

## **NATIONAL RURAL HEALTH MISSION- FREQUENTLY ASKED QUESTIONS**

### **I. Profile, Components, and Strategies**

#### **1. Why a National Rural Health Mission?**

The National Common Minimum Programme spells out the commitment of the Government to enhance Budgetary Outlays for Public Health and to improve the capacity of the health system to absorb the increased outlay so as to bring all round improvement in public health services. The National Rural Health Mission seeks to provide effective health care to the rural population, especially the disadvantaged groups including women and children, by improving access, enabling community ownership and demand for services, strengthening public health systems for efficient service delivery, enhancing equity and accountability and promoting decentralization.

#### **2. What is the coverage of the National Rural Health Mission (NRHM)?**

The NRHM covers the entire country, with special focus on 18 states where the challenge of strengthening poor public health systems and thereby improve key health indicators is the greatest. These are Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura.

#### **3. Is NRHM a new programme of the Government of India?**

The NRHM is basically a strategy for integrating ongoing vertical programmes of Health & Family Welfare, and addressing issues related to the determinants of Health, like Sanitation, Nutrition and Safe Drinking Water. The National Rural Health Mission seeks to adopt a sector wide approach and aims at systemic reforms to enable efficiency in health service delivery. NRHM subsumes key national programmes, namely, the Reproductive and Child Health II project, (RCH II) the National Disease Control Programmes (NDCP) and the Integrated Disease Surveillance Project (IDSP). NRHM will also enable the mainstreaming of Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health (AYUSH).

#### **4. What are the strategies of the NRHM?**

While providing a broad framework for operationalization, NRHM lists a set of core and supplementary strategies to meet its goals.

*Core strategies of NRHM include:* Decentralized village and district level health planning and management, appointment of Accredited Social Health Activist (ASHA) to facilitate access to health services, strengthening the public health service delivery infrastructure, particularly at village, primary and secondary levels, mainstreaming AYUSH, improved management capacity to organize health systems and services in public health, emphasizing evidence based planning and implementation through improved capacity

and infrastructure, promoting the non profit sector to increase social participation and community empowerment, promoting healthy behaviors, and improving intersectoral convergence.

*Supplementary Strategies* include regulation of the private sector to improve equity and reduce out of pocket expenses, foster public–private partnerships to meet national public health goals, re-orienting medical education, introduction of effective risk pooling mechanisms and social insurance to raise the health security of the poor, and taking full advantage of local health traditions.

#### **5. Does the NRHM exclude provision of Health Care to urban populations?**

Under the urban component of RCH II and the National Disease Control Programmes, curative and referral interventions and other programmes for urban poor would continue as before. A Task Group on Urban Health is being constituted to recommend strategies for urban poor.

### **II. Institutional Framework and Fund Flows**

#### **1. What is the institutional set up at National, State and District levels?**

The Mission Steering Group under the Chairmanship of the Union Minister for Health & Family Welfare will provide policy guidance and operational oversight at the National level. Ministerial / Secretary level representatives of Planning Commission, Rural Development, Panchayati Raj, Human Resource Development and Health and Family Welfare Secretaries of four States and ten public health professionals nominated by the Prime Minister will be members of the Mission Steering Group.

At the State level, the State Health Mission shall be led by the Chief Minister. It shall be co-chaired by the Health Minister with the State Health Secretary, as convenient, and representation from related Departments, NGOs, private professionals etc.

The District Health Mission shall be led by the Chairman, Zila Parishad, and be convened by the District Head of the Health Department. It shall have representation from all relevant Departments, NGOs and private professionals. However, States can choose their State specific models. The district and sub district arrangements for the Total Sanitation Campaign would be similar to those of the NRHM, and the activities of the Sanitation guided by the District Health Mission.

#### **2. What will be the role of the State Governments under the NRHM?**

The State Governments have been part of the Stakeholder Consultations for finalization of the strategy of the Mission. The States shall enter into a Memorandum of Understanding (MoU) with the Government of India, stating their agreement to the policy framework of the Mission and the timelines and performance benchmarks against identified activities. The States shall establish State and District Health Missions, and

integrate the multiple Societies for Health and Family Welfare Programmes at State and District levels, as envisaged under the NRHM. A State Action Plan shall be formulated reflecting the needs of the Health Sector, including the determinants of Health, like Sanitation, Nutrition and Safe Drinking Water, and the unmet needs which shall be addressed under the NRHM. The State shall also commit to undertake systemic reform, including devolution of powers to Panchayati Raj Institutions and decentralization of the programme to district levels as envisaged under NRHM, and ensure smooth fund flow, Technical and MIS support.

### **3. What will be the roles of the State and District Health Missions?**

The State Health Mission shall prepare the roadmap for architectural correction of the Health System, including merger/integration of vertical structures; delegation and decentralization of administrative and financial powers; empowering the PRIs; preparation of Operational Guidelines for the implementation of the Mission; logistics arrangements; disease surveillance; IEC; and MIS.

The District Health Mission shall control, guide and manage all public health institutions in the district and at sub-district levels. It will be responsible for preparation and implementation of an integrated District Action Plan in respect of funds received from all funding agencies into the District Health Fund. It shall guide the micro planning for selection and training of ASHAs, organization of Health Camps at Anganwadi levels, services related to immunization and institutional delivery, mainstreaming of AYUSH infrastructure, supply of drugs, upgrading CHCs to IPHS, utilization of Untied Fund at Sub-centre level, and strengthening outreach services through operationalization of mobile medical unit. It shall also ensure intersectoral convergence among related Departments at district and sub-district levels. Above all, the DHM shall ensure the accountability of the public health system to the Panchayati Raj Institutions and to the community.

### **4. What are the flexibilities available to the States under the NRHM?**

The NRHM provides broad operational framework for the Health Sector. Suggestive guidelines are being issued on key interventions like ASHA, Indian Public Health Standards (IPHS), institutional deliveries, immunization, preparation of District Action Plan, role of Panchayati Raj Institutions etc. The States shall have flexibility to project operational modalities in their State Action Plans, which would be decided in consultation with the Mission Steering Group.

The NRHM is being launched as a framework of partnership among Government of India, related Departments of the Government, especially Departments of Women & Child Development, Drinking Water Supply, Panchayati Raj, and Development of North Eastern Region State Governments, Panchayat Raj Institutions, NGOs, and private health providers, and. The detailing of strategies will continue during the Mission with the combined effort of all the stakeholders.

**5. What is the Outlay of NRHM?**

The Outlay of the NRHM for 2005-06 is Rs.6713 crores. The Outlay of the Mission in subsequent years will be dependent on the Outlay of the Ministry of Health and Family Welfare. The State-wise allocation under NRHM for 2005-06 are **annexed**.

**6. Can the States expect an increased outlay in the coming years?**

The Budget Outlay of the Ministry of Health and Family Welfare has increased by 30% in 2005-06 over the previous financial year. The States would prepare comprehensive Action Plans for NRHM, indicating priorities for funding, which shall be covered under the increased Outlays expected in the coming years.

**7. What shall be the State contribution under the NRHM?**

The State Action Plan shall reflect the Outlays available for Public Health expenditure under Centrally Sponsored Schemes, State Budget, State Finance Commission, major Bilateral funded Programmes and Schemes funded by Planning Commission like Rashtriya Samvikas Yojana etc. The States are required to sign MoU with the GoI, committing a minimal increase of 10% for Public Health expenditure in the State Budget each year.

**8. What is the fund flow mechanism?**

The States will be given an advance, indication of funds to be devolved. State Action Plan would be prepared, which would be funded through a financial envelope for RCH-II and funding under NDCP. The Societies for Health and Family Welfare programmes shall merge into one integrated Society at State and District level to enable “funneling” of funds. The NRHM Budget Head would retain Sub-Budget Heads for the erstwhile Societies.

**9. What is the role of Panchayati Raj Institutions (PRI) in the NRHM?**

One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services at various levels. The Village Health & Sanitation Committee (VHC), the standing committee of the Gram Panchayat (GP) will provide oversight of all NRHM activities at the village level and be responsible for developing the Village Health Plan with the support of the ANM, ASHA, AWW and Self Help Groups. Block level Panchayat Samitis will co-ordinate the work of the GP in their jurisdiction and will serve as link to the DHM. The DHM will be led by the Zila Parishad and will control, guide and manage all public health institutions in the district. States will be encouraged to devolve greater powers and funds to Panchayati Raj Institutions.

### **III. Operational Issues**

#### **1. What are key activities for the Year 2005-2006?**

Broadly speaking, the common activities under NRHM, which are uniformly applicable across all States/UTs over and above those proposed under ongoing programmes like RCH and National Disease Control Programmes,, are as follows:

- Constitution of State and District Health Missions
- Merger of Health and Family Welfare Societies
- Preparation of State Action Plan, which identifies sectoral needs and priorities
- Finalizing performance benchmarks for MoU
- Signing of MOU between State and GOI
- Preparation of District Action Plans.
- Upgrading two CHCs in every district to the level of Indian Public Health Standards, including the provision for two rooms in these CHCs for bringing AYUSH practitioners under the same roof.
- Formation of Rogi Kalyan Samitis
- Immunization strengthening through induction of Auto Disabled Syringes and arrangement for alternate vaccine delivery at immunization sites.
- Organizing mobile medical services at district level.
- Organizing Health Camp at AWW level on a fixed day in a month for assured services for women and child health care.
- Provision of household toilets.
- Strengthening institutional delivery under Janani Suraksha Yojana (JSY) through provision of escort and referral services by ASHA & subsidized hospital services for BPL women.
- Establishing systems to increase accountability of health systems to PRIs.
- ✓ Selection and training of ASHA, including provision of drug kits
- ✓ Organizing Health Melas as a platform to inform and educate the public on NRHM
- ✓ Provision of generic drugs, both AYUSH and allopathic, at village, SC/PHC/CHC level, for common ailments.

Some activities as at ✓ above shall be specially funded in the 18 high focus States.

#### **2. What additional inputs will States receive in Year 1?**

- Rs. 20 lakhs/CHC to two CHCs in every district for bringing them on par with IPHS.
- Maintenance grant of Rs. 1 lakh per CHC, after constitution of Rogi Kalyan Samiti at that level.
- Untied fund of Rs. 10,000 per Sub-centre.
- Supply of additional drugs (allopathic and AYUSH) at Sub-centre, PHC and CHC level
- Mobile Medical Unit for district

- 50% districts in EAG states to get Rs. 10 lakhs/district for district planning
- Funds for training of ASHAs

### **3. When are State, District and Village Action Plans due?**

State and District Action Plans are expected to be formulated within the first six months. Village Action Plans can be formulated during the second year.

### **4. What should State Action Plans include?**

State Action Plans in Year I should include outlays for RCH II, National Disease Control Programme and the Integrated Disease Surveillance Programme. The State Action Plan would also include funds under AYUSH, Finance Commission grants-in-aid, Rashtriya Sam Vikas Yojana, external bilateral funding, and large NGO grants. Even though budgeting would remain separate for better convergence, the outlays and programmes to improve sanitation, nutrition etc. should also be reflected in the State Action Plan. Once the District Plans are ready, the State Action Plan should be based on those Plans.

### **5. What should a District Action Plan include?**

For 2005-2006, districts should consolidate existing resources within the HFW sector, plan for convergence with nutrition, water and sanitation, and focus on identifying areas in the district with poor indicators and greatest need of financial resources. After Year 2 detailed District Action Plans, based on Village Health Plans should be developed by the DHM. States are expected to procure technical assistance for districts to support the development of District Action Plans. Under RCH and other donor funded programmes, some districts have already prepared Action Plan for RCH. These will need to be reworked, to include other components under NRHM. The districts, which did not get such funding support, will receive funds for district planning @ Rs. 10 lakhs per district (in EAG States).

### **6. Will NRHM provide for additional project management cost?**

Project Management cost for all districts is covered under the financial envelope of RCH II. 18 high focus States shall make contractual engagement of skilled professionals, viz. CA, MBA & MIS specialist at State and District level for enhancing capacities of programme management and technical support to the NRHM.

### **7. How to integrate Water, Sanitation, and Nutrition in NRHM?**

The institutional arrangement for the NRHM as well as Total Sanitation Campaign will be the same at District and Village levels. However budgeting for the two programmes will remain separate. Integration with ICDS implies joint planning, use of AWC as the hub of the NRHM interventions in the village, joint reporting and monitoring on common indicators, and engagement with the AWW as a key figure in village planning and implementation.

**8. What is the budget profile of NRHM? What will separate sub budget lines look like?**

In Year 1 (2005-2006) there will be no separate Budget Head for NRHM. Creation of a new Budget Head for NRHM will be from 2006 onwards. The existing programmes would maintain sub-Budget Heads under the omnibus NRHM Budget Head.

**9. Will the States have to sign separate MoUs for RCH-II and NRHM?**

There will be only one MOU, subsuming the MOU for all programmes integrated under NRHM. Signing of this MoU shall be the precondition to release of second tranche of funds in October 2005.

**10. What are key performance benchmarks for Year 1?**

Performance benchmarks under NRHM would include performance indicators in respect of all integrated programmes. In addition, NRHM requires the following activities to be completed in Year 1:

- Constitution of State and District Health Missions
- Merger of Health and Family Welfare Societies
- Signing of MOU for NRHM between State and GOI

**IV. Key Activities**

**1. Can states continue to implement existing community health workers programmes?**

The States would have flexibility in this regard. If States have ongoing community worker/volunteer programme, they can continue to engage with those already selected. However, ASHA must be **primarily a woman resident of the village**, preferably, in the age group of 25 to 45 years, **‘Married/Widow/Divorced’** with **formal education up to Eighth Class**. Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

**2. Is ASHA to be selected on a population-based norm?**

States are free to select ASHA as per their own requirements. The norms are “1 ASHA for 1000 population”. For areas like deserts and hilly terrain, these norms may be relaxed.

**3. Is ASHA a paid employee?**

ASHA is not a paid employee. She would not be entitled to any pay or honorarium, but be eligible for compensation for services provided under various schemes and programmes of GoI and State Governments - for institutional delivery under Janani Suraksha Yojana, for completion of DOTS treatment under National TB Control Programme, promotion of household toilets under Total Sanitation Campaign, etc. under the overall guidance of the District Health Mission.

**4. How will ASHA be selected?**

After going through a community mobilization process, a panel of suitable persons would be drawn up and placed before Gram Sabha. The necessary formalities regarding the selection would be done by the Village Health & Sanitation Committee.

**5. Will the ASHA get a formal letter of appointment?**

No, but the minutes of the approval process (in Gram Sabha or Village Health Committee meeting) will be recorded. The Village Health Committee would enter into an agreement with the ASHA (*as in the case of the Village Education Committee and Sahayogini-in Sarva Shiksha Abhiyan*)

**6. Is ASHA to be universal?**

Currently ASHA is envisaged in the EAG States, Assam and Jammu & Kashmir.

**7. Who is ASHA accountable to?**

ASHA would be accountable to the community through the Gram Panchayat. She would be guided by the Anganwadi Worker and the ANM. She would report to the Village Health & Sanitation Committee of the Gram Panchayat.

**8. Will ASHA be getting a drug kit?**

Yes, a drug kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. The kit will be provided to ASHA after adequate training.

**9. What will be her primary roles and responsibilities?**

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

**Frequently Asked Questions on IPHS:**

**1. What is IPHS?**

Indian Public Health Standards are a set of standards envisaged to improve the quality of health care delivery in the country under the National Rural Health Mission.

**2. What is the need for IPHS?**

The health care system in India has expanded considerably over the last few decades, however, the quality of services is not uniform, due to various reasons like non-availability of manpower, problems of access, acceptability, lack of community

involvement, etc. Hence, standards are being introduced in order to improve the quality of public health level.

### **3. Who will be recommending these standards?**

A Task Group under Director General of Health Services was constituted to recommend the Standards. The IPHS is based on its recommendation.

### **4. Who will it be applicable to?**

At present these standards are being applied only to the Community Health Centres (CHCs). As a first step, requirements for a Minimum Functional Grade of a Community Health Centre are being prescribed. Further upgradation will be proposed after these minimum requirements have been met. Subsequently, standards for PHC and SC shall also be developed.

### **5. Why only for CHCs?**

The NRHM aims at strengthening hospital care for rural areas. CHC is a 30-bedded hospital providing specialist care in medicine, Obstetrics and Gynaecology, Surgery and Paediatrics. However due to various reasons, the functioning of CHCs has not been as desired. These centres are the First Referral Units as far as curative care is concerned and are also the link between primary care and tertiary care. With the availability of specialist care in these centres, it was felt that these would be the right breaking ground.

### **6. Why another set of standards?**

Although it is true that there are existing standards as prescribed by the Bureau of Indian Standards for 30-bedded hospital, these are at present not achievable as they are very resource-intensive. Hence a less resource intensive standard suited to the requirements of the system has been developed.

### **7. What is hoped to be achieved by these standards?**

Under the NRHM, the Accredited Social Health Activist (ASHA) is being envisaged in each village to promote the health activities. With ASHA in place, there is bound to be a groundswell of demands for health services and the system needs to be geared to face the challenge. In order to ensure availability and quality of services, we are now establishing the Indian Public Health Standards for CHCs so as to provide a yardstick with which to measure the services being provided in the CHCs. With these standards it will be possible to objectively grade Centres and take up remedial action accordingly.

## **8. What are the various recommendations under IPHS?**

- Improvement in the availability of specialist services in the CHCs by ensuring availability of all the sanctioned specialists. Additional sanction of the post of Anesthetist and Public Health Manager is also envisaged.
- Strengthening support staff, by recommending a Public Health Nurse and an ANM in all these Centres, in addition to the existing staff.
- Norms for infrastructure, equipment, laboratory, Blood storage facilities, and drugs have been formulated.
- Guidelines for management of routine and emergency cases under National Health programmes are being provided to all CHCs, to maintain uniformity, and also optimum standardized treatment.

## **9. How will compliance to these Standards be ensured?**

- Monitoring and evaluation would be both internal as well as external.
- Training of medical as well as para medical staff.
- Charter of Patients' Rights would be prominently displayed in all these centres.
- Rogi Kalyan Samitis would be formed to improve accountability.
- The District Health Mission would monitor the progress for maintenance of standards at facility level.

## **10. How will the Mission address the issues of absentee doctors in rural areas?**

Availability of doctors and paramedics in rural areas is important to the success of the Mission. The States will examine the possibility and modalities for having district level cadres for doctors and Block level cadres for ANMs as resolved in the 7<sup>th</sup> Conference of the Central Council of Health & Family Welfare Ministers, in August 2003. The District Health Missions will have greater flexibility for engaging the services of private doctors on contractual basis to provide services in public health institutions. Most importantly, the States shall indicate their commitment to devolve the funds and programmes for health and family welfare to Panchayati Raj Institutions under the NRHM, to ensure effective accountability of the public health providers at corresponding levels. The Mission also proposes to involve Professional Medical Associations viz. Indian Medical Association (IMA), Federation of Obstetricians and Gynaecologists of India (FOGSI) etc. to build peer and professional support for the programme.