UNIT 6 NATIONAL RURAL HEALTH MISSION

Structure

6.1 OBJECTIVES

After going through this unit, you should be able to:

list the goals and expected outcomes of the National Health Mission;

describe various strategies of National Health Mission and its components;

discuss role of major initiatives under the National Health mission like ASHA, Rogi Kalyan Samiti, Janani Surakshi Yojna, Janani Shishu Suraksha Karyakram;

discuss the initiatives for quality in health care facilities; and

explain the linkage of AYUSH with NHM.

6.2 INTRODUCTION

The National Rural Health Mission (NRHM) was launched on 12th April, 2005. Later, on 1st May, 2013 the Union Cabinet approved the National Urban Health Mission (NUHM). With the launch of NUHM, both the missions are now combined under the overall ambit of National Health Mission.

The NRHM was launched to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. Before the launch of NRHM, it was found that there were striking regional inequalities and social inequities in health care. Rather than comprehensive health care, the approach was fragmented and disease-specific. The out-of-pocket expenditure on health care was huge and disproportionately affected the rural poor. Infrastructure at most of the public health facilities was poor. This called for a comprehensive restructuring of the prevailing strategies to improve the public health services in the country.

6.3 NATIONAL RURAL HEALTH MISSION (NRHM)

Under the NRHM, eighteen states including the Empowered Action Group (EAG) States viz. Uttar Pradesh, Madhya Pradesh, Bihar, Odisha, Rajasthan, Uttarakhand, Jharkhand and Chattisgarh; as well as eight North Eastern States viz. Assam, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Sikkim and Tripura, along with Jammu and Kashmir, and Himachal Pradesh were given special focus.

The mission aimed at providing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels. In order to bridge the gap between the health system and community, a special cadre of Accredited Social Health Activist (ASHA) has been created.

To achieve an acceptable standard of quality of care in public health facilities, Indian Public Health Standards (IPHS) have been introduced for various levels of facilities i.e sub-centres, primary health centres (PHC), and community health centres (CHC). Under the IPHS, minimum standards of requirement such as building, manpower, instruments, equipments, drugs etc have been prescribed for each level.

Under the NRHM, the existing multiple programmes of Health and Family Welfare have been integrated, including –

– Reproductive and Child Health Programme (RCH–II)

– National Vector Borne Disease Control Programme against Malaria, Filaria, Kala-azar, Dengue and Japanese encephalitis

– Revised National Tuberculosis Control Programme

– National Leprosy Eradication Programme

– National Programme for Control of Blindness

– National Iodine Deficiency Disorders Control Programme

– Integrated Disease Surveillance Project

Strategies under NRHM

a) *Core Strategies*

Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services. Health Plan for each village through Village Health Committee of the Panchayat.

Promote access to improved health care at household level through the female health activist (ASHA).

Strengthening sub-centre through an untied fund to enable local planning and action and more Multi-Purpose Workers (MPWs).

Strengthening of existing PHCs and CHCs, as per the Indian Public Health Standards defining personnel, equipment and management standards.

Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation and hygiene and nutrition.

Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.

Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

Promotion of "Rogi Kalyan Samiti" having representatives from elected bodies like Panchayats, Panchayat samiti and Zila Parishad, for management of public health institutions. This will help in decentralized planning, and community participation.

b) *Supplementary Strategies*

Promotion of Public Private Partnerships for achieving public health goals.

Mainstreaming AYUSH – revitalizing local health traditions. Also, to include an AYUSH practitioner at PHC.

Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.

Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

Thus, NRHM brought the necessary political will and funding to revive the primary health care system in India. Though initially the mandate of NRHM was till 2012, in view of its remarkable achievements, it was later extended to 31st March, 2017.The NRHM focused primarily on rural population, and for the health needs of the urban poor, National Urban Health Mission (NUHM) was envisioned.

6.4 NATIONAL URBAN HEALTH MISSION

The National Urban Health Mission (NUHM) was approved by the Cabinet on 1st May 2013, under the ambit of National Health Mission. As per the census 2011, the urban population of country has gone up to 37.7 crores. Urban growth has also led to increase in the urban poor, especially those living in slums. The urban poor suffer from poor health status with a higher burden of mortality and morbidity. Rates of under-nutrition, anaemia, and incidence of vector borne diseases, tuberculosis, and other respiratory infections are significantly higher among the urban poor and slum dwellers as compared to other urban population groups. Despite the proximity of the urban poor to urban health facilities, their access to these health services is severely restricted.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, particularly the slum dwellers and other disadvantaged sections like rickshaw pullers, street children, homeless people, construction site workers, by making essential primary health care services available to them, and reducing their out of pocket expenses for treatment.

The mission aims to strengthen the existing health care service delivery system, particularly for people living in slums, and converging other determinants of health like safe drinking water, sanitation etc. Urban local bodies and communities will be involved in planning, implementation and monitoring of NUHM.

i) Strategies of NUHM

Need based city specific urban health care system to meet the diverse health care needs of the urban poor.

Availability of resources for providing essential primary health care to urban poor.

Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.

Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.

The existing Urban Health Posts and Urban Family Welfare Centres would continue under NUHM. Based on the population covered by them, they will be classified under Urban Health Centres. The staff will be rationalized and the centres will be considered for upgradation.

ii) Service delivery infrastructure under NUHM

1) One Urban Primary Health Centre (U-PHC) for every 50-60 thousand population.

2) One Urban Community Health Centre (U-CHC) for 5-6 U-PHCs in big cities with a population of above 5 lakhs. These will be established for providing in-patient care, and will be 30-50 bedded.

3) Outreach services for slum dwellers and vulnerable sections, by engaging ANMs.

4) One Auxillary Nurse Midwife (ANM) has been proposed for 10,000 population.

iii) Community participation in NUHM

- One ASHA (Community link worker) for 200-500 households.
- *Mahila Arogya Samiti* (*MAS*) – These are women's self help groups which will act as community based peer education group in slums. MAS will facilitate community mobilization, monitoring and referral, with focus on preventive and promotive care, facilitating access to identified facilities and management of grants received. One *MAS* would be set up for every 50-100 households.

NUHM will be implemented in 779 cities and towns having population more than 50,000. Cities and towns with population below 50,000 will continue be covered under NRHM. The existing management systems functioning under NRHM will be strengthened for NUHM.

6.5 NATIONAL HEALTH MISSION

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM).

The main programmatic components include:

- Health system strengthening in rural and urban areas,
- Reproductive- Maternal-Neonatal-Child and Adolescent Health (RMNCH+A)
- Communicable and Non-Communicable Diseases.

6.5.1 Goals and Outcomes

The overall goal of NHM is "*attainment of universal access to equitable, affordable and quality health services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health.*"

Outcomes for NHM in the 12th Plan are synonymous with those of the 12th Plan. The aim would be to ensure achievement of these at national level.

The expected outcomes of NHM by 2017

1) Reduce MMR to 1/1000 live births

2) Reduce IMR to 25/1000 live births

3) Reduce TFR to 2.1

4) Prevention and reduction of anaemia in women aged 15–49 years

5) Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases

6) Reduce household out-of-pocket expenditure on total health care expenditure

7) Reduce annual incidence and mortality from Tuberculosis by half

8) Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts

9) Annual Malaria Incidence to be <1/1000

10) Less than 1 per cent microfilaria prevalence in all districts

11) Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Specific goals for the states will be based on existing levels, capacity and context. Targets for communicable and non-communicable disease will be set at state level based on local epidemiological patterns and taking into account the financing available for each of these conditions.

6.5.2 Strategies of NHM

The strategies under the NHM include the following:

1) *Support and supplement state efforts:*
Build an integrated network of all primary, secondary and a substantial part of tertiary care, providing a continuum from community level to the district hospital, with robust referral linkages to tertiary care and a particular focus on strengthening the Primary Health Care System including outreach services in both rural areas and urban slums.

2) *Decentralized planning:*Build state, district and city capacity for decentralized outcome based planning and implementation, based on varying diseases burden scenarios, and using a differential financing approach.

3) Enable integrated facility development planning which would include infrastructure, human resources, drugs and supplies, quality assurance, and effective *Rogi Kalyan Samitis* (RKS).

4) Create a *District Level Knowledge Centre* within each District Hospital to serve as the hub for a range of tasks including provision of secondary care and selected elements of tertiary care, and the site for skill based training for all cadres of health workers, collating and analyzing data and coordinating district planning.

5) *Improve delivery of outreach services* through a mix of static facilities and mobile medical units with a team of health service providers with the skill mix and capacity to address primary health care needs.

6) *Strengthen the sub-centre/Urban Primary Health Centre* (UPHC) with additional human resources and supplies to deliver a much larger range of preventive, promotive and curative care services- so that it becomes the first port of call for each family to access a full range of primary care services.

7) Prioritize achievement of *universal coverage* for Reproductive Maternal, Newborn, Child Health + Adolescent (RMNCH+A), National Communicable Disease Control and Non-Communicable Diseases programmes.

8) Expand focus from *child survival to child development* of all children 0-18 years through a mix of Community, Anganwadi, and School based health services. The focus of such services will be on prevention and early identification of diseases through periodic screening, health education and promotion of good health practices and values during these formative years and timely management including assured referral for secondary and tertiary level care as appropriate.

9) Achieve the goals of safe motherhood and transition to addressing the broader reproductive health needs of women.

10) Focus on adolescents and their health needs.

11) Ensure the control of communicable diseases, which includes prompt response to epidemics and effective surveillance.

12) Use primary health care delivery platforms to address the rising burden of Non-Communicable Diseases.

13) Converge with Ministry of Women & Child Development and other related Ministries for effective prevention and reduction of under-nutrition in children aged 0-3 years and anaemia among children, adolescents and women.

14) Empower the ASHA to serve as a facilitator, mobilizer and provider of community level care.

15) Strengthen people's organizations such as the *Village Health Sanitation and Nutrition Committees (VHSNC) and Mahila Arogya Samitis* (MAS) for convergent inter-sectoral planning to address social determinants of health and increasing utilization of health and related public services at the community level.

16) Create mechanisms to strengthen *Behaviour Change Communication* efforts for preventive and promotive health functions, action on social determinants and to reach the most marginalized.

17) *Enable Social Protection* Function of Public Hospitals through the universal provision of free consultations, free drugs and diagnostics, free emergency response and patient transport systems.

18) *Develop effective partnerships* with the not-for-profit, non-governmental organizations and with the for-profit, private sector to bring in additional capacity where needed to close gaps or improve quality of services.

19) Improve Public Health Management by encouraging states to create public health cadre, and strengthening/ creating effective institutions for programme management, providing incentives for improved performance and building high quality research and knowledge management structures.

20) Support states to develop a comprehensive strategy for human resources in health, through policies to support improved recruitment, retention and motivation of health workers in rural, remote and underserved areas, improved workforce management, required staff to help achieve IPHS norms of human resource deployment, development of mid level care providers and creation of new cadres with appropriate skill sets, and in-service training.

21) Enhance use of *Information and Communication Technology* to improve health care and health systems performance.

22) *Strengthen Health Management Information Systems* as an effective instrument for programme planning and monitoring, supplemented by regular district level surveys and a strong disease surveillance system.

23) Ensure *universal registration of births and deaths* with adequate information on cause of death, to assist in health outcome measurements and health planning.

24) Establish *Accountability Frameworks* at all levels for improved oversight of programme implementation and achievement of goals. Mechanisms for accountability shall range from participatory community processes like Jan Sunwais/Samwads, Social Audit through Gram Sabhas to professional independent concurrent evaluation.

25) Implement pilots for *Universal Health Coverage (UHC)* in selected districts in both EAG and non EAG States to test approaches and innovations before scaling up.

26) To ensure *equitable health care* and to bring about sharper improvements in health outcomes, a systematic effort to effectively address the intrastate disparities in health outcomes would be undertaken. 25% of all districts in each state that are in the lowest quintile of composite health index have been identified as high priority districts. All tribal and LWE affected districts which are below the state's average of composite health index have also been included as high priority districts. Further, all the LWE districts have been identified as special focus districts. These districts would receive higher per capita funding, relaxed norms, enhanced monitoring and focussed supportive supervision, and encouraged to adopt innovative approaches to address their peculiar challenges.

27) Mainstreaming of AYUSH.

Check Your Progress 1

1) Name the two missions covered under the ambit of National Health Mission.

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2) What is the population covered under the National Urban Health Mission?

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6.6 MAJOR INITIATIVES UNDER NHM

6.6.1 Accredited Social Health Activist (ASHA)

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA is trained to work as a link between the community and the public health system.

Initially it was proposed to have one ASHA per 1000 population. However, there are more than one ASHA per habitation in tribal, hilly and desert areas, depending on the workload. In the urban areas, they will be selected for 200-500 households.

i) Key features of ASHA in rural area:

- ASHA will primarily be a woman resident of the village married/widowed/ divorced, preferably in the age group of 25 to 45 years. She should be a literate woman with due preference in selection to those who are qualified up to tenth standard, wherever they are interested and available. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, the Block Nodal Officer, District Nodal Officer, Village Health and Sanitation Committee and the Gram Sabha.
- ASHAis given induction training over various modules for a total period of 23 days in five episodes, spread over 12 months. Capacity building of ASHA is being seen as a continuous process. After the induction training, periodic refresher trainings are given for about two days, once in every alternate month.

– The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive and Child Health (RCH) and other health care programmes, and construction of household toilets.

ii) Key features of ASHA in urban areas

– ASHA must be a woman resident of the – "slum/vulnerable clusters and belong to that particular vulnerable group which have been identified by City/District Health Society for selection of ASHA.

– She should be preferably 'Married/Widow/Divorced/Separated' and preferably in the age group of 25 to 45 years.

– ASHA should have effective communication skills with language fluency of the area/population she is expected to cover, leadership qualities and be able to reach out to the community.

– She should be a literate woman with formal education of at least tenth Class. If there are women with Class XII who are interested and willing they should be given preference since they could later gain admission to ANM/GNM schools as a career progression path.

– The educational and age criteria can be relaxed if no suitable woman with this qualification is available in the area and among that particular vulnerable group.

– She should have family and social support to enable her to find the time to carry out her tasks.

– Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

– Existing women Community workers under other schemes like-urban ASHAs or link workers under NRHM or RCH II, JnNURM, SJSRY etc. may be given preference provided they meet the residency, age and educational criteria mentioned above.

iii) Selection of ASHA in urban areas

– Prior to the selection of ASHA it is important that City/ District health society undertakes mapping of the city/urban areas with vulnerability assessment of the people living in slums or slum like situations and identifies these "slum/ vulnerable clusters" for selection of ASHA.

– The general norm for selecting ASHA in urban area will be *'One ASHA for every 1000-2500 population'*. Since houses in urban context are generally located within a very small

geographic area an ASHA can cover about 200-500 households depending upon the spatial consideration.

- When the population covered increases to more than 2500 another ASHA can be engaged. In case of geographic dispersion or scattered settlements of socially and economically disadvantaged groups the "slum/vulnerable clusters" selection of ASHA can be done at a smaller population.
- The selected ASHAs will be preferably co-located at the Anganwadi Centre that are functional at the slum level, for delivery of services at the door step.
- The other community volunteers built under Jawahar Lal Nehru National Urban Renewal Mission (JnNURM), Swarna Jayanti Shahari RozgarYojna (SJSRY) etc. can also be utilized for this purpose.

iv) Roles and responsibilities of ASHA

In both urban and rural areas, ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. Her responsibilities include the following:

- *Creation of awareness:* ASHA will create awareness on health and its social determinants. She will provide information to the community on nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.
- *Community mobilization:* ASHA will mobilize the community towards local health planning. She will aim to increase the utilization of the existing health services. She will facilitate the beneficiaries in accessing services available at the Anganwadi/ sub-centre/primary health centers, such as immunization, Ante Natal Check-up (ANC), Post Natal Check-up, supplementary nutrition, sanitation and other services being provided by the government.
- *Escort/Accompany* seriously-ill children or women with pregnancy related complications to the nearest health facility.
- *Minimum package of curative care for minor ailments:* ASHA will provide primary medical care for minor ailments as appropriate and feasible for that level. She has been provided

a drug kit that includes allopathic and AYUSH formulations. She will also make timely referrals, whenever required.

- *Depot holder for essential provisions:* ASHA will act as depot holder for Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), Chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
- *Information of births and deaths:* ASHA will inform about the births and deaths in her village, as well as any unusual health events or outbreaks in the community to the Sub-Centre or Primary Health Centre.
- *Village Health and Sanitation Committee:* ASHA will work with the Village Health and Sanitation Committee and participate in preparing the village health plan. She will also help in organizing village health and nutrition day (VHND) at the Aaganwari centres.
- Promote construction of household toilets under the Total Sanitation Campaign.
- Work for other health programmes under NHM.

v) Remuneration for ASHA

- ASHA worker is primarily an "honorary volunteer" but is compensated for her time in specific situations (such as training attendance, monthly reviews and other meetings).
- In addition she is eligible for incentives offered under various national health programmes.
- She would also have income from social marketing of certain health care products like condoms, contraceptive pills, sanitary napkins etc.
- Her work would be so designed that it is done without impinging on her main livelihood and adequate monetary compensation for the time she spends on these tasks- through performance-based payments should be provided.
- For an ASHA working in a population of 1000 (1000-2500 in urban areas), it is intended that performance based incentives would enable her to earn at least Rs. 3000/- per month. To ensure timely payment, ASHA payments will be linked to MCTS (Mother and Child Tracking Scheme).
- To provide support to ASHA, various platforms are being created such as ASHA mentoring groups, ASHA Resource Centres, different NGOs, and volunteers from the civil society. In-service support system is provided through ANMs and Medical Officers.

Check Your Progress 2

1) Under NHM, who is eligible to be selected as ASHA?

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2) What are the roles and responsibilities of ASHA?

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6.6.2 Village Health Sanitation and Nutrition Committee (VHSNC)

One of the key elements of the National Health Mission is the Village Health, Sanitation and Nutrition Committee (VHSNC). The committee has been formed to take collective actions on issues related to health and its social determinants at the village level. They are particularly envisaged as being central to 'local level community action' under NRHM, which would develop to support the process of decentralised health planning. Thus the committee is envisaged to take leadership in providing a platform for improving health awareness and access of community for health services, address specific local needs and serve as a mechanism for community based planning and monitoring.

Organization of VNSNC

The committee is formed at the revenue village level and it should act as a sub-committee of the Gram Panchayat. It should have a minimum of 15 members which should comprise of elected member of the Panchayat who shall lead the committee, all those working for health and health related services should participate, community members/ beneficiaries and representation from all community sub-groups especially the vulnerable sections and hamlets/habitations. ASHA residing in the village shall be the member secretary and convener of the committee.

Roles and Responsibilities of VHSNC

1) Create awareness about nutritional issues and significance of nutrition as an important determinant of health.

2) Carry out survey on nutritional status and nutritional deficiencies in the village especially among women and children.

3) Identify locally available foodstuffs of high nutrient value as well as disseminate and promote best practices (traditional wisdom) congruent with local culture, capabilities and physical environment through a process of community consultation.

4) Inclusion of Nutritional needs in the Village Health Plan – The committee will do an in-depth analysis of causes of malnutrition at

the community and household levels, by involving the ANM, AWW, ASHA and ICDS Supervisors.

5) Monitoring and Supervision of Village Health and Nutrition Day to ensure that it is organized every month in the village with the active participation of the whole village.

6) Facilitate early detection of malnourished children in the community; tie up referral to the nearest Nutritional Rehabilitation Centre (NRC) as well as follow up for sustained outcome.

7) Supervise the functioning of Anganwadi Centre (AWC) in the village and facilitate its working in improving nutritional status of women and children.

8) Act as a grievances redressal forum on health and nutrition issues.

The committee may, preferably, act as a sub-committee of Gram Panchayat and function under the overall supervision of Gram Panchayat. States are accordingly advised to issue the necessary notifications and guidelines on constitution of VHSNC to all concerned. States are also requested to consider notifying VHSNC as a subcommittee of Gram Panchayat.

VILLAGE HEALTH AND NUTRITION DAY (VHND)

The VHND is to be organized once every month (preferably on Wednesdays, and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organizing the VHND. The AWC is identified as the hub for service provision in the RCH-II, NHM, and also as a platform for inter-sectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system.

– On the appointed day, ASHAs, AWWs, and other will mobilize the villagers, especially women and children, to assemble at the nearest AWC.

– On the VHND, the villagers can interact freely with the health personnel and obtain basic services and information. They can also learn about the preventive and promotive aspects of health care, which will encourage them to seek health care at proper facilities.

The VHSC comprising the ASHA, the AWW, the ANM, and the PRI representatives, if fully involved in organizing the event, can bring about dramatic changes in the way that people perceive health and health care practices.

6.6.3 Janani Suraksha Yojna (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a government health facility.TheYojana, launched on 12th April 2005, is being implemented in all states and UTs with special

focus on low performing states. JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.

The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in ten low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible states and UTs, wherever, AWW (Anganwadi Workers) and TBAs or ASHA like activist has been engaged in this purpose, she can be associated with this Yojana for providing the services.

Important Features of JSY:

1) The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rates namely the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir. These states have been named as Low Performing States (LPS), the remaining states have been named as High performing States (HPS).

2) *Tracking Each Pregnancy*: Each beneficiary registered under this Yojana should have a JSY card along with a MCH card. ASHA/ AWW/ any other identified link worker under the overall supervision of the ANM and the MO, PHC should mandatorily prepare a micro-birth plan. This will effectively help in monitoring Antenatal Check-up, and the post delivery care.

3) *Eligibility for Cash Assistance:*

   – In LPS, financial assistance for institutional delivery is available to all women regardless of age or parity, in case they deliver in a government health facility or a private health facility accredited by the government. There is also no need for BPL certification or marriage certificate, provided they deliver in a government facility or accredited private health facility.

   – In HPS, all BPL/SC/ST women who deliver in a government health facility or accredited private health facility are eligible for financial assistance. BPL Certification is required in HPS. However, where BPL cards have not yet been issued or have not been updated, states/UTs would formulate a simple criterion for certification of poor and needy status of the expectant mother's family by empowering the gram pradhan or ward member.

   – In all HPS and LPS, all BPL pregnant women, who prefer to deliver at home are entitled to financial assistance of Rs. 500- per delivery, irrespective of age and parity. The disbursement of money should be done at the time of delivery or around seven days before the delivery by the ASHA/ANM, so that the woman can use this money to meet the incidental expenses of delivery.

4) *Disbursement of Cash Assistance:* As the cash assistance to the mother is mainly to meet the cost of delivery, it should be disbursed effectively at the institution itself.For pregnant women going to a public health institution for delivery, entire cash entitlement should be disbursed to her in one go, at the health institution. Considering that some women would access accrediting private institution for antenatal care, they would require some financial support to get at least 3 ANCs including the TT injections. In such cases, atleast three-fourth (3/4) of the cash assistance under JSY should be paid to the beneficiary in one go, importantly, at the time of delivery.

   Recently *Adhar Enabled Payment System* has been started to make direct cash payments to the beneficiaries.

Table 6.1: Scale of Cash Assistance for Institutional Delivery under *JSY*

Category	Rural Area		Total	Urban Area		Total
Mother	ASHA	Rs.	Mother	ASHA	Rs.	
LPS	1400	600	2000	1000	400	1400
HPS	700	600	1300	600	400	1000

6.6.4 Janani Shishu Suraksha Karyakram (JSSK)

Launched on 1st June, 2011, JSSK entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. This novel approach eliminates out-of-pocket expenditure for pregnant women, sick neonates and sick infants.

The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home and exemption from all kinds of user charges.

Similar entitlements are available for all sick infants (up to 1 year of age) accessing public health institutions.

All States and Union Territories are implementing this scheme.

6.6.5 Rogi Kalyan Samiti (RKS)

Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Committee is a simple yet effective management structure. This committee, a registered society, acts as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector who are responsible for proper functioning and management of the hospital / Community Health Centre / FRUs. RKS / HMS is free to prescribe, generate and use the funds with it as per its best judgement for smooth functioning and maintaining the quality of services.

Roles and Responsibilities of RKS

- Identifying the problems faced by the patients in CHC/PHC;
- Acquiring equipment, furniture, ambulance (through purchase, donation, rental or any other means, including loans from banks) for the hospital;
- Expanding the hospital building, in consultation with and subject to any Guidelines that may be laid down by the State Government;
- Making arrangements for the maintenance of hospital building (including residential buildings), vehicles and equipment available with the hospital;
- Improving boarding / lodging arrangements for the patients and their attendants;
- Entering into partnership arrangement with the private sector (including individuals) for the improvement of support services such as cleaning services, laundry services, diagnostic facilities and ambulatory services etc.;
- Developing / leasing out vacant land in the premises of the hospital for commercial purposes with a view to improve financial position of the Society;
- Encouraging community participation in the maintenance and upkeep of the hospital;
- Promoting measures for resource conservation through adoption of wards by institutions or individuals; and
- Adopting sustainable and environmental friendly measures for the day-to-day management of the hospital, e.g. scientific hospital waste disposal system, solar lighting systems, solar refrigeration systems, water harvesting and water recharging systems etc.

The RKS/HMS will not function as a Government agency, but as an NGO as far as functioning is concerned. It may utilize all Government assets and services to impose user charges and shall be free to determine the quantum of charges on the basis of local circumstances. It may also raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies.

Check Your Progress 3

1) In High Performing States who are eligible for financial assistance under *Janani Suraksha Yojna?*

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2) What are the entitlements for pregnant women under the Janani Shishu Suraksha Karyakram (JSSK)?

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3) Who are the members of Rogi Kalyan Samiti?

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4) What are the functions of Rogi Kayan Samiti?

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6.7 QUALITY IN HEALTH CARE

It is has been recognized that quality is one of the most important aspect of services being delivered at any health facility. The NHM also affirms to provide good quality health services at all public health facilities. The National Rural Health Mission (NRHM) introduced the concept of quality in government health care system by proposing the Indian Public Health Standards (IPHS).

6.7.1 Indian Public Health Standards (IPHS)

IPHS are a set of uniform standards envisaged to improve the quality of health care delivery in the country. The Indian Public Health Standards (IPHS) were first developed in 2005 for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals.

The standards provide criteria for location, layout and space for buildings and other infrastructural facilities.

IPHS standards also describe the minimum assured services that must be available at these centres and job responsibilities of various functionaries.

These IPHS guidelines act as the main driver for continuous improvement in quality and serve as the benchmark for assessing the functional status of health facilities.

The IPHS documents have been revised keeping in view the changing protocols of the existing programmes and introduction of new programmes especially for Non-Communicable Diseases.

Flexibility is allowed to suit the diverse needs of the States and regions.

To ensure quality, every institution is required to have standard operative procedures (SOPs) and standard treatment guidelines (STGs) for management of common diseases and National Health Programmes.

All health facilities are required to display citizen's charter, and set up Rogi Kalyan Samiti (Patient Welfare Committee), which will ensure community control in hospital management.

6.7.2 National Quality Assurance Framework for Health Facilities

To improve quality of healthcare in over 31,000 public facilities and provide a clear roadmap to States, Quality Standards for District Hospitals (DHs), CHCs and PHCs under National Quality Assurance Framework were rolled out in November, 2014.

This NQAS (National Quality Assurance Standards) Framework comprises of four interrelated approaches and activities to achieve patient centric quality system:

1) Instituting Organizational Framework for Quality
2) Defining Standards of Service Delivery and Patient Care
3) Continuous Assessment of services against set standards
4) Improving Quality through closing gaps and implementing opportunities for Improvement.

6.7.3 'Kayakalp' - An Initiative for Award to Public Health Facilities

Kayakalp initiative has been launched to promote cleanliness, hygiene and infection control practices in public health facilities. Under this initiative public healthcare facilities shall be assessed and the public healthcare facilities that show exemplary performance in meeting standards of protocols of cleanliness, hygiene and infection control will receive awards and commendation.

Further, *Swachhta* Guidelines to promote Cleanliness, Hygiene and Infection Control Practices in public health facilities were released on 15th May, 2015. The Guidelines provide details on the planning, frequency, methods, monitoring etc. with regard to *Swachhta* in public health facilities.

6.8 OTHER INITIATIVES

6.8.1 Strengthening of AYUSH

Under the NHM it is re-emphasized that AYUSH and alternative systems of medicine, such as tribal medicinal practices must be built into the programme, since the cultural acceptance of such forms of medicine is higher in some areas.

Mainstreaming and strengthening of AYUSH continues to be a strategy of NHM, as it enhances choice of services for users and provides an opportunity to revitalize local health care traditions.
In many places, the Indian Systems of Medicine & Homoeopathy continue to be widely used due to their accessibility, and sometimes, because they offer the only kind of medicine within the physical and financial reach of the patient.

– As per the Annual Report of the Ministry of Health and Family Welfare (2015-16), mainstreaming of AYUSH has been taken up by allocating AYUSH facilities in 10042 PHCs, 2732 CHCs, 501

District Hospitals, 5714 health facilities above Sub-Centre but below block level and 421 health facilities other than CHC at or above block level but below district level.

– AYUSH practitioners are being trained in family planning services, as well as preventive and promotive health services, including screening for NCDs.

– AYUSH modules have been included in the training package of ASHA. For management of anaemia during pregnancy, *'punarvadimandoor'* has been included in the drug kit of ASHA, along with seven Ayurvedic and five Unani medicines.

– Integrated AYUSH hospitals with 50/100 bed capacity, along with speciality clinics will be set up in district hospitals.

– Wherever feasible AYUSH doctors will be give training in IUCD insertion, SBA, Essential newborn care, WIFS, monitoring of immunization programme etc.

6.8.2 Universal Health Coverage (UHC)

India has started its efforts to meet the target of achieving Universal Health Coverage (UHC) for all. The State will be responsible or ensuring and guaranteeing UHC for its citizens, and everybody will be entitled for comprehensive health security. It will be obligatory on the part of the State to provide adequate food, appropriate medical care, safe drinking water, proper sanitation, education and health-related information for good health.

It has been recognized that the delivery of UHC requires the availability of adequate healthcare infrastructure, skilled health workforce and access to affordable drugs and technologies to ensure the entitled level and quality of care given to every citizen. Further, the design and delivery of health programmes and services require efficient management systems as well as active engagement of empowered communities.

Under NHM, each state would be encouraged to undertake two to three pilot districts, if they are performing well in the existing programmes. The pilots would demonstrate how access to care and social protection against the costs of care can be meaningfully expanded in the most cost effective manner, while at the same time reducing health inequity.

Three key preparatory activities for undertaking pilot districts are:

1) A good baseline measurement of the effective coverage/access to different services and the current out of pocket expenditure on health care.

2) A good quality district action plan.

3) A health management information system linked to family health cards, which is able to support population-based health services for both RCH and NCDs as well as support continuity of care across different levels of care.

6.8.3 Kilkari

To create awareness among pregnant women, parents of children and field workers about the importance of Ante-Natal Care (ANC), Institutional Delivery, Post-Natal Care (PNC) and Immunization, it was decided to implement the Kilkari and Mobile Academy services across India in phased manner. In the first phase Kilkari would be launched in 6 States viz. Uttarakhand, Jharkhand, Uttar Pradesh, Odisha, Rajasthan High Priority Districts (HPDs) and Madhya Pradesh High Priority Districts (HPDs). The Mobile Academy would be launched in 4 States viz. Uttarakhand, Jharkhand, Rajasthan and Madhya Pradesh.

Kilkari is an Interactive Voice Response (IVR) based mobile service that delivers time-sensitive audio messages (Voice Call) about pregnancy and child health directly to the mobile phones of pregnant women, mothers of young children and their families. The service covers the critical time period – where the most maternal/infant deaths occur from the 4th month of pregnancy until the child is one year old. Families which subscribe to the service receive one pre-recorded system generated call per week. Each call will be 2 minutes in length and serve as reminders for what the family should be doing that week depending on woman's stage of pregnancy or the child's age. Kilkari services will be available to states in regional dialect too.

6.8.4 Mobile Academy

It is an anytime, anywhere audio training course on interpersonal communication skills that the ASHA can access from her mobile phone. It gives ASHAs tips on how to convince families to adopt priority RMNCH behavioors, while refreshing her existing knowledge. The course is 240 minutes long and consists of 11 chapters with 4 lessons each. At the end of each chapter, there is a quiz for them the ANM/ ASHAs who pass the course will be provided with a certificate.

Check Your Progress 4

1) What are the various quality initiatives under the National Health Mission?

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2) What do you understand by the term "Universal Health Coverage"?

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3) How will AYUSH doctors be involved in National Health Mission?

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6.9 LET US SUM UP

In this unit, you have learnt about the main features of the National Health Mission (NHM). The NHM encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The NRHM focused primarily on rural population, and for the health needs of the urban poor, National Urban Health Mission (NUHM) has been launched.

You also learnt that the main strategy of NHM is strengthening of primary health care system, and community participation. The key feature of having a female health activist chosen from the local community i.e. ASHA (Accredited Social Health Activist), which was initially launched under NRHM, will continue to be strengthened under NHM. ASHA is envisaged as a change agent, who will create health awareness, promote good health practices, mobilize the community and provide a minimum package of curative care. The important initiatives under NHM i.e. financial assistance for institutional delivery under *Janani Suraksha Yojna*, entitlements for pregnant women, neonate and sick young infants, under JSSK (*Janani Shishu Suraksha Karyakram)*, Kilkariand mobile academy have been described. The processes of community involvement like Rogi Kalyan Samitis and Mahila Arogya Samuh have also been discussed. The strengthening of AYUSH is another key strategy under the NHM.

You also learnt about the quality initiatives under NHM, including the Indian Public Health Standards, National Quality Assurance Framework, and Kayakalp initiatives. You have been introduced to the concept of Universal Health Coverage and that under the NHM, UHC will be piloted in selected districts of the country.

6.10 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) (i) National Rural Health Mission (ii) National Urban Health Mission on covered under NUHM is the urban population, with special focus on urban poor, particularly the slum dwellers and other disadvantaged sections like rickshaw pullers, street children, homeless people, and construction site workers.

Check Your Progress 2

1) The criteria for selection of ASHA are:

   ASHA must be a woman resident of the village (in rural areas) or slum/vulnerable cluster (in urban areas).

   She should be preferably 'Married/Widow/Divorced/Separated' and in the age group of 25 to 45 years.

   She should be a literate woman with education up to tenth standard.

2) Roles and responsibilities of ASHA are:

Creation of awareness regarding nutrition, basic sanitation and hygienic practices, immunization, information on existing health services etc.

Counselling on birth preparedness, safe delivery, breast-feeding and complementary feeding, immunization, contraception

Community mobilization: She will facilitate the beneficiaries in accessing services available at the Anganwadi/sub-centre/primary health centres.

Escort/Accompany seriously-ill children or women with pregnancy related complications to the nearest health facility.

Minimum curative care for minor ailments

Depot holder for essential provisions like ORS, Iron Folic Acid Tablet (IFA), Chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.

Information of births and deaths, as well as any unusual health events or outbreaks in the community to the Sub-Centre or Primary Health Centre.

Participation in Village Health and Sanitation Committee. She will also help in organizing village health and nutrition day (VHND) at the Aaganwari centres.

Check Your Progress 3

1) In High Performing States, all BPL/SC/ST women who deliver in a government health facility or accredited private health facility are eligible for financial assistance under *Janani Suraksha Yojna*.

2) Under JSSK, all pregnant women delivering in public health institutions are entitled for free delivery, including caesarean section.The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home, and exemption from all kinds of user charges.

3) Members from local Panchayati Raj Institutions (PRIs), NGOs, local elected representatives and officials from Government sector are the members of Rogi Kalyan Samiti.

4) The RKS works for smooth functioning of the hospital and for ensuring quality of services. It identifies the problems faced by the patients in CHC/PHC; encourages community participation in the maintenance and upkeep of the hospital; helps in acquiring equipment, furniture, and ambulance etc.

Check Your Progress 4

1) The various quality initiatives under the National Health Mission are:

- Indian Public Health Standards
- National Quality Assurance Framework
- *Kayakalp* initiative

2) Universal Health Coverage (UHC) means all individuals will be entitled for comprehensive health security. It will be obligatory on the part of the State to provide adequate food, appropriate medical care, safe drinking water, proper sanitation, education and health-related information for good health.

3) It is planned to integrated AYUSH hospitals with 50/100 bed capacity, along with specialty clinics will be set up in district hospitals. AYUSH practitioners are being trained in family planning services, as well as preventive and promotive health services, including screening for NCDs.

   Wherever feasible AYUSH doctors will be give training in IUCD insertion, SBA, Essential newborn care, WIFS, monitoring of immunization programme etc.

6.11 FURTHER READINGS

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