NATIONAL RURAL HEALTH MISSION

MEETING PEOPLE'S HEALTH NEEDS

IN PARTNERSHIP WITH STATES

THE JOURNEY SO FAR

2005 – 2010

Ministry of Health and Family Welfare

Government of India

FROM THE MINISTER'S DESK

It gives me immense pleasure to place before you a report on the progress of National Rural Health Mission till January 2010. Though the journey of NRHM began in April 2005, its detailed Framework for Implementation was approved in July 2006. Given the diversity of needs of over a million hamlets and villages in our country in rural areas, it took a while to reach the programme to every corner. I am happy to share with you that ASHA, the visible face of NRHM, as the Community Health Worker is there in all the high focus States. Most non-high focus States have also chosen the Community Health Worker as it has contributed towards better utilisation of health services.

Health is a State subject and the Government of India has always tried to work in partnership with States to meet people's needs. As the report will indicate, it is through this partnership with constant monitoring and support that we have provided for increasing the out-patient cases, in-patient cases, institutional deliveries availability of drugs, diagnostic services and full immunization through public health system. In many ways NRHM signals the rejuvenation of the public system of health care. By adding over one lakh doctors, specialists, nurses, ANMs, AYUSH doctors, paramedics, NRHM is a revolution in human resources. To further strengthen our resolve to improve the challenge of human resources, we have taken important decisions regarding availability of post-graduate and MBBS doctor seats in States as also regarding the establishment of medical colleges in backward areas. We are also contemplating the introduction of Bachelor of Rural Health Care Service to tackle the human resources shortages.

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. Alongside our efforts on human resources, NRHM has the potential to completely transform the availability of quality care in rural areas.

ASHAs are connecting households to health facility and the thrust of NRHM in strengthening the system through decentralised management of health care is leading to community ownership and participation on an unprecedented scale. Community processes take a little time and I am sure the results of NRHM will confirm the intensive efforts made to link households with the health system.

To meet the challenges of difficult, most difficult and inaccessible areas we have made special provision for human resources as also for priority to districts whose health indicators are unsatisfactory. In partnership with States, we propose to put our total focus in the rural areas on improving the quality of health care in difficult, most difficult and inaccessible areas.

Some early results of our efforts have started showing in the decline in infant mortality, maternal mortality, total fertility etc. I am confident that concerted efforts by this Mission with the unstinted support of State Governments will lead India towards achieving National Health Goals 2012 as also the Health Millennium Development Goals 2015.

GHULAM NABI AZAD
MINISTER,
MINISTRY OF HEALTH AND FAMILY WELFARE

8 MARCH 2010

NEW DELHI

FROM THE SECRETARY'S DESK

I am very pleased that NRHM is bringing out a publication on the progress made by the Mission over the last five years. Public health is a major challenge in our country and NRHM is a concerted effort to drive reforms with resources. The Mission has been trying to provide quality health care that is accessible, affordable and accountable. It has also made efforts to work with the wider determinants of health care like clean water, sanitation, nutrition, women's empowerment, social empowerment of vulnerable groups, etc. Though health is a State subject, the Ministry of Health and Family Welfare has been working closely with the States to take evidence based decisions in moving forward the public health agenda.

Efforts have been made to further focus on vulnerable social groups and districts with unsatisfactory health indicators. A process of identifying most difficult, difficult and inaccessible areas has been under way to enable provision of monetary and non-monetary incentives to attract human resources for health in remote facilities.

We have been trying to learn and improve as we roll out the NRHM in partnership with States. This publication is intended to encourage further debate and discussion on the best way forward. NRHM is committed to a larger role for the civil society organisations in the planning, monitoring and implementation of NRHM. Efforts to further strengthen the processes of community monitoring to make the public system accountable to the people will be made in the months to come.

Ms. K. Sujatha Rao
Secretary,
Department of Health and Family Welfare

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I - EXECUTIVE SUMMARY

I. N R H M

- Launched in April 2005
- Framework for Implementation approved in July 2006
- Provides support to States for strengthening system of health care in rural areas through provision of physical infrastructure, human resources, equipment, emergency transport, drugs, diagnostics and other support
- Covers all programmes in the health sector except HIV/AIDS, Mental Health and Cancer
- Provides untied funds to all health facilities starting from Village Health and Sanitation Committees to District Hospitals
- Provides management support to strengthen capacity for decentralised management of health
- Provides for constitution of community institutions at health facility level
- Provides a community worker called ASHA in every village
- Allows States to innovate and promotes flexible financing to allow local decision making

II. Human Resources

- 7.49 lakh ASHAs selected
- 7.05 lakh ASHAs trained up to first module
- 5.65 lakh ASHAs trained up to fourth module
- 5.20 lakh ASHAs with drug kits in villages
- 46,690 ANMs appointed on contract
- 26,793 Staff Nurses appointed on contract
- 8,624 MBBS doctors appointed on contract

- 2,460 Specialists appointed on contract
- 7,692 AYUSH doctors appointed on contract
- 14,490 Paramedic Staff appointed on contract
- Pressure on States to fill up existing vacancies
- Responsibility for existing vacancy with State Government
- NRHM provides support on contract for new positions as per Indian Public Health Standards at various levels

III. Physical Infrastructure and its upkeep

- NRHM provides for untied funds and maintenance grants to all government health facilities from Sub Centres, PHCs, CHCs, Sub District and District Hospitals
- All District Hospitals provided Rs.20 lakhs as initial grant for up-gradation of facilities to meet increased case load
- District Hospitals in the North Eastern region provided rupees one crore for hospital up-gradation of hospitals
- All Community Health Centres provided Rs.20 lakhs for up-gradation of facilities to meet increased case load
- 9144 Sub Centres for new construction and 8997 for renovation taken up under NRHM
- 1009 Primary Health Centres taken up for new construction and 2081 for renovation under NRHM
- 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.
- 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 and 357 District Hospitals for renovation have been taken up under NRHM

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

IV. Mobile Medical Units, Ambulances and Emergency Transport

- 1031 Mobile Medical Units operational under NRHM in States
- Emergency Transport System operational in 12 States with the assistance of 2919 Ambulances
- Another 1674 Ambulances provided to States for working at PHC, CHC, Sub District and District Hospital

V. Communitisation under NRHM

- 451,473 Village Health and Sanitation Committees set up under NRHM
- 29,223 Rogi Kalyan Samitis set up under NRHM

VI. Service guarantees under NRHM

- 146,036 Sub Centres Functional in the country
- 23,458 Primary Health Centres functional
- Of these, 8,324 have been made 24X7
- 4,276 Community Health Centres in the country
- 15,196 health facilities in rural areas (not counting District Hospital) made 24X7
- 2,463 First Referral Units in the country

VII. Financing of NRHM

- Increasing public expenditure on health to 2-3%. GDP was stated at the launch of NRHM.

- While expenditure of State Governments and Central Government has increased, it is not enough to reach 2-3% GDP.
- As per Economic Survey 2010, the increase is from 1.19% in 2004-05 to 1.45% in 2009-10.
- As per the National Health Accounts of the Ministry of Health, the increase is from 0.84% in 2004-05 to 1.1% in 2008-09
- In 2005-06 Rs.6730 crores was the outlay for NRHM against which Rs.5703 crores was released.
- In 2006-07 the NRHM outlay was Rs.9000 crores against which Rs.7486.6 crores was released
- In 2007-08 Rs.10890 crores was allotted to NRHM. The expenditure was Rs.10310 crores (94%)
- In 2008-09, Rs.11930 crores was allotted and the expenditure was Rs.11260 crores
- In 2009-10, Rs.14050 crores was allotted and the expenditure was Rs.10013.01 crores (till 31st January 2010).
- The utilization of funds in the States has considerably improved over the last few years. Under the RCH Flexible Pool the expenditure has gone up from Rs.301.49 crores in 2005-06 to Rs.972.74 crores in 2006-07, Rs.1999.25 crores in 2007-08, Rs.3077.16 crores in 2008-09 and Rs.2098.88 crores in 2009-10.
- Under the Mission Flexible Pool the utilization has gone up from Rs.41 crores in 2005-06 to Rs.431 crores in 2006-07, Rs.1527 crores in 2007-08, Rs.3256 crores in 2008-09 and Rs.2679 crores in 2009-10.
- This clearly shows how the absorptive capacity in the States has considerably increased over the years.
- More financial resources are needed to provide quality health care in rural areas as this sector was totally neglected in the past.

Assessment of Progress under NRHM

	Expected Outcomes	**Baseline and Achievement as per last independent survey**
1.	IMR reduced to 30/1000 live births by 2012	IMR was 58 in 2005. It is down to 53 in 2008. There has been a 3 point decline in rural IMR as against 1 point in urban IMR in 2008. More concerted efforts to tackle malnutrition and neo-natal mortality will facilitate a 5 point decline required for achievement of expected outcome. 5 States have achieved the goal and 12 States are in the 30-40 range.
2.	Material Mortality reduced to 100/100,000 by 2012	MMR was 301 in 2001-03. It was 254 in 2004-06. JSY was launched in 2005 and early gains are captured in the reduction. The thrust on institutional deliveries and assured referral transport, together with efforts to improve the quality of care in facilities is likely to further increase the pace of reduction of MMR. 8 States are below 200 in 2004-06 and Kerala was already at 95.
3.	TFR reduced to 2.1 by 2012	TFR was 2.9 in 2005. It reduced to 2.6 in 2008. 14 States/UTs are already below replacement level. 7 States and UTs are between 2.2 and 2.6. Bihar, UP, MP, Rajasthan, Jharkhand, and Chhattisgarh have TFR between 2.7 and 3.9.
4.	Malaria Mortality Reduction Rate - 50% up to 2010, additional 10% by 2012	45.23% reduction in malaria mortality reported in first two years (2006 to 2008). There is an issue of under reporting of cases which also needs to be examined.
5.	Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.	21.93% reduction in deaths from 2006 to 2008.
6.	Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.	26.74% reduction from 2006 to 2008.

7.	Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level until 2012	56.52% reduction of deaths in first two years (2006 to 2008).
8.	Cataract operations-increasing to 46 lakhs until 2012	Already being achieved every year.
9.	Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less that 1 per 10,000 thereafter.	Target achieved in December 2005 and maintained thereafter.
10.	Tuberculosis DOTS maintain 85% cure rate through entire Mission Period	87% cure rate has been maintained. Case detection rate has moved from 70% to 72%.
11.	Upgrading Community Health Centers to Indian Public Health Standards	Physical infrastructure up-gradation, human resource augmentation, equipment provision taken up in nearly all Community Health Centres. DLHS-III found 90.1% having normal delivery services. Since the IPHS provides for a high standard, it will take some time before augmentation is as per IPHS. However, service guarantees have shown considerable improvement in the Common Review Missions.
12.	Increase utilization of First Referral units from less than 20% to 75%.	Though no separate data on utilization levels in FRUs is currently available, the Common Review Mission has reported much higher utilization of in-patient facilities due to increased institutional deliveries.
13.	Engaging 2,50,000 female Accredited Social Health Activists (ASHAs) in 10 states	7.49 lakh ASHAs in all States/UTs (except HP and Tamil Nadu) have been selected. 5.65 lakh have completed training up to IV Module. 5.20 Lakh has been provided drug kits.

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

I - INTRODUCTION – THE JOURNEY SO FAR

The NRHM was launched by the Hon'ble Prime Minister in April 2005. Its detailed Framework for Implementation which gave it the mandate for large scale health sector reforms was approved in July 2006. The design of the National Rural Health Mission (NRHM) was a very inclusive process. A large number of task forces were set up with the best of public health experts, civil society representatives and government servants to look at some of the key areas where interventions are required. These task forces examined issues like health financing, primary health structure, partnership with non-governmental organizations, medical and nursing education, role of rural health practitioners etc. It was through this consultative process that the framework for NRHM was finalized.

2. It provided for adequate flexibility for States to identify their key concerns and to develop interventions that address their specific problems. Human resources has been a priority in the planning stage itself as it was felt that a major issue in India is the non-availability of skilled health personnel round the clock. The NRHM also had the advantage of having the report of National Commission for Macro Economics and Health and the Mid Term Appraisal note on the X Plan prepared by the Planning Commission. The framework for implementation made use of all these reports in the public domain to arrive at a robust framework for Centre-State partnership to improve outcomes in the health sector.

3. In its journey of last five years, NRHM has tried to push reforms with resources in partnership with the State and UT governments. Health is a State subject and NRHM has respected the leadership of the States and UTs in bringing about reform and improvement in health indicators. The NRHM Framework for Implementation has pushed communitisation of facilities, adequate and flexible financing with community accountability, monitoring progress against Indian Public Health Standards,

innovations in human resources, engagement and building of capacity at all levels for effective and efficient decentralized management of the health system.

4. Besides the Annual Common Review Mission which visits 13 – 17 States with a team of public health experts, civil society representatives, development partners etc., the NRHM has been subjected to a large number of external surveys and studies during the last four years. From the DLHS-III Survey 2007-08 conducted under the supervision of IIPS Mumbai to the SRS of the Census of India, the Performance Audit by the CAG, Citizens' Report by Civil Society, Community Monitoring Reports through the Advisory Group on Community Action, Planning Commission Study by Ms. Kaveri Gill, Jeffry Sachs' and Nirupam Bajpai's study in three North Indian States, evaluation studies on the Janani Suraksha Yojana programme in eight States, etc. have been brought out during this period. It is actually possible to take stock of which way the Mission has moved during these years.

5. Based on a careful evidence based assessment of progress as recorded by independent studies and review missions, it is clear that NRHM has led to increase in outpatient cases, inpatient cases, institutional deliveries, availability of ambulances, presence of community health worker in every village, better availability of drugs and diagnostics and most importantly a sincere effort to craft a credible public system. The weakness of the health system in India before NRHM is public knowledge and it is also well known that India was incurring one of the lowest public expenditure on health in the world with less than 1% GDP. It is also well known how public system had become dysfunctional in a large number of States and how new programme after programme for diseases and family welfare were working on the flawed assessment that there was primary care system waiting to deliver services. NRHM questioned this very basic paradigm and gave the maximum thrust to human resources for health and that too,

specific to institutions and on a contract to enable greater community accountability of the human resource deployed under NRHM.

6. NRHM also provided an opportunity at each level from the Village to the Sub Centre, the PHC, the CHC, the Sub Divisional Hospital, and the District Hospital to create a community institution under the umbrella of the Panchayati Raj local government system, with provision of untied funds to meet institution and village specific needs for health care. Effective decentralized management is a difficult exercise as it always involves delegation of powers and financial resources to local community institutions. Large systems have a tendency to stall decentralisation as many government systems perceive this as an empowerment of local level facilities. It is for this reason that in a number of States the utilisation of untied funds at the local village, sub centre, PHC, CHC level remains slow in the initial phase. Many institution heads at these levels had lost the confidence to spend as per their felt need on account of over centralization over the last five decades. That confidence has come by and today as the Common Review Mission report indicates a large number of institutions have made good use of these resources as per their felt need. The unspent balances pointed out by Performance Audit in the initial period are on account of this uncompromising priority of NRHM for decentralized management of the health system.

7. NRHM has a mandate to ensure that 70% of the financial resources get spent at the block and the below block level and only 20% at the district level. NRHM has pushed this quest for flexible financing with local level community accountability and this did indeed lead to slow utilisation in the initial years. NRHM has successfully set up institutions for communitisation and is engaged in the process of making them even more vibrant and effective government institutions. It has gone beyond the monopoly of PRI by also co-opting self help groups, women's groups or any one with motivation in the Village Health and Sanitation Committees constituted under the umbrella of PRI. These community processes take time especially in a sector like health where

decentralization was not on the agenda at all over most parts of the country and PHCs, CHCs functioned without any control of local government in most States.

8. The studies on JSY have brought out the fact that institutional deliveries have increased tremendously across all States and more so in States like MP, Orissa, Rajasthan, Assam, Bihar and over the last two years in UP as well. Some other studies like one by Human Rights Watch in UP has also highlighted the issue of quality of care and the denial of good services to poor women at many facilities. While resources are available with government facilities for improving the quality of care, it is also true that the pace of refurbishment and improvement of quality in health facilities has not kept pace with the demand for institutional delivery services in many States on account of the JSY financing. States like Jharkhand and Chhattisgarh have moved slowly on institutional deliveries and by and large their strength has remained at the sub centre and community health worker level rather than at higher level institutions.

9. The journey of NRHM is one of State/UT government led reforms with resources. The Government of India only indicates the resource envelope to the States and it is the States that develops the detailed Programme Implementation Plan based on the District Health Action Plans in their State. There is a State Health Mission under the Chief Minister monitoring the progress of NRHM in the State. This has led to innovations on an unprecedented scale across the country. From Boat Clinics in Assam to partnerships with Tea Gardens for the health care to the poor, partnerships for diagnostics in Bihar and West Bengal, emergency transport systems designed as per local needs in Haryana, Andhra Pradesh, Gujarat, Rajasthan and many other States. There has been large scale innovation in human resource engagement with Rural Medical Assistants selected in Chhattisgarh and Rural Health Practitioners selected in Assam. Orissa has recruited AYUSH doctors to provide services at PHC where there was no MBBS doctor. States have been encouraged to think through their problems and come forward with their own solutions. Government of India has played the role of

sharing good practices through thematic workshops across States so that States can learn from each other and emulate the best practice. Efforts to set up procurement and logistic systems like the Tamil Nadu Medical Service Corporation has been made in few States and a greater thrust is being placed on it to ensure availability of quality, drugs and equipments at all levels in a sustainable manner. Similarly, buildings are either being renovated or constructed in over 20% Sub Centres and 75% CHCs and District Hospitals under the NRHM.

10. The SRS Data has indicated that IMR is down to 53 with a reduction of three points in rural IMR in 2008. IMR is a complex indicator where many factors play a role and, therefore, attribution is difficult. For example, nutrition has a role in reduction of mortality and morbidity and it is looked after by another department. Even then, NRHM has undertaken successful experiments in Nutrition in a number of States. Similarly, reduction in maternal mortality as indicated by SRS was from 301 in 2001-03 to 254 during the period 2004-06. These were initial years of NRHM and the Mission is confident that there would be a significant decline on maternal mortality on account of the large scale interventions for strengthening health system under NRHM and demand side financing under JSY. There is no doubt that quality needs to improve manifold and that even after addition of 7.49 lakh ASHAs as community health workers, over 73,000 Nurses and ANMs, over 18,000 Doctors, AYUSH Practitioners and over 14,000 Paramedics, Lab Technicians etc. under NRHM, there is still a long way to go on human resources. Certain structural changes are being attempted in Medical and Nursing Education to meet human resource shortfalls, but a lot has been done to make government service interesting and attractive for young medical graduates. The proof of this lies in the growing number that have once again started joining government service in State after State where systems of recruitment have been simplified. Non-monetary incentives like admission to PG courses by serving in rural areas have caught the motivation of young doctors. Special monetary incentives in naxalite areas and

difficult and inaccessible areas have also encouraged help human resources to move in areas where they are needed.

1. SPECIFIC GAINS TO THE HEALTH SYSTEM

	Activity/Intervention	The Specific gain from NRHM
1.	Human Resources	7.49 lakh ASHAs (Community Health Workers) selected. 7.05 lakhs ASHAs trained upto 1st Module and 5.65 lakhs upto 4th Module; 5.20 Lakh ASHAs with drug kits in villages. 8,624 MBBS Doctors 2460 Specialists, 46,660 ANMs, 26,793 Staff Nurses, 7692 AYUSH Doctors, 3143 AYUSH Paramedics added to the system under NRHM.
2.	Physical Infrastructure	9144 new Health Sub Centre buildings, 8997 up-gradation of Sub Centre buildings, 1009 new PHC buildings, 2081 up-gradation of PHC buildings, 435 new CHC buildings and 1255 upgradation of CHC buildings, 57 new District Hospitals and 387 up-gradations of District Hospitals have been taken up under NRHM.
3.	Untied grants for maintenance and local action.	All Health Sub Centres, PHCs, CHCs, Sub District and District Hospitals are provided untied grants to improve the facilities under the supervision of Panchayati Raj Institutions and Rogi Kalyan Samitis at the facility levels. This has considerably improved the maintenance of facilities all over the country.
4.	Janani Suraksha Yojana	Considerable progress has been made in JSY. From 7.04 lakh women covered under JSY in 2005-06, the coverage in 2008-09 was 86.22 lakhs, and 78.41 in 2009-10 so far, which is nearly one third of all deliveries in India every year.
5.	Mobile Medical Units	1031 MMUs under NRHM are working to provide diagnostic and outpatient care closer to hamlets and villages in remote areas.
6.	Emergency Medical transport and ambulance systems	States have used NRHM funds to provide a variety of emergency transport systems and ambulances to improve timely attention hospital referral for households.
7.	Doctors, drugs and diagnostics	NRHM has added doctors and paramedics on a large scale leading to more care for patients. Availability of resources for drugs and diagnostics has improved with NRHM support to States.

Service Guarantee under NRHM

Sl. No.	State / UTs	No. of Sub Centres	No. of Primary Health Centres	No. of Community Health Centres	24X7 PHCs	24x7 health inst at all levels	First Referral Units (FRUs)
High Focus Non - NE States							
1	Bihar	8858	1641	70	533	625	76
2	Chhattisgarh	4741	721	136	418	578	56
3	Himachal Pradesh	2071	449	73	95	204	51
4	Jammu & Kashmir	1907	375	85	105	149	58
5	Jharkhand	3958	330	194	194	388	19
6	Madhya Pradesh	8834	1149	270	212	533	87
7	Orissa	6688	1279	231	64	282	48
8	Rajasthan	10742	1503	349	500	1267	100
9	Uttar Pradesh	20521	3690	515	648	1037	136
10	Uttarakhand	1765	239	55	94	198	72
High Focus NE States							
11	Arunachal Pradesh	592	116	44	55	86	10
12	Assam	4592	844	103	343	464	60
13	Manipur	420	72	16	20	36	1
14	Meghalaya	401	103	26	14	40	9
15	Mizoram	366	57	9	56	67	8
16	Nagaland	397	86	21	33	54	11
17	Sikkim	147	24	4	24	48	3
18	Tripura	579	76	11	58	80	5
Non High Focus States – Large							
19	Andhra Pradesh	12522	1570	167	800	1026	194
20	Goa	172	19	5	13	19	2
21	Gujarat	7274	1073	273	331	627	148
22	Haryana	2433	420	86	318	429	104
23	Karnataka	8143	2195	323	940	1413	149
24	Kerala	5094	909	107	178	337	65
25	Maharashtra	10579	1816	407	663	1106	466
26	Punjab	2858	484	126	182	332	126
27	Tamil Nadu	8706	1215	206	1215	3060	291
28	West Bengal	10356	924	349	168	592	61
Non High Focus Smalls & UTs							
29	A & N Island	114	19	4	17	21	1
30	Chandigarh	14	0	2	0	2	3
31	D & N Haveli	38	6	1	6	7	2
32	Daman & Diu	22	3	1	2	3	3
33	Delhi	41	8	0	1	35	25
34	Lakshadweep	14	4	3	4	7	9
35	Puducherry	77	39	4	20	44	4
	Total	146036	23458	4276	8324	15196	2463

Sl.No.	States	Crude Birth Rate										
		2003	2004	2005	2006	2007	2008	Change (in points)				
								2004 / 2003	2005 / 2004	2006 / 2005	2007 / 2006	2008 / 2007
	ALL INDIA	**24.8**	**24.1**	**23.8**	**23.5**	**23.1**	**22.8**	**-0.7**	**-0.3**	**-0.3**	**-0.4**	**-0.3**
1	Andhra Pr.	20.4	19.0	19.1	18.9	18.7	18.4	-1.4	0.1	-0.2	-0.2	-0.3
2	Assam	26.3	25.1	25.0	24.6	24.3	23.9	-1.2	-0.1	-0.4	-0.3	-0.4
3	Bihar	30.7	30.2	30.4	29.9	29.4	28.9	-0.5	0.2	-0.5	-0.5	-0.5
4	Chhatisgarh	25.2	27.4	27.2	26.9	26.5	26.1	2.2	-0.2	-0.3	-0.4	-0.4
5	Gujarat	24.6	24.3	23.7	23.5	23.0	22.6	-0.3	-0.6	-0.2	-0.5	-0.4
6	Haryana	26.3	25.1	24.3	23.9	23.4	23.0	-1.2	-0.8	-0.4	-0.5	-0.4
7	Jharkhand	26.3	26.2	26.8	26.2	26.1	25.8	-0.1	0.6	-0.6	-0.1	-0.3
8	Karnataka	21.8	20.9	20.6	20.1	19.9	19.8	-0.9	-0.3	-0.5	-0.2	-0.1
9	Kerala	16.7	15.2	15.0	14.9	14.7	14.6	-1.5	-0.2	-0.1	-0.2	-0.1
10	Madhya Pr.	30.2	29.8	29.4	29.1	28.5	28.0	-0.4	-0.4	-0.3	-0.6	-0.5
11	Maharashtra	19.9	19.1	19.0	18.5	18.1	17.9	-0.8	-0.1	-0.5	-0.4	-0.2
12	Orissa	23.0	22.7	22.3	21.9	21.5	21.4	-0.3	-0.4	-0.4	-0.4	-0.1
13	Punjab	20.6	18.7	18.1	17.8	17.6	17.3	-1.9	-0.6	-0.3	-0.2	-0.3
14	Rajasthan	30.3	29.0	28.6	28.3	27.9	27.5	-1.3	-0.4	-0.3	-0.4	-0.4
15	Tamil Nadu	18.3	17.1	16.5	16.2	15.8	16.0	-1.2	-0.6	-0.3	-0.4	0.2
16	Uttar Pr.	31.3	30.8	30.4	30.1	29.5	29.1	-0.5	-0.4	-0.3	-0.6	-0.4
17	W. Bengal	20.3	19.3	18.8	18.4	17.9	17.5	-1.0	-0.5	-0.4	-0.5	-0.4
18	Arunachal Pr	18.9	21.2	23.3	22.5	22.2	21.8	2.3	2.1	-0.8	-0.3	-0.4
19	Delhi	17.3	18.4	18.6	18.4	18.1	18.4	1.1	0.2	-0.2	-0.3	0.3
20	Goa	13.9	13.8	14.8	15.1	14.7	13.6	-0.1	1.0	0.3	-0.4	-1.1
21	Himachal Pr .	20.6	19.2	20.0	18.8	17.4	17.7	-1.4	0.8	-1.2	-1.4	0.3
22	J & K	18.6	18.7	18.9	18.7	19.0	18.8	0.1	0.2	-0.2	0.3	-0.2
23	Manipur	15.5	13.9	14.7	13.4	14.6	15.8	-1.6	0.8	-1.3	1.2	1.2
24	Meghalaya	24.7	25.2	25.1	24.7	24.4	25.2	0.5	-0.1	-0.4	-0.3	0.8
25	Mizoram	16.0	19.1	18.8	17.8	18.2	17.8	3.1	-0.3	-1.0	0.4	-0.4
26	Nagaland	na	13.9	16.4	17.3	17.4	17.5		2.5	0.9	0.1	0.1
27	Sikkim	21.9	19.5	19.9	19.2	18.1	18.4	-2.4	0.4	-0.7	-1.1	0.3
28	Tripura	14.5	15.0	16.0	16.6	17.1	15.4	0.5	1.0	0.6	0.5	-1.7
29	Uttarakhand	17.2	20.5	20.9	21.0	20.4	20.1	3.3	0.4	0.1	-0.6	-0.3
30	A&N Islands	17.1	16.9	15.7	15.7	15.8	16.9	-0.2	-1.2	0.0	0.1	1.1
31	Chandigarh	14.8	16.1	17.3	15.8	15.7	16.4	1.3	1.2	-1.5	-0.1	0.7
32	D&N Haveli	30.3	28.8	29.4	28.1	27.8	27.0	-1.5	0.6	-1.3	-0.3	-0.8
33	Daman & Diu	22.4	20.0	19.1	18.4	17.8	17.5	-2.4	-0.9	-0.7	-0.6	-0.3
34	Lakshadweep	19.0	20.4	19.1	18.9	18.3	14.3	1.4	-1.3	-0.2	-0.6	-4.0
35	Puducherry	17.5	17.0	16.2	15.7	15.1	16.4	-0.5	-0.8	-0.5	-0.6	1.3

Sl.No.	States	Infant Mortality Rate										
		2003	2004	2005	2006	2007	2008	Change (in points)				
								2004 / 2003	2005 / 2004	2006 / 2005	2007 / 2006	2008 / 2007
	ALL INDIA	**60**	**58**	**58**	**57**	**55**	**53**	**-2.0**	**0.0**	**-1.0**	**-2.0**	**-2.0**
1	Andhra Pr.	59	59	57	56	54	52	0.0	-2.0	-1.0	-2.0	-2.0
2	Assam	67	66	68	67	66	64	-1.0	2.0	-1.0	-1.0	-2.0
3	Bihar	60	61	61	60	58	56	1.0	0.0	-1.0	-2.0	-2.0
4	Chhatisgarh	70	60	63	61	59	57	-10.0	3.0	-2.0	-2.0	-2.0
5	Gujarat	57	53	54	53	52	50	-4.0	1.0	-1.0	-1.0	-2.0
6	Haryana	59	61	60	57	55	54	2.0	-1.0	-3.0	-2.0	-1.0
7	Jharkhand	51	49	50	49	48	46	-2.0	1.0	-1.0	-1.0	-2.0
8	Karnataka	52	49	50	48	47	45	-3.0	1.0	-2.0	-1.0	-2.0
9	Kerala	11	12	14	15	13	12	1.0	2.0	1.0	-2.0	-1.0
10	Madhya Pr.	82	79	76	74	72	70	-3.0	-3.0	-2.0	-2.0	-2.0
11	Maharashtra	42	36	36	35	34	33	-6.0	0.0	-1.0	-1.0	-1.0
12	Orissa	83	77	75	73	71	69	-6.0	-2.0	-2.0	-2.0	-2.0
13	Punjab	49	45	44	44	43	41	-4.0	-1.0	0.0	-1.0	-2.0
14	Rajasthan	75	67	68	67	65	63	-8.0	1.0	-1.0	-2.0	-2.0
15	Tamil Nadu	43	41	37	37	35	31	-2.0	-4.0	0.0	-2.0	-4.0
16	Uttar Pr.	76	72	73	71	69	67	-4.0	1.0	-2.0	-2.0	-2.0
17	W. Bengal	46	40	38	38	37	35	-6.0	-2.0	0.0	-1.0	-2.0
18	Arunachal Pr	34	38	37	40	37	32	4.0	-1.0	3.0	-3.0	-5.0
19	Delhi	28	32	35	37	36	35	4.0	3.0	2.0	-1.0	-1.0
20	Goa	16	17	16	15	13	10	1.0	-1.0	-1.0	-2.0	-3.0
21	Himachal Pr .	49	51	49	50	47	44	2.0	-2.0	1.0	-3.0	-3.0
22	J & K	44	49	50	52	51	49	5.0	1.0	2.0	-1.0	-2.0
23	Manipur	16	14	13	11	12	14	-2.0	-1.0	-2.0	1.0	2.0
24	Meghalaya	57	54	49	53	56	58	-3.0	-5.0	4.0	3.0	2.0
25	Mizoram	16	19	20	25	23	37	3.0	1.0	5.0	-2.0	14.0
26	Nagaland	NA	17	18	20	21	26		1.0	2.0	1.0	5.0
27	Sikkim	33	32	30	33	34	33	-1.0	-2.0	3.0	1.0	-1.0
28	Tripura	32	32	31	36	39	34	0.0	-1.0	5.0	3.0	-5.0
29	Uttarakhand	41	42	42	43	48	44	1.0	0.0	1.0	5.0	-4.0
30	A&N Islands	18	19	27	31	34	31	1.0	8.0	4.0	3.0	-3.0
31	Chandigarh	19	21	19	23	27	28	2.0	-2.0	4.0	4.0	1.0
32	D&N Haveli	54	48	42	35	34	34	-6.0	-6.0	-7.0	-1.0	0.0
33	Daman & Diu	39	37	28	28	27	31	-2.0	-9.0	0.0	-1.0	4.0
34	Lakshadweep	26	30	22	25	24	31	4.0	-8.0	3.0	-1.0	7.0
35	Puducherry	24	24	28	28	25	25	0.0	4.0	0.0	-3.0	0.0

Sl.No.	States	Crude Death Rate										
		2003	2004	2005	2006	2007	2008	Change (in points)				
								2004 / 2003	2005 / 2004	2006 / 2005	2007 / 2006	2008 / 2007
	ALL INDIA	**8.0**	**7.5**	**7.6**	**7.5**	**7.4**	**7.4**	**-0.5**	**0.1**	**-0.1**	**-0.1**	**0.0**
1	Andhra Pr.	8.0	7.0	7.3	7.3	7.4	7.5	-1.0	0.3	0.0	0.1	0.1
2	Assam	9.1	8.8	8.7	8.7	8.6	8.6	-0.3	-0.1	0.0	-0.1	0.0
3	Bihar	7.9	8.1	8.1	7.7	7.5	7.3	0.2	0.0	-0.4	-0.2	-0.2
4	Chhatisgarh	8.5	7.7	8.1	8.1	8.1	8.1	-0.8	0.4	0.0	0.0	0.0
5	Gujarat	7.6	6.9	7.1	7.3	7.2	6.9	-0.7	0.2	0.2	-0.1	-0.3
6	Haryana	7.1	6.6	6.7	6.5	6.6	6.9	-0.5	0.1	-0.2	0.1	0.3
7	Jharkhand	8.0	8.0	7.9	7.5	7.3	7.1	0.0	-0.1	-0.4	-0.2	-0.2
8	Karnataka	7.2	6.9	7.1	7.1	7.3	7.4	-0.3	0.2	0.0	0.2	0.1
9	Kerala	6.3	6.1	6.4	6.7	6.8	6.6	-0.2	0.3	0.3	0.1	-0.2
10	Madhya Pr.	9.8	9.2	9.0	8.9	8.7	8.6	-0.6	-0.2	-0.1	-0.2	-0.1
11	Maharashtra	7.2	6.2	6.7	6.7	6.6	6.6	-1.0	0.5	0.0	-0.1	0.0
12	Orissa	9.7	9.6	9.5	9.3	9.2	9.0	-0.1	-0.1	-0.2	-0.1	-0.2
13	Punjab	7.0	6.4	6.7	6.8	7.0	7.2	-0.6	0.3	0.1	0.2	0.2
14	Rajasthan	7.6	7.0	7.0	6.9	6.8	6.8	-0.6	0.0	-0.1	-0.1	0.0
15	Tamil Nadu	7.6	7.5	7.4	7.5	7.2	7.4	-0.1	-0.1	0.1	-0.3	0.2
16	Uttar Pr.	9.5	8.8	8.7	8.6	8.5	8.4	-0.7	-0.1	-0.1	-0.1	-0.1
17	W. Bengal	6.6	6.3	6.4	6.2	6.3	6.2	-0.3	0.1	-0.2	0.1	-0.1
18	Arunachal Pr	4.7	4.7	5.0	5.0	5.1	5.2	0.0	0.3	0.0	0.1	0.1
19	Delhi	5.0	4.7	4.6	4.7	4.8	4.8	-0.3	-0.1	0.1	0.1	0.0
20	Goa	8.1	7.2	7.1	7.4	7.2	6.6	-0.9	-0.1	0.3	-0.2	-0.6
21	Himachal Pr .	7.1	6.8	6.9	6.8	7.1	7.4	-0.3	0.1	-0.1	0.3	0.3
22	J & K	5.7	5.6	5.5	5.9	5.8	5.8	-0.1	-0.1	0.4	-0.1	0.0
23	Manipur	4.8	4.3	4.1	4.5	4.4	5.0	-0.5	-0.2	0.4	-0.1	0.6
24	Meghalaya	7.4	7.3	7.5	8.0	7.5	7.9	-0.1	0.2	0.5	-0.5	0.4
25	Mizoram	5.1	5.2	5.1	5.5	5.2	5.1	0.1	-0.1	0.4	-0.3	-0.1
26	Nagaland	NA	3.7	3.8	4.8	5.0	4.6		0.1	1.0	0.2	-0.4
27	Sikkim	5.0	4.9	5.1	5.6	5.3	5.2	-0.1	0.2	0.5	-0.3	-0.1
28	Tripura	5.5	5.5	5.7	6.3	6.5	5.9	0.0	0.2	0.6	0.2	-0.6
29	Uttarakhand	6.5	7.2	7.4	6.7	6.8	6.4	0.7	0.2	-0.7	0.1	-0.4
30	A&N Islands	5.6	3.7	4.7	5.1	4.5	4.8	-1.9	1.0	0.4	-0.6	0.3
31	Chandigarh	3.8	2.9	4.5	4.1	4.0	4.4	-0.9	1.6	-0.4	-0.1	0.4
32	D&N Haveli	6.1	5.2	5.1	4.8	4.8	5.4	-0.9	-0.1	-0.3	0.0	0.6
33	Daman & Diu	6.6	5.8	5.6	5.5	5.5	5.3	-0.8	-0.2	-0.1	0.0	-0.2
34	Lakshadweep	5.2	7.3	6.3	6.4	6.5	7.1	2.1	-1.0	0.1	0.1	0.6
35	Puducherry	6.3	8.0	7.1	7.3	7.7	7.5	1.7	-0.9	0.2	0.4	-0.2

Sl.No.	States	T F R										
		2003	2004	2005	2006	2007	2008	Change (in points)				
								2004 / 2003	2005 / 2004	2006 / 2005	2007 / 2006	2008 / 2007
	ALL INDIA	**3.0**	**2.9**	**2.9**	**2.8**	**2.7**	**2.6**	**-0.1**	**0.0**	**-0.1**	**-0.1**	**-0.1**
1	Andhra Pr.	2.2	2.1	2.0	2.0	1.9	1.8	-0.1	-0.1	0.0	-0.1	-0.1
2	Assam	2.9	2.9	2.9	2.7	2.7	2.6	0.0	0.0	-0.2	0.0	-0.1
3	Bihar	4.2	4.3	4.3	4.2	3.9	3.9	0.1	0.0	-0.1	-0.3	0.0
4	Chhatisgarh		3.3	3.4	3.3	3.1	3.0	..	0.1	-0.1	-0.2	-0.1
5	Gujarat	2.8	2.8	2.8	2.7	2.6	2.5	0.0	0.0	-0.1	-0.1	-0.1
6	Haryana	3.0	3.0	2.8	2.7	2.6	2.5	0.0	-0.2	-0.1	-0.1	-0.1
7	Jharkhand		3.5	3.5	3.4	3.2	3.2	3.5	0.0	-0.1	-0.2	0.0
8	Karnataka	2.3	2.3	2.2	2.1	2.1	2.0	0.0	-0.1	-0.1	0.0	-0.1
9	Kerala	1.8	1.7	1.7	1.7	1.7	1.7	-0.1	0.0	0.0	0.0	0.0
10	Madhya Pr.	3.8	3.7	3.6	3.5	3.4	3.3	-0.1	-0.1	-0.1	-0.1	-0.1
11	Maharashtra	2.3	2.2	2.2	2.1	2.0	2.0	-0.1	0.0	-0.1	-0.1	0.0
12	Orissa	2.6	2.7	2.6	2.5	2.4	2.4	0.1	-0.1	-0.1	-0.1	0.0
13	Punjab	2.3	2.2	2.1	2.1	2.0	1.9	-0.1	-0.1	0.0	-0.1	-0.1
14	Rajasthan	3.8	3.7	3.7	3.5	3.4	3.3	-0.1	0.0	-0.2	-0.1	-0.1
15	Tamil Nadu	1.9	1.8	1.7	1.7	1.6	1.7	-0.1	-0.1	0.0	-0.1	0.1
16	Uttar Pr.	4.4	4.4	4.2	4.2	3.9	3.8	0.0	-0.2	0.0	-0.3	-0.1
17	W. Bengal	2.3	2.1	2.1	2.0	1.9	1.9	-0.2	0.0	-0.1	-0.1	0.0
18	Arunachal Pr	..	..	..	..	..	..	..	..	..	..	..
19	Delhi		2.1	2.1	2.1	2.0	2.0	..	0.0	0.0	-0.1	0.0
20	Goa	..	..	..	..	..	..	..	..	..	..	..
21	Himachal Pr .	2.1	2.1	2.2	2.0	1.9	1.9	0.0	0.1	-0.2	-0.1	0.0
22	J & K		2.4	2.4	2.3	2.3	2.2	..	0.0	-0.1	0.0	-0.1
23	Manipur	..	..	..	..	..	..	..	..	..	..	..
24	Meghalaya	..	..	..	..	..	..	..	..	..	..	..
25	Mizoram	..	..	..	..	..	..	..	..	..	..	..
26	Nagaland	..	..	..	..	..	..	..	..	..	..	..
27	Sikkim	..	..	..	..	..	..	..	..	..	..	..
28	Tripura	..	..	..	..	..	..	..	..	..	..	..
29	Uttarakhand	..	..	..	..	..	..	..	..	..	..	..
30	A&N Islands	..	..	..	..	..	..	..	..	..	..	..
31	Chandigarh	..	..	..	..	..	..	..	..	..	..	..
32	D&N Haveli	..	..	..	..	..	..	..	..	..	..	..
33	Daman & Diu	..	..	..	..	..	..	..	..	..	..	..
34	Lakshadweep	..	..	..	..	..	..	..	..	..	..	..
35	Puducherry	..	..	..	..	..	..	..	..	..	..	..

Increase in Hospital Bed Strength in Government Institutions

2005 to2009

(upto CHC level) [PHC Beds not included]

S.No.	Name of State/UTs	Bed Strength 2005	Bed Strength 2009
1	Andhra Pradesh	35,021	34,333
2	Arunachal Pradesh	2,053	2,218
3	Assam	3,000	7,622
4	Bihar	3,030	22,494
5	Chhattisgarh	5,565	9,428
6	Goa	2,639	2,988
8	Haryana	7,118	7,879
9	Himachal Pradesh	7,786	7,961
10	Jammu & Kashmir	3,295	3,945
11	Jharkhand	1,410	5,414
12	Karnataka	41,304	63,741
13	Kerala	25,839	31,285
14	Madhya Pradesh	17,702	19,918
15	Maharashtra	76,447	49,579
16	Manipur	670	2,243
17	Meghalaya	2,157	2,582
18	Mizoram	1,169	1,224
19	Nagaland	2,060	2,150
20	Orissa	13,146	14,763
21	Punjab	8,973	10,620

22	Rajasthan	32,080	32,067
23	Sikkim	730	1,000
24	Tamil Nadu	43,567	47,198
25	Tripura	2,231	2,262
26	Uttar Pradesh	8,820	32,460
27	Uttarakhand	1,080	7,965
28	West Bengal	58,516	59,759
	India	**4,69,559**	**5,40,328**

Source: National Health Profile 2005 & 2009, MoHFW, Government of India

Source HMIS Portal (as on 15.03.2010)

Progress under NRHM (As on 31.01.2010)

Sl. No.	State	Primary Health Centre 24X 7		FRU	
		As on 31.3.2005	As on 31.1.2010	As on 31.3.2005	As on 31.1.2010
High Focus Non - NE States					
1	**Bihar**	**0**	**533**	**0**	**76**
2	**Chhattisgarh**	**125**	**418**	**48**	**56**
3	**Himachal Pradesh**	**0**	**95**	**10**	**51**
4	**Jammu & Kashmir**		**105**	**0**	**58**
5	**Jharkhand**	**0**	**194**	**0**	**19**
6	**Madhya Pradesh**	**180**	**212**	**0**	**87**
7	**Orissa**		**64**	**0**	**48**
8	**Rajasthan**		**500**	**0**	**100**
9	**Uttar Pradesh**	**225**	**648**	**42**	**136**
10	**Uttarakhand**	**8**	**94**	**29**	**72**
High Focus NE States					
11	**Arunachal Pradesh**	**25**	**55**	**7**	**10**

12	**Assam**	**229**	**343**	**46**	**60**
13	**Manipur**	**0**	**20**	**0**	**1**
14	**Meghalaya**	**0**	**14**	**0**	**9**
15	**Mizoram**	**0**	**56**	**0**	**8**
16	**Nagaland**	**0**	**33**	**0**	**11**
17	**Sikkim**		**24**	**0**	**3**
18	**Tripura**	**52**	**58**	**3**	**5**
Non High Focus States - Large					
19	**Andhra Pradesh**		**800**	**190**	**194**
20	**Goa**		**13**	**0**	**2**
21	**Gujarat**	**0**	**331**	**0**	**148**
22	**Haryana**	**53**	**318**	**4**	**104**
23	**Karnataka**	**0**	**940**	**24**	**149**
24	**Kerala**	**0**	**178**	**65**	**65**
25	**Maharashtra**	**0**	**663**	**194**	**466**
26	**Punjab**	**81**	**182**	**134**	**126**
27	**Tamil Nadu**	**180**	**1215**	**160**	**291**
28	**West Bengal**	**86**	**168**	**27**	**61**
Non High Focus Smalls & UTs					
29	**A & N Island**		**17**	**0**	**1**
30	**Chandigarh**	**0**	**0**	**1**	**3**
31	**D & N Haveli**	**0**	**6**	**0**	**2**
32	**Daman & Diu**		**2**	**3**	**3**
33	**Delhi**		**1**	**0**	**25**
34	**Lakshadweep**		**4**	**0**	**9**
35	**Puducherry**	**19**	**20**	**0**	**4**
	Total	**1263**	**8324**	**987**	**2463**

III - PLANNING PROCESS UNDER NRHM

The Planning process under NRHM has seen significant evolution from norm based funding in 2005-06 under NRHM to a bottom up process resulting in 619 Integrated District Health Action Plans for the country in 2009-10. The District Plan as the key instrument of planning has contributed significantly to the considerable achievement of NRHM in a short span of 5 years. It's contribution in setting up of enabling institutional structures right from the village to the State level , provision of untied resources for local action, identifying areas for focused attention through facility and household surveys, convergence with wider determinants , have been some of the many achievements of decentralised planning. The Broad Framework for preparation of District Health Action Plans, issued in August 2006 by the Ministry of health and Family Welfare, has been the basis for planning under NRHM. It laid down a comprehensive structure for the planning process and all programme divisions provided the basic formats within which information was required for the effective planning and implementation of NRHM. The broad contours of the District Health Action Plan, resource allocation and norms, system of conducting situation analysis, Block level consultations, setting objectives, district planning workshop, work plan and average costs, monitoring and programme management and the structure of the District Health Action Plan, were discussed in great detail in the Broad planning framework for NRHM. This has formed the basis for decentralized planning.

The initial journey of resource and input intensive planning has been essential to galvanize a hitherto underfunded and underperforming, public health system. The provision of resources has led to expansion of public health infrastructure, additional human resources, and creation of community structures for greater community ownership. This strong push to system strengthening, in a decentralized and non verticalized framework has also had positive programmatic

impact evident in increased access to public health systems, evident in increased number of OPD, IPD cases, immunization, institutional delivery, reduction in disease related morbidities etc.

However, now as NRHM enters mid course, focus on consolidation, accelerated pace of implementation for faster achievement of health outcomes becomes imperative. In its five years' course, a lot of evidence both from primary (household and facility survey, community monitoring reports, internal HMIS data etc) and secondary sources (DLHS-III, SRS, Common/ Joint Review Mission, Independent Survey and Evaluations etc) have thrown up newer challenges which need to become the base for a newer evidence based planning.

The Initiatives undertaken for the Annual Plans of 2010-11

The planning process for 2010-11 has been initiated in the month of October 2009 as per the following schedule.

- State to send Resource envelope to Districts –October 2009
- District Plans based on Village/Gram Panchayats /Block Panchayat Samiti Plans –December 2009.
- First Draft PIP before State Health Mission- First Week January 2010.
- Pre-appraisal meetings in January up to 15th February, 2010.
- Final NPCC meetings between February and 15th March, 2010.

Preparation of Detailed Planning Guidelines for preparation of Annual Plans for 2010-11

Detailed planning guideline has been sent to States for facilitation of the PIP for 2010-11. Letters have also been sent highlighting the focus areas in Plans and key deliverables to be achieved. The following key areas have been identified as priority action for 2010-11;

- ***Clear Action Plan for Backward Districts as part of the PIP -*** The State must identify backward areas for greater attention (difficult, left wing affected, minority, tribal, SC/ ST gender etc.). Special incentive to medicos and para-medicos for performing duties in difficult areas, which was part of 100 days agenda of this Ministry may be made part of the State PIPs for the year 2010-2011.
- ***Clear Action Plan for streamlining of procurement and logistics*** - Supply Chain Management System, Procurement Management Information System (ProMIS) and Rational Drug Use to be streamlined**.** To ensure sustainable drug supply at all levels and its replenishment, logistic and information systems arrangement needs strengthening on a priority. States may be requested for fully reflect their plans for strengthening logistic arrangements in the PIPs for 2010-2011.
- ***Clear Action Plan for Operationalising HMIS up to facility level -*** The States must endeavour to have a road map for web enabled facility based reporting and put in place tracking of information on pregnant mothers and children's immunization.
- ***Capacity Development of all Institutions crafted under NRHM –*** ASHA, VHSC, RKS, PRIs, Programme Management Units, MIS etc
- ***Higher utilization of financial resources under NRHM -*** Greater thrust should now be on facility specific reporting of progress on expenditure.
- ***Clear plan for human resources for health*** which should interalia include the steps undertaken by the States in filling up vacancies.
- ***Clear Action Plan on Training and Skill Development*** aiming at a comprehensive and integrated training plan.

The following key priority themes have been identified for priority action in 2010-11;

- Neo Natal Mortality – Facility and Home based care for newborn.
- Population Stabilization.

- Malaria.
- MDR – TB.
- Making facilities family friendly – water, electricity, clean toilets, lights, security.
- Vibrant VHSCs and RKSs.
- NABH/ISO certification of government facilities.

Constitution of District Planning Teams and Ranking of Backward Districts for Planning

235 High Focus districts identified based on ranking of 13 indicators from the DLHS-III data prepared by the Statistics Division of the Ministry, districts with 35% or more with SC/ST population , 33 districts Left Wing Extremists Affected Districts prepared for focused planning.

District Planning Teams constituted for visiting the high focus districts to observe and facilitate the planning and ensure adequate attention to these districts in the planning process. The entire process has been coordinated by the NHSRC.

Sub Group Meetings to be held in States with civil society participation of CRM members

As suggested by Secretary (H&FW), PIP pre-appraisal meetings have been held in States to sensitize and involve District officials in the planning process, by forming the Zones (East, West, North, South, Central) and grouping the adjacent states together in a common venue. Except the smaller States, these meetings have been completed in bigger states and the NE states. The PIPs have been uploaded on website of NRHM. The civil society members have also actively participated in the appraisal process.

IV - HUMAN RESOURCES UNDER NRHM

Human Resource under NRHM

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	ligarh	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

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.

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 has 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.

V - 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 lakhs 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 Hospital for renovation as an initial grant.

2. Besides these resources Annual Maintenance Grants for Sub Centres, Primary Health Centres, Community Health Centres, Sub District and District Hospitals are also provided to the Rogi Kalyan 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 146,036 Sub Centres, 78,803 are in government buildings, 49,035 in rented buildings and 18,198 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 57,812 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 Governments have also taken up a large number of Sub Centre constructions from Finance Commission grants or State Government Plan funds. NRHM's effort is to ensure that all Sub Centres have a building of their own, or, are located in a Panchayat building before the completion of

the Mission in 2012. Buildings of new Sub Centres being established by State Governments are also being taken up for construction. The State wise progress and construction is indicated in ***table*** form at the end of this section.

3. As regards Primary Health Centres, the Rural Health Statistics 2008 had pointed out that of the 23,458 functioning PHCs, 19,706 were in 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 Governments have also taken up PHC construction through Finance Commission and State Plan resources.

4. 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 up for construction and another 1255 for renovation. States have also used Finance Commission funds and State Plan funds for construction of Community Health Centres.

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

6. NRHM has similarly undertaken the strengthening of District Hospitals 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 States had large Finance Commission grants to spend and in many of them arrangements for large scale construction works from the Health Department was not in place. Most State Governments have now resolved these issues. All State Mission teams had been sent to Gujarat to study the Infrastructure Implementation Unit that the State has set up for quality Civil Works. The resources for repair and maintenance of government buildings under NRHM have been used very effectively to improve the upkeep of health facilities. Government health facilities are looking much better maintained, cleaner and with more resources to meet their physical infrastructure needs. NRHM is also supporting the States 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

- NRHM provides for untied funds and maintenance grants to all government health facilities from Sub Centres, PHCs, CHCs, Sub District and District Hospitals
- All District Hospitals provided Rs.20 lakhs as initial grant for up-gradation of facilities to meet increased case load
- District Hospitals in the North Eastern region provided rupees one crore for hospital up-gradation of hospitals
- All Community Health Centres provided Rs.20 lakhs for up-gradation of facilities to meet increased case load
- 9144 Sub Centres for new construction and 8997 for renovation taken up under NRHM
- 1009 Primary Health Centres taken up for new construction and 2081 for renovation under NRHM

- 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

- 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 and 357 District Hospitals for renovation have been taken up under NRHM

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

Infrastructure Development under NRHM

S.No.	Name of State/UTs	Works taken up under	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	NA
27	Uttarakhand	153	53
28	West Bengal	862	339

Union Territories			
1	A&N Island	21	9
2	Chandigarh	2	2
3	D&N Haveli	43	28
4	Daman & Diu	32	
5	Delhi		
6	Lakhsadweep		
7	Puducherry	18	18

Infrastructure Development under NRHM

Sl.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.

VI - COMMUNITIZATON UNDER NRHM

2. INSTITUTIONAL STRENGTHENING

	Institution/Activity	Effort so far
1.	Village Health and Sanitation Committee in all 6.38 Lakh revenue villages of India. Village health and Nutrition Day every month in every village at Anganwadi Centre. ASHAs in every village	4.51 lakh Village Health and Sanitation Committees already constituted and provided Rupees 10,000 as untied grant. 1.87 crore Village health and Nutrition Days organized over the last four years under NRHM. 7.49 lakh ASHAs already selected.
2.	Sub Centre and VHSC level joint account of ANM and Sarpanch	4.43 lakh such accounts have already been operationalized to handle untied grants to institutions.
3.	Rogi Kalyan Samiti at PHCs	16687 PHCs have RKS out of the total 23458 PHCs. They have annual untied grants for improving the maintenance of the facility and for local health action.
4.	Rogi Kalyan Samitis at CHC, Sub Divisional Hospitals and District Hospitals	Nearly all such facilities have already formed the Rogi Kalyan Samiti and have received untied funds for facility improvement.
5.	District Health Mission and District Health Society	District Health Mission under the Chairman Zila Parishad/ District Tribal Council and District Health Society under the District magistrate have been constituted in nearly all the States/UTs.
6.	State Health Mission and State health Society	State Health Mission under the Chief Minister and the State Health Society under the Chief Secretary have been constituted and meet regularly in nearly all the States.
7.	Mission Steering Group of NRHM at the national level	Mission Steering Group under the Minister Health and Family Welfare at the National level has been meeting regularly to take all decisions regarding the NRHM.

ASHAs UNDER NRHM

Sl. No.	State	ASHA		
		Selection	Training (upto IVth Module)	Drug Kit
High Focus Non - NE States				
1	Bihar	71350	20225	
2	Chhattisgarh	60992	60992	59489
3	Himachal Pradesh	2393	0	2393
4	Jammu & Kashmir	9500	8930	9500
5	Jharkhand	40788	35675	36659
6	Madhya Pradesh	48783	26830	45971
7	Orissa	38838	31884	38838
8	Rajasthan	43111	40310	32429
9	Uttar Pradesh	135522	127145	124309
10	Uttarakhand	9873	9873	0
High Focus NE States				
11	Arunachal Pradesh	3554	1349	2437
12	Assam	28669	26225	26225
13	Manipur	3878	3000	3000
14	Meghalaya	6258	6175	6075
15	Mizoram	943	943	943
16	Nagaland	1700	1700	1700
17	Sikkim	637	637	637
18	Tripura	7362	7362	7082
Non High Focus States - Large				
19	Andhra Pradesh	70700	70700	51201
20	Goa	0	0	
21	Gujarat	25861	12413	0
22	Haryana	14000	14000	0
23	Karnataka	39000	39000	21500
24	Kerala	30909	0	23350
25	Maharashtra	8765	8765	8338
26	Punjab	17056	0	15475
27	Tamil Nadu	2650	0	0
28	West Bengal	23518	9075	0
Non High Focus Smalls & UTs				
29	A & N Island	65	0	49
30	Chandigarh	200	0	0
31	D & N Haveli	107	87	87
32	Daman & Diu	107	0	0
33	Delhi	2266	2266	2266
34	Lakshadweep	85	0	0
35	Puducherry	0	0	0
	Total	749440	565561	519953

Communitization under NRHM

Sl. No.	State / UTs	Rogi Kalyan Samiti (RKS)	Village Health & Sanitation Committee (VHSC)
High Focus Non - NE States			
1	Bihar	518	5493
2	Chhattisgarh	932	18570
3	Himachal Pradesh	565	2071
4	Jammu & Kashmir	476	6788
5	Jharkhand	484	30011
6	Madhya Pradesh	1244	24520
7	Orissa	1444	44236
8	Rajasthan	1922	40478
9	Uttar Pradesh	3659	51822
10	Uttarakhand	124	14646
High Focus NE States			
11	Arunachal Pradesh	123	2827
12	Assam	987	26816
13	Manipur	101	3498
14	Meghalaya	133	5568
15	Mizoram	80	813
16	Nagaland	160	1278
17	Sikkim	32	637
18	Tripura	104	1040
Non High Focus States – Large			
19	Andhra Pradesh	1827	21916
20	Goa	14	303
21	Gujarat	1216	17751
22	Haryana	2938	6282
23	Karnataka	3052	23064
24	Kerala	1164	18003
25	Maharashtra	2274	40889
26	Punjab	511	13199
27	Tamil Nadu	1683	15158
28	West Bengal	1362	13312
Non High Focus Smalls & UTs			
29	A & N Island	26	263
30	Chandigarh	3	22
31	D & N Haveli	2	70
32	Daman & Diu	7	28
33	Delhi	0	0
34	Lakshadweep	9	9
35	Puducherry	47	92
	Total	29223	451473

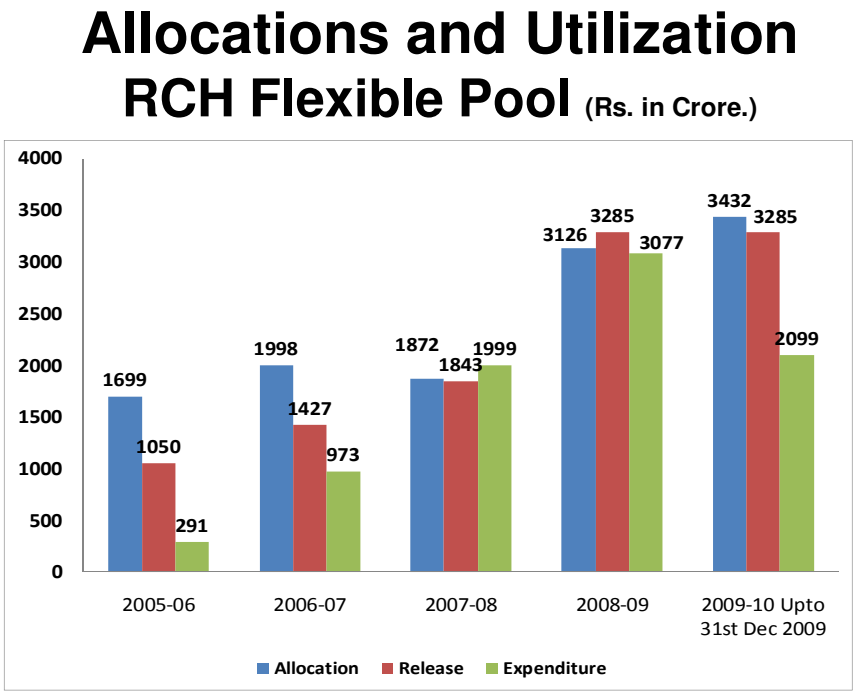
VII - FLEXIBLE AND ADEQUATE FINANCING

Flexible, decentralized planning is the pivot on which the entire concept of the Mission revolves. Till the year 2005, central funding to states was on normative basis. During the FY-2005-06, basic states Programme Implementation Plans (PIPs) were prepared. During FY 2007-08, FY 2008-2009, FY 2009-10 detailed state PIPs were appraised before release of funds. For the financial year 2010-11, all the state PIPs were received by the Ministry and are being appraised and approved by the National Programme Coordination Committee (NPCC).

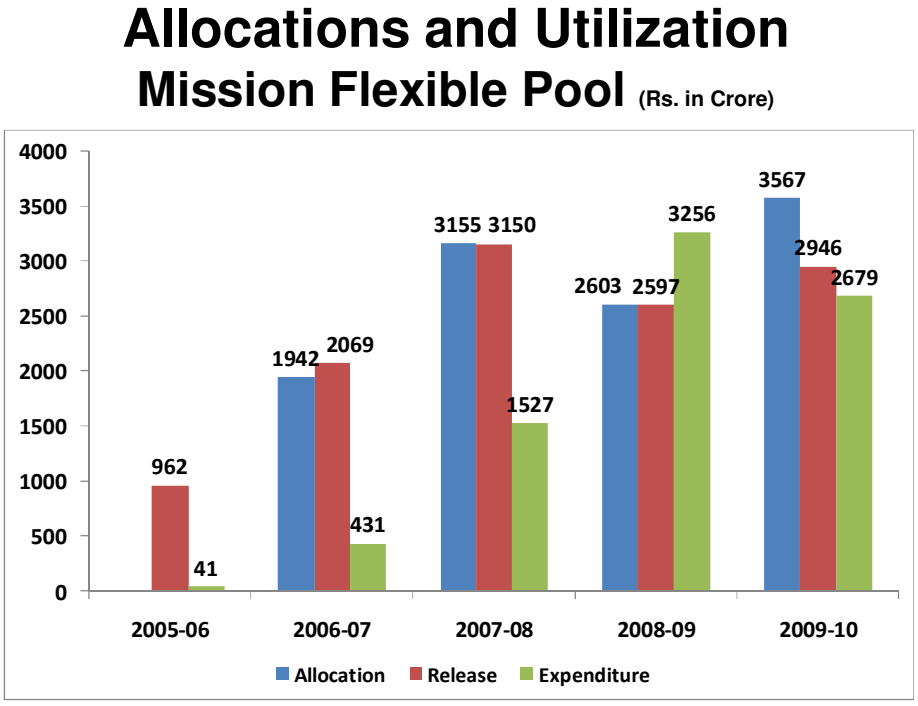
A Financial Management Group (FMG) has been operationalised in Government of India, MoHFW to oversee the release of funds, monitoring of Utilisation Certificates and Audit Reports. The increased focus on accurate and timely reporting of SOEs and UCs has substantially improved status of outstanding funds with the states. Since the number of financial transactions in the sector is expected to increase substantially in the coming years, the NRHM has envisaged augmentation of accounting manpower at the level of the PHCs in all states. The concerted efforts have resulted into improved financial performance year after year.

The **allocation, release and expenditure** under the RCH Flexible Pool Rs.1699.16 Cr, Rs.1049.52 Cr and Rs.301.49 Cr respectively in the year 2005-06 has increased to Rs.3432 Cr, Rs.3285.14 Cr (as on 31.01.2010 date) and Rs.2098.88 Cr (till 31.12.2009) in the year 2009-10 which is also shown in the chart below:

Year	RCH Flexible-Pool			Mission Flexible-Pool			Total Under NRHM	
	Allocation	Releases	Expenditure	Allocation	Releases	Expenditure	Allocation	Releases
2005-06	1699.16	1049.52	301.49	-	962.13	40.76	6730	5703
2006-07	1998.22	1427.03	972.74	1943.18	2069.36	430.93	9000	7486.59
2007-08	1872	1842.72	1999.25	3155	3149.97	1526.85	10890	10310
2008-09	3126.04	3072.97	3077.16	2603.24	2597.44	3256.08	11930	11200.52
2009-10	3432	3285.14	2098.88	3567.27	2946.34	2679.25	14050	10013.01
TOTAL	12127.42	10677.38	8449.52	11268.69	11725.24	7933.87	52600	44713.12



Similarly, under the Mission Flexi Pool **Release and Expenditure** of Rs.962.13 Cr and Rs.40.76 Cr in the year 2005-06 has increased to Rs.2946.34 Cr (till 31.01.2010) and Rs.2679.25 Cr (till 31-12-2009) respectively and is shown in the chart below:.



The year-wise progress under NRHM is as below:

For better monitoring of the flow of funds and internal control purposes ministry has further implemented various new things which are as under:

1. Advisory issued for implementation of customized, especially for NRHM Accounting, latest version of Tally ERP.9 accounting solution for each State/UT and Districts.

2. Implemented Concurrent Audit System in all the States and Districts through C.A. Firms with a regular follow-up by the ministry.

3. To have transparency in the selection of Statutory Auditor for annual audit of State and Districts Health Societies rolled out the System of Open Tender System.

4. Ensuring timely submission of Financial Monitoring Reports on quarterly basis by all the States/ UTs. In this Financial Year all the FMRs have been received in time for all 3 Quarters.

5. Vigorously following up with more and more States for implementation of e-Banking Solution for Funds Transfer and Reporting of Expenditure by each implementing units.

The total expenditure on health in India is estimated to be anywhere between 4.5 to 5.5% of the GDP. Of this, the current level of public expenditure is less than 1% of GDP. The NRHM has made a commitment for increase in public expenditure to a level of 2-3% of GDP. Even if this were to happen, there would still be a substantial health care expenditure which is out of pocket and often made during distress and under severe duress. One also has to acknowledge that even though 30,000 MBBS Graduates pass out every year in our country, the entire rural health system up to the block level does not have more than 27,000 Doctors at any given point of time. The case of Specialists is worse with the vacancies in Government being extremely high. Specialists are largely available in the Non-Governmental sector and if we want people to have Specialist health services, we have to have mechanisms to enter into partnerships with

them. The NSSO 60th Round 2004-05 has clearly brought out the fact that there is more than Rs.3,000/- expenditure in Government Hospitals in rural areas during every hospitalization, which is made out of pocket. The out of pocket expenditure in the urban areas and in private hospitals is 2 to 3 times more than this. *Clearly, mechanisms have to be found to ensure cashless hospital treatment for poor households in Government hospitals.*

Need for new health financing mechanism

There is a need to explore new health financing mechanisms in order to reduce the health distress of poor households. The fact that more than Rs.100,000 crores a year is spent by households, mostly out of pocket, and in times of health distress is reason enough to explore new ways of health financing. The National Commission on Macroeconomics & Health has pointed out that 3.3% of India's population is impoverished every year on account of health distress. There is also evidence to suggest that the poorest 10% of the population rely on sale of assets to meet their health care needs. A study in some of the poorest districts by Jha & Jhingran 2002 had revealed that illness of a family member is the most common reason among poor households leading to a financial crisis and causing a sense of insecurity. Nearly 40% of the Below Poverty Line families reported having faced a financial crisis during the last two years and about 69% of these was on account of illness and 11% on account of a death of a family member. Clearly poor people in rural areas are spending significant amounts on health care leading to their pauperization.

Health Expenditure in India (in Rs.000)

Type of Expenditure	2005-06	2006-07	2007-08	2008-09
Public Expenditure	344,461,722	406,788,591	486,852,110	586,813,788
Private Expenditure	1,150,005,214	1,278,405,733	1,426,902,392	1,573,935,382
External Flow	21,488,597	22,402,612	26,538,964	37,015,853
Total Health Expenditure	**1,515,915,533**	**1,707,596,936**	**1,940,293,466**	**2,197,765,023**
Gross Domestic Product (Rs.000)	35,803,440,000	41,458,100,000	47,234,000,000	53,217,530,000
Health Expenditure as share of GDP %	4.23	4.12	4.11	4.13
Public Expenditure as share of GDP %	0.96	0.98	1.03	1.10

Notes: 2007-08 and 2008-09 are Revised Estimates and Budget Estimates
Source: National Health Accounts of India, Ministry of Health and Family Welfare, 2009.

ECONOMIC SURVEY 2009-2010

Public Expenditure on health as percentage of GDP

2004-05 - 1.16%
2005-06 - 1.23%
2006-07 - 1.22%
2007-08 - 1.23%
2008-09 - 1.37%
2009-2010 – 1.45%

VIII – NRHM – EXTERNAL ASSESSMENTS

NRHM – The independent sources of evidence/assessment

- SRS RGI – Census – IMR, MMR, TFR, Birth Rate.
- DLHS-III 2007-08 – facility preparedness, family welfare performance, district specific.
- IAP Study – Jeff Sachs, Nirupam Bajpai.
- Kaveri Gill's Study for Planning Commission.
- PRC study in 31 districts.
- Citizen's Reports – CHSJ, VHAI, JSA.
- Community Monitoring Reports.
- External Evaluation of JSY in 7 States.
- Common Review Missions of NRHM – Large non – governmental representation on teams.
- Qualitative and insightful field notes.
- Performance Audit of NRHM by CAG.

Mid Term Appraisal in health sector – key requirements

While making assessment of the NRHM, it is important to keep in mind the framework for such assessments in the health sector. Attribution is difficult at the easiest of times and we need to realize that outcomes take some years for many health indicators. We may therefore have to look at inputs, processes and outputs as well. Given the gross neglect of the health sector in many States, we also need to look at the State specific baseline more carefully before judging progress on an absolute scale of progress. Some of the key points that need to be kept in mind are the following:

- Evidence as basis.
- Willingness to look at all assessments.
- Issues in attribution in the health sector.
- Process, inputs and outputs very important in the short run – outcomes take a little time.
- Very necessary to realize the baseline – abject neglect of public systems of health care.
- Important to realize that some solutions will never be overnight – they will take time.
- Need to understand wider determinants – nutrition.
- Deepening decentralized management – important to understand institutional/governance arrangements.

SRS Data – what does it say?

- IMR down to 53 in 2008 from 58 in 2005.
- Rural areas register 3 point decline in 2008.
- Decline across all States including backward States – Bihar, Rajasthan, MP, Orissa.

- MMR 2004-06 at 254 from 301 in 2001-03.
- TFR at 2.6 in 2008 from 2.9 in 2005.
- Birth rate at 22.8 in 2008 from 23.8 in 2005.
- Faster rate of decline needed to achieve NRHM goals – can nutrition and neonatal mortality focus (facility and home) make a difference?

DLHS-III – what does it say?

- Confirms increase in institutional deliveries and full immunization.
- Gains very significant in hitherto backward regions – Rajasthan, Bihar, Orissa, MP.
- Significant increase in 24X7 PHCs, CHC preparedness, availability of ASHA, JSY, ANM.
- District data shows improvement in human resources and services being provided.
- Also shows HR gaps and lack of blood storage in large number of FRUs.

	Key Facility/ Community access Indicators	Achievement
1.	Villages having beneficiary under Janani Suraksha Yojana (JSY)	90.7%
2.	Villages with Sub Centres within 3 kilometers	72.6%
3.	Sub Centres with ANM	90.6%
4.	PHCs functioning on 24 hour basis	53.1%
5.	PHCs having AYUSH Medical Officer	19.2%
6.	CHCs having 24 hour normal delivery services	90.1%

The DLHS-III data below provides an insight into the performance of States. Improvement there is but then there are miles to go before the public system ins fully geared to deliver quality health services for all.

DISTRICT LEVEL HOUSEHOLD SURVEY – III KEY FINDINGS 2007-08

State/UT	ANM living in Quarter where available	PHCs functioning on 24 hour basis	CHCs designated as FRU	FRUs having blood storage facility
INDIA	57.8%	53.1%	52.0%	9.2%
Andhra Pradesh	40.7%	51.1%	89.4%	28.5%
Assam	37.1%	65.6%	32.5%	25.9%
Bihar	20.3%	64.5%	87.9%	0.0%
Chandigarh	0.0%	NA	50.0%	0.0%
Chhattisgarh	62.0%	58.6%	56.6%	7.7%
D & N Haveli	47.8%	100.0%	100.0%	0.0%
Daman and Diu	0.0%	50.0%	100.0%	0.0%
Delhi	100.0%	42.9%	NA	NA
Goa	5.1%	62.5%	80.0%	0.0
Gujarat	37.9%	46.9%	74.1%	8.9%
Haryana	31.4%	38.2%	44.0%	18.9%
Himachal Pradesh	60.5%	52.8%	35.8%	3.0%
Jammu and	64.1%	32.4%	71.2%	15.3%
Jharkhand	44.2%	79.3%	87.5%	0.0%
Karnataka	46.5%	47.0%	75.4%	5.6%
Kerala	47.7%	11.7%	18.5%	2.6%
Lakshadweep	0.0%	100%	33.3%	0.0%
Madhya Pradesh	48.5%	73.1%	61.4%	6.3%
Maharashtra	71.5%	78.1%	58.7%	11.6%
Meghalaya	46.4%	62.7%	46.2%	16.7%
Mizoram	79.3%	69.8%	70.0%	85.7%
Orissa	43.2%	49.1%	53.7%	15.4%
Puducherry	19.2%	73.3%	75.0%	0.0%
Punjab	17.7%	17.2%	39.4%	8.2%
Rajasthan	55.1%	56.9%	52.7%	15.0%
Sikkim	79.8%	95.6%	NA	NA
Tamil Nadu	57.6%	50.6%	42.4%	1.3%
Tripura	7.7%	70.9%	25.0%	0.0%
Uttar Pradesh	37.2%	45.5%	55.8%	1.3%
Uttarakhand	63.4%	72.6%	53.7%	2.0%
West Bengal	45.6%	25.9%	17.9%	10.0%

The detailed District Level Household Survey – III (2007-08) gives the first detailed picture of performance of NRHM. It provides very useful insights into the strengthening of the health system and the extent to which these efforts have translated into better services. It also highlights the need to have patience in seeking changes in the health sector given the challenges of human resources. It highlights the key factors that contribute in making public systems credible and accountable. There is no going away from a thrust on improved governance to be able to translate a larger workforce into better health outcomes. The findings of the DLHS-III is very much in line with Kaveri Gill's assessment that change is taking place but the speed needs to be faster. A deeper analysis of some of the structural issues especially with regard to the human resources, will clearly indicate how all challenges of the health system cannot be addressed in 2-3 years. The neglect of the Indian public system of care has been colossal and it will take time to set right a dysfunctional system. There will be quick gains but to look for all the basic services including blood storage, it will take time. It is also because health care providers are often public as well as private providers. The behavioural issues in some parts are related to a fear of the government doctor of losing private clients if the public system could actually start providing quality care. These explain the fact that in many facilities untied funds are available but the will to improve patient amenities are weak. There is also a fear that using discretion in improving patient amenities through use of untied funds will result in audit objections at some future point of time. There is a need to deepen the processes of decentralization by building capacities and an enabling environment at each level. Decentralization always has winners and losers and those who lose authority often try their level best to slow down the pace of effective decentralization.

IAP (Jeff Sachs and Nirupam Bajpai) Study – Rajasthan, UP, MP

- Confirms positive contribution of ASHA.

- Confirms facility improvement on an unprecedented scale.
- Highlights slow pace of utilization of untied in some facilities – confidence to spend.
- Raises issue regarding more training for ASHAs.
- Management structure needs further strengthening.
- Highlights HR challenges.
- Pleads for higher financial allocation for NRHM – NRHM seen as delivering services.

Key findings of IAP Study

- 71% CHCs reported improvement in infrastructure and 86% improvement in human resources after NRHM.
- 100% institutions reported increase in institutional deliveries and 57% reported increase in OPD services.
- 71% PHCs reported improvement in infrastructure and 55% reported improvement in manpower.
- 74% reported increase in institutional deliveries and 48% reported increase in OPD cases.
- 93% ANMs have received untied grants and 90% ANMs felt that ASHA is contributing to mobilizing the community.
- 71% ASHAs belong to SC, ST and OBC community.
- 92% ASHAs work for the same village where they stay.
- 97% ASHAs confirmed receiving training – days varied from 8-19 days.
- 95% ASHAs found training to be useful, 88% received drug kits, 88% had ORS with them, 92% had iron tablets, 81% had oral pills and 87% had condoms.

Kaveri Gill Study

- AP, UP, Rajasthan, Bihar.
- Finds uneven progress in the States.
- Different States perform differently on different parameters – suggests something is happening.
- NRHM institutional arrangements are in place.
- Confidence to spend is taking time in some places.
- Not much evidence of corruption.
- NRHM has created hope for rural infrastructure in health.

Kaveri Gill's insightful conclusion based on the short sample study of a few institutions in four States indicates the wide range of challenges that public systems in health care face:

" Encouragingly, we find that despite obstacles, even the focus states of Uttar Pradesh, Bihar and Rajasthan are making inroads on some fronts, so that they are seen to do better or match the non-focus state of Andhra Pradesh in at least a few areas, and certainly are not seen to lag behind it on every dimension, as might be expected[31]. So to the question of whether the NRHM delivers on health care services for the poor, the findings outlined here begin to give the nuanced answer that through the NRHM, the UPA government has put rural public health care firmly on the agenda, and is on the right track with the institutional changes towards decentralisation (and communitisation) it has introduced within the health system. True, there are many problems in implementation, so that delivery is far from what is ought to be. On physical infrastructure, medicines and funding, processual problems might be more easily scaled with time (in some instances, they already appear to have been overcome), whereas on human resources, and to the extent these impact actual availability of

services, structural issues of some complexity need careful resolving with a definite long term investment in the training and education of paramedical and medical staff, especially women, and close monitoring of attendance. However, the parameters of the question this study seeks to answer are very much within the ambit of how to better performance under the NRHM, and not whether the Mission ought to have been undertaken in the first place, of which there can be no doubt."

PRC Rapid Appraisal of NRHM in 31 districts

- Carried out in 16 States.
- Percentage of Gram Panchayats in districts report improvement after NRHM – 82.6% in Ambala, 78.3% in Banaskatha, 17.4% in Janjgir Champa, 75% in Warangal, 50% in Anuppur, 92.3% in Jorhat, 58.8% in Baramulla, 66.7% in Koppal, 41.7% in Jaisalmer, 77.85% In Garhchiroli, 100% in Madurai, 22.7% in Udham Singh Nagar, 66.7% in Bankura.

Citizens' Reports

- Would like deepening of decentralized management to be faster.
- JSY is putting pressure on public system.
- System preparedness inadequate.
- Question ability of PRI to hold system accountable – community monitoring.
- Looking for even faster roll out of community processes – would like greater efforts at building capacity at district-sub district levels – civil society involvement in roll out.
- Invest in ability and confidence to spend.

Community Monitoring Reports

- AGCA led the process in 9 States.

- Public hearings on working of PHCs.
- Pointed out shortcomings in PHC functioning.
- Helped in rectifying weaknesses in Maharashtra and Rajasthan. Non – responsiveness in MP. Interest in Tamil Nadu.
- Demands responsive to State machinery.
- Role for community other than elected representatives.

JSY studies

- Popularity of the scheme.
- Confirms increase in institutional deliveries.
- Points out quality issues at facilities.
- Points out low 48 hour stay cases.
- Large case load – need to expand services.
- JSY – changing health seeking behaviour of households – habit of going to PHC.
- Issues in timeliness of payments.
- Role of ASHA in demand creation.

JSY study: Key findings

The following was the conclusion of the study:

- "The extent of success of the JSY programme can be judged by the proportion of all the deliveries conducted in an institution, mainly government centres and private hospitals accredited under the JSY scheme. Seventy-three per cent of the births during the year 2008, in Madhya Pradesh and Orissa were reported to be

institutional deliveries, while it was 59 per cent in Rajasthan, 49 per cent in Bihar and 58 per cent in Uttar Pradesh. Among these institutional deliveries, those conducted in government centres and in accredited private hospitals were found to be 68 per cent in MP and 67 per cent in Orissa. Thus the direct beneficiary of the JSY scheme was to the tune of 67–68 per cent in these two states. The per centage of beneficiaries of the JSY scheme comes out to be 52 per cent in Rajasthan, 41 per cent in Bihar and 37 per cent in Uttar Pradesh. Overall, the combined estimates of five states together indicate that 55 per cent of the births from last year occurred in an institution and the direct beneficiaries of JSY (delivering either in a government facility or in an accredited private facility) were 47 per cent.

- Majority of the deliveries were conducted in PHCs in the state of Bihar (70 per cent), Orissa (58 per cent) and Madhya Pradesh (42 per cent). While in the state of Uttar Pradesh and Rajasthan around 44 to 47 per cent of the deliveries were reported in CHCs while these two states also witnessed deliveries taking place in the PHCs to the tune of 29 and 37 per cent respectively.

- Though the proportion of deliveries conducted in an institution in all the five states have increased substantially from its levels in the past, the duration of stay by the mothers at the institution after delivery remains a cause for concern. The policy documents recommend at least 48 hours of stay after delivery, but the study found that 84 per cent of mothers who delivered in the institution stayed only for a day or less in Bihar. In Uttar Pradesh also, majority of them (73 per cent) stayed for a shorter period than the recommended duration of stay. In Orissa and Rajasthan, 43 per cent of mothers stayed for at least 2 days after delivery; while in Madhya Pradesh 67 per cent were reported having stayed for more than 48 hours. Mothers delivering at an institution were asked about their experience at the institution. Majority of them across these five states reported

that they were immediately attended after their arrival for delivery and a delay of 15 minutes or more was reported by only a meager proportion of mothers. Majority of the deliveries were conducted by a nurse in four states, the percentage varying between 68 and 90 per cent, except in Orissa where 81 per cent of the deliveries were reported to have been conducted by the doctors. An overwhelming proportion of mothers opined that the toilet facilities were reasonable at the institution and only a small fraction of them rated this aspect as poor in all the five states."

Performance Audit by CAG – Its Conclusion

"The NRHM is an ambitious programme that attempts to consolidate all existing disease control programmes under a common umbrella while simultaneously improving the capacity of the health care system in the country. The Mission also seeks to set in place standards for public health and enhance awareness of health issues. The Mission, while aiming at improving national health indicators, seeks to address local endemic diseases through a focus on community participation and feedback.

The targeted interventions under the Mission towards improving health infrastructure, and better grass-roots outreach through health workers such as ASHAs have shown early positive results with outpatients returning to health centres and improved manpower staffing through appointment of contractual staff. However, the Mission has yet to completely mainstream the various State Health Societies implementing disease control programmes. Monitoring of the utilization of substantial funds released also needs strengthening and institution of systems. New organizations such as the Rogi Kalyan Samitis are yet to realize their full potential and decentralized planning had not fully taken off. The problems that confronted facilities and services availability, convergence with other departments, etc. are an off shoot of the lack of

focused planning and effective monitoring – activities requiring dedicated ground work so as to help resolve health issues in accordance with local needs.

However, the Mission is a major step forward and with greater State participation and effective monitoring of fund usage, more localized mass-media efforts and community oriented health measures to tackle malnutrition and locally endemic diseases and raise awareness, has the potential to transform health delivery systems in the country." (Performance Audit Report of NRHM, 2009)

Findings of the Third Common Review Mission of NRHM (December 2009), which had civil society, public health experts, development partners, central and state representatives as members:

"The overall impression across all States is of continuing improvement in strengthening of the public health service system, in increasing utilization of the services and in increasing access to health care. In the States which had initiated activities early on, there is a sense of the State NRHM having matured to a point where it is able to consolidate the gains of the first three years and initiate creative approaches with confidence. Making use of the platform NRHM offers, they have progressed through incremental strengthening of the health infrastructure and human resource at facilities, strengthening of the ASHA programme, initiation and strengthening of other community processes, and in management structure and processes."

IX - BUILDING CAPACITY AT ALL LEVELS

3. SYSTEM STRENGTHENING

	System Strengthening	Achievement so far
1.	Financial Management	Finance Managers provided at the State and district levels, besides Accountants at CHC/PHC level under the NRHM. Systems of e-banking, electronic transfer of funds, concurrent district audit, performance audit of CAG, annual audit by chartered accountant, and regular reporting through Financial Monitoring Reports (FMRs) fully operational in most States.
2.	Programme Management	Programme Managers provided at State and District levels. Some States have also provided for Block level Health Managers. They have facilitated faster and more efficient management of the health system at all levels.
3.	Data Management	Data Managers provided at the State and the district level with Data Assistants at PHC/CHC levels as per need, under the NRHM. Supporting Information Technology equipments have also been provided to enable development of a robust web-based system of Health Management Information System (HMIS). HMIS will also provide facility specific web based reporting in partnership with the States.
4.	Development of Standards	Indian Public Health Standards (IPHS) have been developed for eight levels of public sector health institutions, from Sub Centres to 500 bed Hospitals. These Standards provide details of the physical infrastructure, equipment, human resources and service guarantees that each such facility ought to provide. The IPHS is the basis for identifying gaps in provision that is then supported under the NRHM. Process of up-grading Health facilities up to ISO 9001 Standards and NABH Standards have been taken up under the NRHM, in States. 10 District Hospitals have received ISO 9001 certification and one PHC has received NABH accreditation.
5.	Capacity Development for public health	Courses in management of public health in partnership with eight all India institutions, Family Medicine programme with CMC Vellore, and Diploma programme in public Health through Public Health Resource Network and IGNOU have

		already been started under NRHM. The National Health System resource Centre and the North Eastern Regional resource Centre has been providing assistance in this process. State level Health Resource Centres are being set up to further facilitate capacity building.
6.	Accountability System	Concurrent evaluation taken up in 200 districts. Community monitoring has been undertaken through NGOs in 9 States. Community institutions crafted at all levels for accountability.

X - NRHM IN THE STATES/UTs

STATE WISE PHYSICAL AND FINANCIAL PROGRESS

STATE/UT	PHYSICAL PROGRESS	FINANCIAL PROGRESS
BIHAR	Block PHCs fully functional with doctor, drugs and diagnostics; Sub Centres and Additional PHCs still not functional; Huge increase in OPD, Institutional Deliveries and IPD. Large HR augmentation through Doctors, Nurses and ANMs; ASHA training weak; VH&SCs still being set up. Slow progress on civil works and equipment provision. The involvement of the Directorate of Health is weak. TNMSC like procurement and logistics system is before the State Cabinet.	88.73% utilization under RCH 2005-2009. 18.83% utilization under NRHM Mission Flexible Pool during the same period. State utilizing Finance Commission funds on priority, therefore under utilization of NRHM funds in initial years. While Accounts and Finance Managers have been provided, reporting of utilization still taking time. Greater thrust needed on collecting utilization certificates and reporting expenditures on time.
CHHATISGARH	Strong Community Health Worker Programme with strong institutional support through the State Health System Resource Centre.; Good experiment with Rural Medical Assistants (3 year programme) in PHCs; Well developed HR incentive plan for Naxalite affected areas; Nurse, doctor and Specialist shortages; Procurement streamlining under process. Mitanins being admitted to ANM Schools. Low institutional deliveries; high early breast feeding; high immunization coverage.	35.76% utilization under Mission Flexible Pool 2005-2009. 78.28% under RCH during the same period. Programme has picked up considerably in 2009-10 with good state level leadership. Likely to do much better in the current financial year.

HIMACHAL PRADESH	Has a strong primary health care system with a strong Aanganwadi Centre network; recruited doctors with incentives for remote areas; using NRHM resources to drive reforms for decentralization within the framework of PRIs. Slow progress on civil works and procurements.	72.53% utilization under Mission Flexible Pool and 55.44% under RCH 2005-2009. Likely to pick up with finalization of procurement and speeding up of civil works under hospital based institutional set up.
J&K	Focus on civil works in new districts and at sub district, district hospital levels; HR provision likely to improve with new instructions on contractual staff; need for facility specific service guarantees; satisfactory implementation of ASHA, and other programme components.	62.12% utilization under Mission Flexible Pool and 78.28% under RCH in the 2005-2009 period. JSY had been stopped for some months in J&K. Pace is good this year.
JHARKHAND	Strong Sahiyya programme; good sub centres; problems of governance at the State level affecting civil works and procurements; Over 900 regular doctors recruited recently after 19 years in the State. Civil works has begun but closer monitoring for completion needed. Need to renovate existing facilities on a priority.	65.35% utilization under Mission Flexible Pool and 95.73% utilization under RCH in 2005 to 2009; need for closer review of procurement system to ensure full transparency.
MADHYA PRADESH	Strong emphasis on JSY and institutional deliveries; ASHA programme still weak in MP; human resource provision has improved; construction activities have picked up; need for greater thrust on transparent procurement arrangements.	51.85% utilization under NRHM Mission Flexible Pool and 104.08% under RCH in 2005-2009. Civil works expenditure needs to pick up; a timely reporting system of financial expenditure needs to be further strengthened.
ORISSA	Strong ASHA programme; sub centre, PHC, CHC programmes well implemented; shortage of human resource being augmented; civil works progress is slow; good improvement in institutional deliveries; good performance in immunization.	47.10% utilization in Mission Flexible Pool and 83.26% utilization under RCH in 2005 to 2009; strong HMIS and financial monitoring systems.

RAJASTHAN	Good programme implementation with focus on all components; ASHA Sahayogini linked to ICDS; strong emphasis on guaranteed services from selected facilities. Human resource priority. Emergency transport system in place.	80.17% utilization under Mission Flexible Pool and 92.87% utilization under RCH in 2005 to 2009. Good financial systems in place.
UTTAR PRADESH	Pace of implementation is slow; VHSCs formed and utilizing funds; Sub Centres active; recruitment of nurses and ANMs is slow; Governance issues regarding HR deployment and procurement; basic infrastructure for service provision available in many places; District level Hospitals are functioning well.	46.86% utilization in Mission Flexible Pool and 85.47% utilization under RCH in 2005 to 2009. Need to improve reporting systems for quick submission of utilization. Management system needs strengthening.
UTTARAKHAND	Strong ASHA programme; Sub Centres doing well; new efforts to augment nursing services; untied funds well used; 108 emergency transport system working effectively.	50.06% utilization under Mission Flexible Pool and 88.66% under RCH in 2005 to 2009 period.. Good systems of management in place.
ARUNACHAL PRADESH	15 PHCs being run by NGOs and showing good satisfaction levels; HR augmentation has taken place; need to improve governance to ensure that the health worker is available to the community; good ASHA programme; Mobile Medical Units;	80.44% utilization in Mission Flexible Pool and 92.72% utilization in RCH in 2005 to 2009 period; need to further strengthen financial systems.
ASSAM	Large number of innovations; HR augmentation at all levels; 768 doctors joined the system recently; nurses deployed in large numbers; thrust on immunization and institutional deliveries; ASHA programme is strong.	89.02% utilization under the Mission Flexible Pool and 59.59% utilization under the RCH in 2005-to 2009 period. Need to increase involvement of the Directorate of Health in the NRHM.
MANIPUR	Expansion of the system has had problems on account of insurgency. Basic maintenance of the system is proceeding satisfactorily; indicators	85.70% utilization under the Mission Flexible Pool and 60.30% under RCH in 2005 to 2009 period. Need for further strengthening financial

	are satisfactory.	management systems.
MEGHALAYA	Started slowly but has picked up; 108 system is operational; other NRHM components also getting implemented.	54.78% utilization under Mission Flexible Pool and 39.86% under RCH in 2005 to 2009 period; Expenditure likely to pick up in the current financial year.
MIZORAM	Good indicators of health; NRHM supplementing quality improvement and infrastructure gaps; Satisfactory programme implementation.	97.20% utilization under the Mission Flexible Pool and 82.50% under RCH in 2005 to 2009 period.
NAGALAND	Efforts made to strengthen the primary care system; problem of health functionaries in the hilly and remote areas; Mobile Units are operational; communitisation facilitates utilization of funds at the lowest levels;	108.09% utilization under the Mission Flexible Pool and 67.33% under RCH in 2005 to 2009 period..
SIKKIM	Sikkim has made satisfactory progress under NRHM. Primary health care strengthening and provision of equipments in the District Hospitals has been undertaken.	95.58% utilization under the Mission Flexible Pool and 76.07% under the RCH in the 2005 to 2009 period. Systems in place for effe4ctive supervision.
TRIPURA	Using NRHM to strengthen primary care system. ASHA, PHC strengthening, etc. satisfactory.	52.15% utilization under the Mission Flexible Pool and 36.68% under RCH in the 2005 to 2009 period.
AP	Large number of innovations: 108, 104, Aarogyasri; need to step up quality care in APVVP Hospitals; need for improved co-ordination with Health system; governance issues regarding utilization of funds; ANM having to work with 2-3 Gram Panchayats; need for facility specific monitoring to ensure rational HR deployment and fuller utilization of facilities.	93.88% utilization in Mission Flexible Pool and 82.89% in RCH in the 2005 to 2009 period.
GOA	Emerging non – communicable disease burden; effective 108 system;	44.55% utilization in Mission Flexible Pool and 46.98% in RCH in

	community activities need a push; specialists in CHCs.	the 2005 to 2009 period.
GUJARAT	Good progress on physical infrastructure and hospital up-gradation; Sub Centre strengthening and community processes need more attention; Need to address malnutrition more effectively; Good utilization of funds.	97.03% utilization in Mission Flexible Pool and 83.31%in RCH in the 2005 to 2009 period.
HARYANA	Has picked up in last one year after slow start; vacancies filled up but governance needs more attention; New drug system and surgical package effective; community activities enhanced; simultaneous attention need to quality service guarantees from facilities.	94.28% utilization in Mission Flexible Pool and 72.28% in RCH in 2005 to 2009 period.
KARNATAKA	Late start but programme has picked up in last 2 years; HR position has improved but service outcomes need close monitoring; low utilization of in-patient services at PHCs; community action getting strengthened – VHSCs, etc.; need for public health thrust at Directorate level – need for re-organization.	75.89% utilization in Mission Flexible Pool and 81.70% in RCH in 2005 to 2009 period.
KERALA	Good work in Hospital strengthening and ASHA programme for public health needs; low utilization of services in PHCs; need for rational HR deployment for full effectiveness and efficiency; thrust on non-communicable diseases.	96.69% utilization in Mission Flexible Pool and 85.39% in RCH in 2005 to 2009 period.
MAHARASHTRA	Good progress over last 3 years; rational deployment of HR needed; further strengthening of community processes needed; Greater focus on malnutrition; skill up-gradation of nursing staff needed.	96.44% utilization under Mission Flexible Pool and 63.62% under RCH in the 2005 to 2009 period.

PUNJAB	Late start but good progress over last 2 years; strong ASHA programe; governance challenges in deployment of nurses and doctors; service guarantees needed through facility specific follow up; rational HR deployment using HMIS.	59.03% utilization under the Mission Flexible Pool and 64.82% under RCH in the 2005 to 2009 period.
TAMIL NADU	Excellent progress in strengthening PHCs for 24X7 service; well – established protocols; need to step up progress on civil works and community monitoring; change in job content of ANMs – deliveries and immunization now taking place at PHC.	79.04% utilization under the Mission Flexible Pool and 62.92% under the RCH in the 2005 to 2009 period.
WEST BENGAL	Good progress in second ANM from same Gram Panchayat and in strengthening Gram Panchayat Headquarter Sub Centre; need to speed up expenditure; slow pace in strengthening of other level of health institutions and in pushing procurement reforms. .	37.18% utilization under the Mission Flexible Pool and 54.86% under RCH in the 2005 to 2009 period.

XI – REACHING OUT TO REMOTE AREAS, MOBILE MEDICAL UNITS AND REFERRAL TRANSPORT SYSTEMS UNDER NRHM

NATIONAL RURAL HEALTH MISSION

MOBILE MEDICAL UNITS

	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**

NATIONAL RURAL HEALTH MISSION
EMERGENCY TRANSPORT SYSTEM AND AMBULANCES

	STATE / UT	EMERGENCY TRANSPORT SYSTEM – 102, 108, Janani Express, other systems of referral	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**
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**

XII – NRHM – LOOKING BACKWARDS, LOOKING FORWARDS

A detailed evidence based mid-term assessment of the NRHM confirms the positive impact that NRHM is making on reaching health care to households in remote areas. It also brings out a few key issues with regard to provision of human resources and governance. Health being a State subject, NRHM has to be a vibrant partnership with States in its quest to push reforms with resources. The Mid Term Appraisal also brings out the fact that achievement of decline in IMR, MMR and TFR would require extraordinary efforts and innovative approaches. Based on a careful consideration of the evidence brought out by the independent studies, the following recommendations are suggested to make the impact of the programme on health indicators even more effective:

i) To have a bigger impact on decline of IMR, NRHM needs to strengthen the home based care component in the training programme of ASHAs. It also needs to strengthen basic provisioning for neo-natal care at all facilities to address the key reasons like Sepsis, ARI and Hypothermia. There is also a need to look at nutrition more carefully and further strengthen efforts not only to secure food for households but also to ensure that infections are reduced through effective public health measures. The linkages with Water, Sanitation, Nutrition in the common institutional platform of the Village Health and Sanitation Committee needs to be further strengthened;

ii) The requirements of the health system need Public Health Specialists at all levels. While NRHM has started supporting Medical Officers from State Governments for a one year PG Diploma in Health Management, it must also be ensured that State Governments start making use of such Public Health oriented Medical Officers in key administrative responsibilities at District and State levels. In the

long run, every State must have a public health cadre. It may also be useful to explore the possibility of having an Indian Public Health Service;

iii) There is a need to universalize basic protocols of care at all levels with wide publicity at facilities to ensure that all facilities across the country have the basic protocols in place. There is a need to keep a thrust of basic protocols and design of training and skill development programmes in such a manner that Medical Officers, Nurses, Paramedics and Community Health Workers are able to operationalize basic protocols after training. There is a lot to learn from the protocols followed by the armed forces hospitals and dispensaries in this regard;

iv) While a lot has moved on delegation of Administrative and Financial powers, NRHM needs to further deepen decentralized management and accountability by engaging non-governmental organizations for community monitoring at all levels. The NGO programme of the Ministry needs to be revised in such a manner that presence of quality NGOs for community monitoring and skill development can be crafted from the block to the district to the state levels;

v) While resources have reached institutions across the length and breadth of the country under NRHM, a time has come for every facility to develop its detailed institutional plan for making use of untied resources being made available to it. Timely utilization of such resources, their effectiveness and their efficiency ought to be assessed from time to time. Governance reforms and greater supervision in this regard will help;

vi) The recent changes in Medical Education and Nursing Education are useful and the efforts to make full use of such changes in establishment of Medical and Nursing Institutions in deficient States ought to be given top most priority;

vii) The expansion of Nursing and Paramedic Institutions in deficient States needs top most attention to enable an increase in the density of skilled health workers in the rural areas;

viii) A large number of emerging public health challenges in the last few years make it necessary to develop the Urban Health Mission also on a priority to face up to public health challenges in urban areas;

ix) Given the need for partnerships with non-governmental sector as also to make health care an entitlement of households, there is a need for a National Health Bill that looks at basic standards, costs, rights of patients and most importantly a community led arrangement for public health management;

x) While NRHM has added a large number of human resources in the States, the effectiveness of such addition would be more pronounced if supervisory structures and job descriptions of every worker are well established. NRHM also needs to strengthen further its efforts at facility specific HMIS to enable a more rational deployment of resources in the health sector;

xi) NRHM envisaged the creation of Village Health Registers to track all mortality and morbidity in every village. That process needs to be speeded up so that the local needs can become the basis for interventions;

xii) Linkages with RSBY in government hospitals as also in provision of care in the private sector needs to be further strengthened to enable cashless services for the poor. RSBY payments can also help to incentivize service delivery in government hospitals.

xiii) Malaria, TB and Disease Surveillance programmes ought to be further integrated into the NRHM in such a manner that the public health challenges of

infectious diseases also become fully community owned and community led. Malaria, TB and Disease Surveillance require a community approach that NRHM has initiated through its decentralized institutions. All programmes not only in the health sector but also in Water, Sanitation, Education and Nutrition ought to become accountable to the village level Health and Sanitation Committees in order to ensure full convergence at the ground level.

xiv) NRHM has started a useful process of accreditation of government hospitals by bodies like the National Accreditation Board for Hospitals (NABH) and ISO 9001. Such processes should be further speeded up to ensure service guarantee for quality outcomes at every health facility.

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. The 700,000 ASHA s across the country have demonstrated their ability to link households to facilities. The challenge in the coming years would be to honour the entitlement of every household for quality health care that is accessible, accountable and affordable. NRHM is very much on a right track and it only needs to further put pressure for better governance and for larger civil society involvement at all levels through public hearings and community monitoring. NRHM started an excellent community monitoring system in nine States and the challenge is to make it universal before the end of the 11th Plan so that local communities begin to demand health care in a rights and entitlement framework. This would also call for behaviour change in the way public system interfaces with poor households and particularly the women. The challenge of NRHM is to craft credible public systems and this would also call for new systems of public recruitments which are institution specific and based on service guarantees with complete local level accountability. NRHM has promoted this culture of local recruitments and local

accountability through contractual appointments. There is a need to develop a new paradigm of public recruitment based on the learning of the last five years.