CHAPTER – V

NATIONAL RURAL HEALTH MISSION

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5. National Rural Health Mission

5.1 Evolution of Maternal and Child Health Programs

1. Safe motherhood and child health programs

Safe motherhood and child health activities are critical and important public health issues in a country which has high level of infant and maternal mortality. Efforts have been made by Government from the first and second five year plans[63] (1951-56 and 1956-61) to strengthen maternal and child health services. In 1952, a national family planning program was launched with the objective of population stabilization. The reactions to population control measures in the 70's prompted the Government to adopt the vision **of Stokhey committee**[64] which was close to the Alma Ata declaration on primary health care which sought commitment of Government to health as a fundamental right, community involvement, integration of health services, universal coverage, choice of appropriate technology, effective use of traditional system of medicine and use of essential drugs.

2. Family Planning Services

Family planning services were integrated with maternal and child health and nutritional programs from fifth five year plan (1974-79) with an objective to provide basic health services to vulnerable groups of pregnant women, lactating mothers and preschool children. In rural areas, MCH services were delivered mainly by Government-run primary health centres and sub-centres. In urban areas, these services were availed from Government or municipal hospitals/ dispensaries, hospitals run by voluntary bodies and private nursing or maternity homes.

3. Child Survival and Safe Motherhood (CSSM)

Based on National Health Policy, 1983, Universal immunization program (UIP) was launched in 1985 to provide universal coverage of immunization to infants and pregnant women. In 1992-93, UIP was strengthened under Child Survival and Safe Motherhood (CSSM) project and was augmented with activities like oral rehydration therapy, prophylaxis for control of blindness in children and control of acute respiratory infections. Under safe motherhood component, training of traditional birth attendants,

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[63] Maternal and Child Health: Chapter 9, National Family Health Survey, 1992-93, Government of India.

[64] Report of Sub-Committee on National Health (Stokhey) Committee Report-Government of India, National Planning Committee- Vora, Mumbai,1948.

provision of aseptic delivery kits and strengthening of first referral units to deal with high risk obstetric emergencies were taken up.

5.2 Reproductive and Child Health Program

In 1996, safe motherhood and child health services were incorporated into the Reproductive and Child Health Program (RCH I). The components of RCH I included family planning, child survival & safe motherhood, adolescent reproductive health and prevention/management of RTI/STD/HIV. The management of the program envisaged client- centric approach, community needs assessment through participatory approach, training and capacity building, management information system and target free approach.

5.2.1 RCH Phase II Program

Second phase of RCH program commenced from April, 2005 along with NRHM for five year period up to 2010 (later extended to 2012). The main objectives of the program were to bring about a change in three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realize the outcomes envisioned in the NPP 2000, NHP 2002, MDG, the Tenth Plan Document and India Vision 2020.

The salient features of RCH - II program are: Sector-wide approach to extend the program reach beyond RCH to the entire family welfare sector; building State ownership by involving all the States; decentralization through development of district and State level need based plans; flexible programming to allow States to develop need based work plans with freedom to decide upon program inputs and; capacity building at district, state and the central level to ensure improved program implementation. There is stress on strengthening financial management systems and monitoring and evaluation capabilities at different levels; performance based funding to ensure adherence to program objectives; reward good performance and support weak performers through enhanced technical performance; and convergence, both inter-sectoral as well as intra- sectoral to optimize utilization of resource as well as infrastructural facilities.

5.2.1 RCH II Program in Gujarat

When NRHM was launched, RCH outcomes in Gujarat were better than the national performance for most of the indicators. In order to achieve the goals under the program, targets were set for various RCH indicators (Table 5.1). The implementation of the RCH II program is for a period of 5 years starting from April 2005 to March 2010, extended till 2012. In the initial years emphasis was given on institutional strengthening followed by technical strengthening before it can be scaled at a higher level.

Table 5.1	RCH II: Targets		
Indicator	**2005**	**2007**	**2010**
% Receiving complete Ante natal care	27.21	70	90
% Institutional deliveries	51	67	80
No. of FRUs for emergency obstetric care	39	102	102
% new born weighed at birth	60	80	90
% women contacted by health worker within 3 days of delivery	50	80	90
% unmet need for family planning	9	7	3
% couple using spacing method	11	20	30

5.3 National Rural Health Mission (NRHM)

NRHM is mission mode initiative with a framework to implement NHP, 2002. It subsumes key national programs, namely RCH II, National disease control programs and integrated disease surveillance project under the same umbrella. It was launched to improve the availability and access to quality health care, particularly to vulnerable rural population. NRHM seeks to provide universal access, equitable, affordable and quality healthcare, reduction of maternal and child mortality as well as population stabilization with gender and demographic balance during its implementation period 2005-12.

To achieve these goals, NRHM will facilitate improved access and utilization of quality health services by all; forge partnership between central, state and local Governments; provide platform for involving panchayat raj institutions in the management of primary health care; provide flexibility to the States and community to promote local initiatives and; develop framework to promote inter-sectoral convergence. Under the mission, the expected outcomes by 2012 are to reduce the IMR to 30 per 1000 live births; to reduce MMR to 100 per 100000 live births; to reduce TFR to 2.1; reduce malaria mortality by 50% in 2010 and by another 10% in 2012; eliminate Kala-Azar by 2010; reduce Filaria/Microfilaria by 70% in 2010, 80% in 2012 and elimination by 2015; reduce dengue mortality by 50% in 2010; reduce Leprosy prevalence rate from 1.8 per 100000 to less than 1 per 100000 and; increase bed occupancy from < 20% to 75%.

The key features[65] of the mission are to make the public delivery system accountable to community, human resource management, community involvement, decentralization, monitoring and evaluation, convergence of health programs and flexible financing to improve the health indicators. These features are operationalized by

i. Improvement of infrastructure by providing funds for construction/up-gradation of Sub-Centres/PHC/CHC/District hospitals
ii. To ensure availability of requisite equipments and drugs and improve outreach to un-served and under-served areas through mobile medical units.
iii. To ensure availability of critical manpower through initiatives like introduction of Accredited Social Health Activist (ASHA) and Community Based Health Volunteers (CBHV) in urban areas.
iv. To provide managerial support by setting up Program Management Units (PMU) at State and District levels, capacity building of ASHA, ANM, nurses and rural health practitioners by way of continuous skill development
v. Decentralization and convergence of health programs at village and district panchayat levels, preparation of village and district health action plans for planning, convergence, implementation and monitoring of activities under the mission.
vi. To have flexibility in funding by bringing funds under different budget heads under single budget head and flow of funds through societies at State and District level.
vii. Since the mission is based on rights-based approach, to have three pronged accountability- community based, external surveys and internal monitoring. All these efforts will be backed by a strong MIS of indicators and components.

While the mission covers the entire country, 18 states with weak public health indicators and health infrastructure are identified for special attention. The high focus states would be supported by additional ASHA and financial support. Gujarat falls under non-focus major state.

[65] Meeting people's health needs in rural areas, National Rural Health Mission-Framework for implementation-2005-2012: Ministry of Health and Family Welfare, Government of India.

5.3.1 NRHM in Gujarat[66]: Vision & Strategy

Vision

The overall goal is to improve the quality of life of people living in Gujarat as articulated in Vision 2010 and State Population Policy 2002. NRHM aims to contribute to this and plans to improve the Reproductive and Child Health Status of the people living in the State by implementing RCH II (2005-2012). The specific objectives of the program are to

1. Reduce MMR from 172 (in 2006) to below 100 per 100000 live births by 2012
2. Reduce IMR from 50 to 30 by 2012
3. Stabilize population by reducing TFR from 2.4 to 2.1 by 2012

Strategies and Interventions

The strategies and interventions include program and services for improving maternal health, child health, family planning and adolescents' health.

1. Maternal Healthcare

The goal is to reduce Maternal Mortality Rate (MMR) from the present level of 172 per 100,000 to below 100 per 100,000 live births by 2012. In order to achieve this, the objectives are to 1) improve coverage of antenatal care (90%) by 2010 2) increase the deliveries attended by Skilled Birth Attendants by 90% and institutional deliveries by 80% 3) increase access to Emergency Obstetric Care for complicated deliveries 4) increase coverage of post partum care (90%) 5) increase access to early & safe abortion services (1/100,000 Pop) and 6) improve access to RTI/ STI services in all PHCs and all CHC.

2. Child Healthcare

To achieve the goal to bring down the Infant Mortality Rate (IMR) from the present level of 60 per thousand live births to less than 30 per thousand live births by 2012, the objectives are to 1) provide essential care to new born at community and facility level 2) promote exclusive breast feeding 4) provide critical newborn care at FRU level, 5) universalise immunisation coverage 6) manage of diarrhoea and ARIs 7) implement Integrated Management of Neonatal and Childhood Illness (IMNCI) in State to manage

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[66] Reproductive and Child Health Program (RCH II) Annual Plan 2007-08, State Program Implementation Plan, Gujarat: Commissionerate of Health & Family Welfare, Department of Health and Family Welfare, Government of Gujarat, March 2007.

sick neonates and children in phased manner and 8) develop Public Private Partnership for critical neonatal care.

3. Family Planning

The goal is to stabilize State population by reducing Total Fertility Rate (TFR) from 3.0 to 2.1 by 2012. In order to achieve this, the objective are to 1) reduce current unmet need for family planning by 75% 2) reduce unmet need for spacing 3) reduce unmet need for terminal methods 4) increase access to non-clinical contraceptives through community based distribution system and 5) improve access to non-clinical contraceptives through Social Marketing and 6) popularise IUD 380- A as an alternative to sterilisation.

4. Adolescent Health

In Gujarat, 22% of population is adolescents (10-19 year group). About one-third (32.26%) of the boys and two-fifths of the girls (38.95%) dropped-out of the school after class 5 in 1997-98. Department of Women and Child Development (DWCD) is supporting Adolescent Counseling Centres in several districts in Gujarat. These Centres are run by NGO with the support of DWCD.

The aim is to improve adolescent health by 1) providing Adolescent Friendly Health Services (AFHS) at CHC/ PHC to increase awareness among the adolescents about the services available 2) Adolescent Reproductive and Sexual Health (ARSH) service to influence the health seeking behaviour of adolescents who are in sexually active age 3) developing linkages for referral services, and 4) Anemia control in adolescent girls and boys.

5.3.2 NRHM Plan

1. Institutional Strengthening

The State would engage the service of experts/ consultants/ staff to put effective management systems in place which will strengthen health care institutions. State health society, family planning bureaus, State supervisory board and other authorities under PNDT Act, State and district level quality assurance committees, District Health Society, training institutions and medical colleges are covered under this activity.

2. Training

Capacity building of human resources is recognised as priority intervention in RCH II for which a program management unit has been planned at district level. The activities include IEC training, program management training for the district and state

managers in collaboration with Indian Institute of Management, Ahmedabad and NGO training by Regional Resource Centre. RCH II orientation, MIS, finance, institutional components and technical training for service providers have been planned in the initial years of the program through State Institute of Health & Family Welfare. Apart from the internal faculties, experts will be invited for the training.

National Institute of Health and Family Welfare (NIHFW) is the nodal institute for training under NRHM. It has the responsibility to organize national level training courses and coordination of the training activities under NRHM with the help of collaborating training institutions in various parts of the country. In Gujarat, the overall responsibility of training programs will be with SIHFW. The Divisional training centre and District training team will provide trainings to doctors, paramedical personnel and supervisors.

3. Financial Management

In Gujarat, a Governing Body of State Health Society mechanism has been established for externally aided programs. For RCH II, Governing body of State health society receives fund from Government of India. The Program Director is responsible for disbursement of funds and its proper accounting with the support of Operations Manager and develop tailor made accounting software suitable for the state and district level for disbursement of funds and its monitoring.

4. Quality Assurance

Continuous monotoring of quality of services provided is required to assess service to clients and supplies utilized to ensure that the public health system provides the best possible service. Quality Assurance is considered as an important management approach to minimize variations and standardize managerial and clinical practices and procedures to improve the health outcomes. This is institutionalized by establishing quality assurance teams at State and district level to ensure quality and effective management of services and designing and implementing quality interventions to enhance user's satisfaction with the service.

Its functions are to review centers (public/private) providing family planning services in the state and district and ensure implementation of national standards; review & report conception due to failure of sterilization in the state and district; review and report complications due to IUD/Oral pills; review quality assurance activities at state and district level; suggest measures to improve quality of family planning services and;

collect and publish six monthly reports of the number of persons sterilized as well as the number of deaths or complications arising out of sterilization.

District level committee periodically visits the facilities and meets every month to discuss the findings and feedback is given to district health authorities and state level committee. Need based improvement is undertaken to improve the quality of programs. This will be an ongoing process covering all the RCH components and facilities.

5. Behaviour Change Communication (BCC)

Goals set under various national health programs and RCH II can be achieved by increasing the demand for services and improving the coverage and utilization of services. On one side, community requires awareness of various health services and their benefits. On other side, service providers require coping up with demand for health care. Communication strategy will be formulated keeping in mind these two objectives.

Behavior change communication plan is combination of tools focusing on the individuals to ultimately bring about a societal change involving the NGOs and private sector with appropriate communication message.

6. NGOs involvement in RCH II

Gujarat is well known for its voluntary movements and cooperative sector movements. A significant number of NGOs are actively working in the field of health care and development. In Gujarat, NGO partnership is envisaged for running PHC, programs like pulse polio, training, and involvement in HIV/AIDS and ICDS programs. Other specific activities identified for NGO involvement are the issues of female foeticide and declining sex ratio, community mobilization, emergency transport and ambulance services, adolescent health, monitoring public health system and initiatives for empowerment of women and community.

7. Convergence and Coordination

Convergence is required for complementary working of departments or agencies to achieve common goals and objectives under NRHM. In order to achieve synergy, NRHM plan seeks convergence in program planning, resources, training, IEC activities, activity time line and monitoring. Coordination mechanism is required with Women and Child Development, Urban development, Rural Development, Social Justice & Empowerment, Education, Panchayat and Youth Affairs departments.

Institutional mechanism for convergence at State level comprises of the Governing Body of State Health Society which has Chief Secretary as Chairperson, Principal Secretary, Health & Family Welfare as Vice chairperson, Commissioner of

Health, Principal Secretaries of Education, Rural Development, Urban Development and Women & Child Development as members and RCH Director as Member Secretary. District Level Coordination and Convergence is under District Health Society in which District Collector is Chairperson with members from various departments and NGO.

8. District Implementation plans

The district specific implementation plans are prepared based on local needs. In addition to this, community specific interventions with NGOs, CBOs and community mobilization for demand generation will be thrust areas of district plans. Equity and gender issues will be addressed looking into the local situation. Health Workers will be trained to monitor the unmet need for family planning and other services. After two years, the objectives of all districts will be revisited based on information collected through community needs assessment approach.

9. Thrust Activities under NRHM/RCH II

i. Comprehensive malnutrition Scheme[67]

Realizing the need to focus on malnutrition in the state, a detailed plan has been prepared and sanctioned under NRHM. With a life cycle approach to the problem, the plan aims at improvement in quality of food intake; universal coverage of pregnant, lactating mothers, children up to 14 years through Mamta Abhiyan, ICDS and MDM; iron supplementation for adolescent girls; making financial provision as per the actual requirement; special component for tribal areas; awareness generation and sensitization for developing healthy food habits; training and sensitization of ICDS and MDM cooks and helpers and; replacement of fire wood with solar cooker.

ii. Strengthening Outreach Services (Mamta Abhiyan):

Mamta Abhiyan[68] is an approach to strengthen the comprehensive outreach of RCH Services. It aims at preventive, promotive and curative services through convergence with ICDS and participation of community. Four components of Mamta Abhiyan are Mamta Divas (Health and Nutrition Day), Mamta Mulakat (Post natal care visit), Mamta Sandarbh (Referral and Services) and Mamta Nondh (Record and Reports)

Mamta divas is a fixed day and fixed site preventive/promotive health care service for mother and children of the village conducted every month. All pregnant women,

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[67] A Leadership agenda for Action: The Coalition for Sustainable Nutritional Security in India, September 19, 2008.

[68] Yoong, Joanne- Does Decentralization Hurt Childhood Immunization?- Department of Economics, Stanford University, October 20, 2007.

breast feeding women and under-five children are beneficiaries of this session. Services provided include health check up, immunization, primary treatment, referral and counselling services. These services are provided by a team of health workers, ICDS workers, Kishori Shakti Yojna girls, Mahila Swasthya Sangh representative and NGO representatives.

. Mamta mulakat is a home visit on 1st, 3rd and 7th day after delivery for preventive/ promotive health care and timely referral of sick mother and child to prevent neonatal and maternal mortality in this critical phase. Mamta Sandarbh is the development and mapping of fixed day and fixed site referral services for ANC, PNC, ENBC and RTI – STI. Mamta Nondh services are important to monitor coverage and quality of RCH services. A comprehensive individual recording of health status and health services with antenatal registration tracked upto the age of 3 years of the child. All health monitoring and health service records are maintained on Mamta card given to mother.

iii. Services to difficult areas and marginalized communities

Several interventions which include initiatives under RCH have been taken up to address the equity issues in health. Initiatives like Chiranjeevi Yojna in partnership with private providers aims at access of indigent sections to quality maternity services by removing access barriers like finance, distance and time for proper health care. To reach out the marginalized communities living in far-flung areas, the State has 108 Mobile Health Units (MHU) that are currently functioning in tribal, peri-urban, difficult areas and earthquake affected areas.

iv. Public Private Partnerships

To increase access to safe delivery services, the state has initiated "Chiranjeevi Yojna" wherein all BPL families will be covered is an example of public private partnership initiative. Under this scheme, an expectant mother from BPL family will be given entitlement coupon for deliveries. She can use it to avail health care from an identified private provider/ facility for delivery. The coupon will cover all delivery costs as part of a package. The scheme has been inbuilt into the RCH-II phase and State will bridge the funding gap to cover entire state.

The above RCH objectives envisage a result oriented approach under the NRHM by improvement in management of the program at all levels. One striking feature of the program is its focus on management of resources to attain these objectives. In Gujarat, the program is dovetailed with the existing management structures and programs from State to village level. The approach is to cover entire spectrum of issues involved in running the

program: institutional set up; planning; man power; financial power; infrastructure enhancement; training etc.

10. Reporting System

The program lays special emphasis on timely submission of reports. Software and MIS tools have been developed for use upto PHC level where they will ensure uniformity and regularity in data collection and reporting.