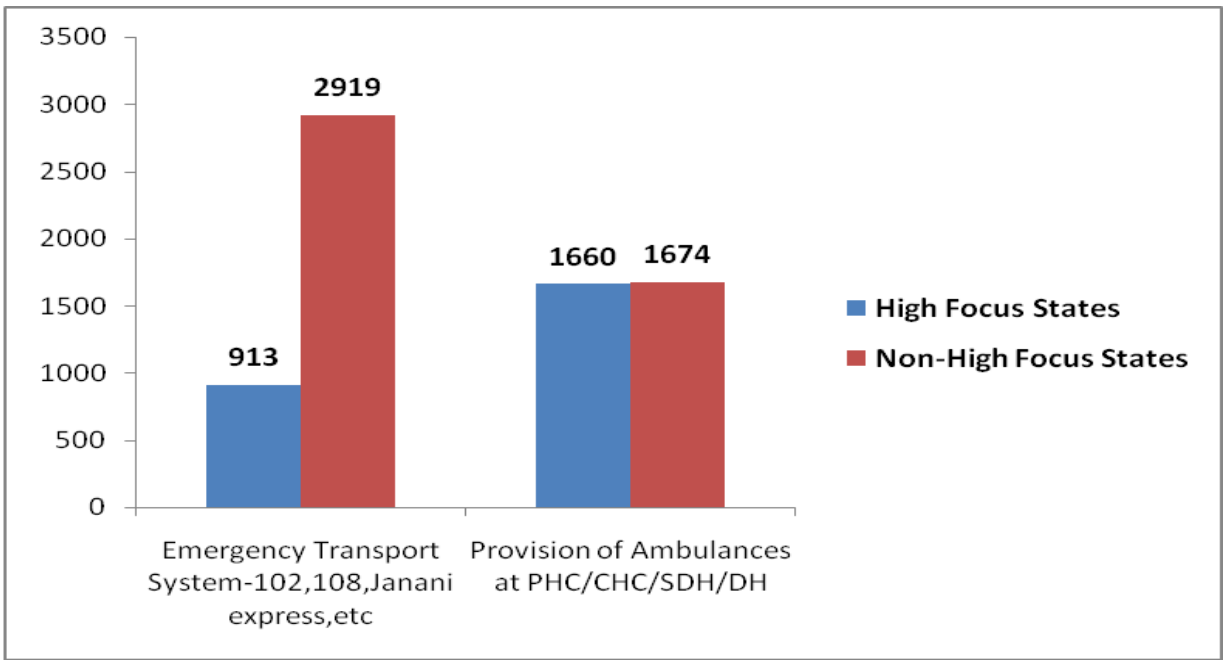
Need of the hour- Emergency Transport System & Ambulances:

To reach to maximum people and thus improve the Accessibility to public health NRHM also stresses on the improvement of Ambulances & emergency Transport.

Category of state/UT	Emergency transport system-102,108,Janani express, etc	Provision of Ambulances at PHC/CHC/SDH/DH
High focus states	913	1660
Non-High focus states	2919	1674

2.3.9- Emergency Transport & Ambulances in High focus & Non-high Focus

The number of Emergency transport is higher (2006) in non-high focus states then non-high focus state (913), though a lot has to be achieved by non-high focus state in terms of Ambulances at facilities. Emergency transport facility is also the backbone of referral services in any health care system. On total it can be concluded that in India a total of 2919 MMUs are currently providing health care services. Also a total of 1674 ambulances are currently functioning across various facilities.



2.3.9- Emergency Transport & Ambulances in High focus & Non-focus states

Chapter 4. Conclusion & Recommendations

The design of the National Rural Health Mission (NRHM) was a very inclusive process. Based on a careful review of assessment of progress as recorded by independent studies, Surveys, HMIS portals, periodic reports, periodic bulletins and review missions, it is clear that NRHM has led to increase in outpatient cases, functional facilities, availability of ambulances, MMUs, presence of ANMs at health SC/PHCs, doctors at PHCs, specialists at CHCs, Nurse Midwife at PHC/CHC, pharmacists at PHC/CHCs, radiographers at CHCs and most importantly a sincere effort to craft a credible public system

On the basis of review it is revealed that growth in the CHC construction was much more remarkable than other facilities. It recorded a total of 31% increase in the number of CHC. Human resources on the other hand showed a 34.40% growth in number of ANMs at health sub-centres/PHCs, 49.73% growth in doctors at PHCs, 42.59% growth in specialists at CHCs, 62.12% growth in Nurse Midwife at PHC/CHC, 18.60% growth in number of pharmacist at PHCs/CHCs, 41.06% growth in Radiographers at CHCs. Preliminary in its first 5 years a lot of improvements has been achieved but still a lot has to be achieved further. We therefore conclude that NRHM appears to be a well designed program and lots of thought process has gone into it prior to its implementation. However, it would be too early to predict its outcome in terms of success or failure.

NRHM has unleashed a lot of positive synergies and the Ministry should make all the efforts to further deepen such processes of community health in a manner that every household is able to seek its entitlement to care. There is a need to develop a new paradigm of Infrastructure strengthening, supporting referral transport services, entering in Public Private partnership for the provision of ambulances at all facilities, public recruitment based on the learning of the last five years.

And the most importantly NRHM is all about "Bringing people back to the Public system" and this has indeed increased the accessibility to the public health care delivery system in India.

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