

# NATIONAL HEALTH MISSION



Centurion  
UNIVERSITY

*Shaping Lives...  
Empowering Communities...*

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# HEALTH SCENARIO

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- Multiple burden of disease –communicable, non-communicable and unattended morbidities.
- High child and maternal deaths.
- 50% under nourished and anaemic women and children.
- Water and sanitation challenges remain.
- Food security.
- Malaria, dengue, chikunguniya on the rise.
- Public health regulation – very weak.

# NHM

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National Health Mission (NHM) encompassing two Sub-Missions

- National Rural Health Mission (NRHM)
- National Urban Health Mission (NUHM).

**NATIONAL RURAL**  
**HEALTH MISSION**



# **NATIONAL RURAL HEALTH MISSION**

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- The National Rural Health Mission was launched since April 2005 throughout the country for providing better rural health services. National rural health mission has special focus on following 18 states:
- Empowered action group (EAG) states: Bihar, Jharkhand, MP, Chattisgarh, Up, Uttaranchal, Orissa and Rajasthan.
- North east states: Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura.
- Other states: Himachal Pradesh, Jammu and Kashmir

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- National Rural Health Mission (NRHM) was launched at the National Level in April 2005 for a period of seven years (2005-2012) extended up to year 2017.

# AIMS

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- The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care and bridging the gap in rural health care through the creation of a cadre of Accredited Social Health Activist.
- Provision of a female health activist in each village.
- Health & Sanitation Committee of the Panchayat.
- It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.



# GOALS

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- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)
- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to comprehensive primary healthcare.
- Population stabilization, gender and demographic balance.
- Mainstreaming AYUSH.
- Promotion of healthy life styles.



# CORE STRATEGIES

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1. Train and enhance capacity of Panchayat Raj institutions.
2. Promote access to improved health care at household level through the female health activist.
3. Health plan for each village through village health committee of the panchayat.
4. Strengthening sub center and more MPW's.
5. Strengthening existing PHC's and CHC's.

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6. Strengthening capacities for data collection, assessment and evidence based planning, monitoring and supervision.
  7. Developing capacities for preventive health care at all levels by promoting healthy life styles, reduction in tobacco consumption, alcohol etc.
  8. Preparation and implementation of an district health plan prepared by the district health mission.

## SUPPLEMENTARY STRATEGIES

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1. Regulation of private sector to ensure availability of quality service to citizens at reasonable cost.
2. Mainstreaming AYUSH.
3. Reorienting medical education to support rural health issues including regulation of Medical care.
4. Ensuring accessible, affordable, accountable and good quality hospital care.

# **PLAN OF ACTION/COMPONENTS**

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1. Accredited social health activists
2. Strengthening sub-centers
3. Strengthening primary health centers
4. Strengthening CHCs for first referral
5. District health plan under NRHM
6. Converging sanitation and hygiene under NRHM
7. Strengthening disease control program
8. Public-private partnership for public health goals, including regulation of private sector
9. New health financing mechanisms
10. Reorienting health/medical education to support rural health issues

# 1. ASHA

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- ❖ Resident of the village, a woman (M/W/D) between 25-45 years, with formal education up to 8<sup>th</sup> class, having communication skills and leadership qualities.
- ❖ One ASHA per 1000 population.
- ❖ Chosen by the panchayat to act as the interface between the community and the public health system.
- ❖ Bridge between the ANM and the village.
- ❖ Receiving performance based compensation .

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## **RESPONSIBILITIES:**

- To create awareness among the community regarding nutrition, basic sanitation, hygienic practices, healthy living.
- Counsel women on birth preparedness, imp of safe delivery, breast feeding, complementary feeding, immunization, contraception, STDs.
- Escort/ accompany pregnant women, children requiring treatment and admissions to the nearest PHC's.
- Primary medical care for minor ailment such as diarrhea, fevers.
- Provider of DOTS.



## 2. STRENGTHENING SUB-CENTRES

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- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM.
- Supply of essential drugs, both allopathic and AYUSH, to the Sub-centers.
- In case of additional Outlays, Multipurpose Workers (Male)/Additional ANMs wherever needed, sanction of new Sub-centers, and upgrading existing Sub-centers, including buildings for Sub-centers functioning will be considered.



### **3. STRENGTHENING PRIMARY HEALTH CENTRES**

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- Mission aims at Strengthening PHC for quality preventive, promotive, curative, supervisory and outreach services, through:
  - Adequate and regular supply of essential quality drugs and equipment to PHCs
  - Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States.
  - Strengthening of ongoing communicable disease control programs, new programs for control of non communicable diseases, up gradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need.

## 4. STRENGTHENING CHCs FOR FIRST REFERRAL CARE

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- Operationalizing 3222 existing Community Health Centers (30-50 beds) as 24 Hour First Referral Units, including posting of anesthetists.
- Setting norms for infrastructure, staff, equipment for CHCs.
- Promotion of (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.
- Creation of new Community Health Centres(30-50 beds) to meet the population norm as per Census 2001.

## 5. DISTRICT HEALTH PLAN

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It would be a combination through:

- Health Plans would form the core unit of action in areas like water supply, sanitation, hygiene and nutrition.
- District becomes core unit of planning, budgeting and implementation.
- Centrally Sponsored Schemes could be accordingly in consultation with States.
- All Health and Family Welfare Programmes at District and state level merge into one common “District Health Mission” at the District level and the “State Health Mission” at the state level.

## 6. CONVERGING SANITATION AND HYGIENE UNDER NRHM

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- Total Sanitation Campaign (TSC) is presently implemented in 350 districts, and is proposed to cover all districts in 10th Plan.
- Components of TSC include IEC activities, individual household toilets, women sanitary complex, and School Sanitation Program.
- The District Health Mission would guide activities of sanitation at district level, and promote joint IEC for sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Program .
- ASHA would be incentivized for promoting household toilets by the Mission.



## 7. STRENGTHENING DISEASE CONTROL PROGRAMMES

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- National Disease Control Program for Malaria, TB, Kala Azar, Filariasis, Blindness & Iodine Deficiency and Integrated Disease Surveillance Program shall be integrated under the Mission, for improved program delivery.
- New Initiatives would be launched for control of Non Communicable Diseases.
- Disease surveillance system at village level would be strengthened.
- Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.

## **8. PUBLIC-PRIVATE PARTNERSHIP FOR PUBLIC HEALTH GOALS, INCLUDING REGULATION OF PRIVATE SECTOR**

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- Since almost 75% of health services are being currently provided by the private sector, there is a need to refine regulation.
- Need to develop guidelines for Public-Private Partnership (PPP) in health sector. Identifying areas of partnership, which are need based.
- Management plan for PPP initiatives: at District/State and National levels.

## 9. NEW HEALTH FINANCING MECHANISMS

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- The District Health Missions to move towards paying hospitals for services by way of reimbursement.
- Standardization of services – outpatient, in-patient, laboratory, surgical interventions.
- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.
- All existing CHCs to have wage component paid on monthly basis.
- Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.



## **10. REORIENTING HEALTH/MEDICAL EDUCATION TO SUPPORT RURAL HEALTH ISSUES**

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- While district and tertiary hospitals are necessarily located in urban centres, they form a part of the referral care chain serving the needs of the rural people.
- Medical and para-medical education facilities need to be created in states, based on need assessment.

# ROLE OF STATE GOVERNMENTS UNDER NRHM

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- The Mission covers the entire country. There are 18 high focus States. Government of India would provide funding in these 18 high focus States. Other States would fund interventions like ASHA, and up gradation of SC/PHC/CHC.

# ROLE OF PANCHAYATI RAJ INSTITUTIONS

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- The Mission envisages the following roles for PRIs:
- The District Health Mission to be led by the Zila Parishad. The DHM will control, guide and manage all public health institutions in the district, Sub-centers, PHCs and CHCs.
- ASHAs would be selected by and be accountable to the Village Panchayat.
- The Village Health Committee of the Panchayat would prepare the Village Health Plan.
- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

# GOALS TO BE ACHIEVED BY NRHM

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## NATIONAL LEVEL:

- Infant mortality rate reduced to 30/1000live births
- Maternal mortality ratio reduced to 100/100000
- Total fertility rate reduced to 2.1
- Malaria mortality rate reduction -50% by 2010, additional 10% by 2012
- Kala-azar mortality rate reduction – 100% by 2010 and sustaining elimination until 2012
- Filaria / microfilaria rate reduction – 70% by 2010, 80% by 2012 and elimination by 2015

## Cont....

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- Dengue mortality rate reduction – 50% by 2010 and sustaining at that level until 2012
- Japanese encephalitis mortality rate reduction – 50% by 2010 and sustaining at that level until 2012
- Cataract operation : increasing to 46 lakhs per year by 2012
- Leprosy prevalence rate : reduce from 1.8/10000 in 2005 to less than 1/10000 thereafter
- Tuberculosis DOTS services : maintain 85% cure rate through entire mission period
- Upgrading community health centres to Indian Public Health Standards
- Increase utilization of first referral units from less than 20% to 75%
- Engaging 250000 female Accredited Social Health Activist (ASHAs) in 10 states.



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## **COMMUNITY LEVEL:**

- Availability of trained community level worker at village level, with drug kit for generic ailments.
- Health day at Anganwadi level on a fixed day/ month for provision of immunization, antenatal / postnatal check-ups.
- Availability of generic drugs for common ailments at sub centre and hospital level.
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level.
- Improved access to universal immunization.
- Janani Surakshya Yojana (JSY) for the below poverty line families
- Availability of safe drinking water

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- Provision of household toilets .
- Improved outreach services to medically underserved remote areas.
- Increase awareness about preventive health including nutrition.



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## NATIONAL URBAN HEALTH MISSION

# INTRODUCTION

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- **National Urban Health Mission (NUHM) approved** by the cabinet on 1st May 2013.
- The scheme will now be introduced as a sub-mission under the National Health Mission (NHM). The mission will be implemented in 779 cities and towns, each with a population of more than 50,000, and cover over 7.75 corer people.

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The NUHM will focus on:

- Urban poor population living in slums
- All other vulnerable population such as homeless, ragpickers, street children, rickshaw pullers, kiln workers, sex workers, and other temporary migrants.
- Public health focus on sanitation, clean drinking water, vector control.

# Why NUHM?

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- Urban population is estimated to increase from 35.7 crores in 2011 to 43.2 crores in 2021.
- Rapid increase in the urban population can lead to increase in the number of slums.
- Slum population is growing at the rate of 7% annually.
- Poor health status of the urban slums.
- Inadequacy of the health care delivery to the slum population.

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- Slum people are at greater health hazards due to:-
    - Overcrowding
    - Poor living conditions
    - Poor sanitary conditions
    - Lack of safe water supply
    - Environmental pollution
    - Outbreak of communicable diseases
    - Increased incidence of STIs, RTIs, HIV/AIDS

# GOAL

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- To improve the health status of the urban population but particularly of the poor and other disadvantaged sections:
  - ✓ by facilitating equitable access to quality health care
  - ✓ through a improved public health system,
  - ✓ outreach services
  - ✓ involvement of the community and urban local bodies.



# CORE STRATEGIES

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- Improving the efficiency of public health system in the cities by strengthening and improving existing government primary urban health structure and referral facilities.
- Promotion of access to improved health care at household level through community based groups : Mahila Arogya Samitis.
- Strengthening public health through innovative action.
- Increased access to health care.
- IT enabled services (ITES) and e- governance for improving access improved surveillance.
- Prioritizing the most vulnerable amongst the poor.
- Ensuring quality health care services.

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# COMPONENTS

# 1. URBAN- COMMUNITY HEALTH CENTRE (U-CHC)

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## **Population Norms:**

- One U-CHC for 4-5 U-PHCs in big cities.
- The U-CHC would cater to a population of 2,50,000.

## **Services:**

- It would provide in patient services and would be a 30-50 bedded facility.
- It would provide medical care, minor surgical facilities and facilities for institutional delivery.

## 2. URBAN PRIMARY HEALTH CENTRE (U-PHC)

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### **Population Norms:**

- Functional for a population of around approximately 50,000-60,000.
- It may be located preferably within a slum or near a slum within half a kilometre radius catering to a slum population of approximately 25,000-30,000.
- The cities based upon the local situation may establish a U-PHC for 75,000 for areas with very high density.

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## **Services:**

- OPD (consultation); Basic lab diagnosis, drug /contraceptive dispensing, Distribution of health education, Material and counselling for all communicable and non communicable diseases.
- It will not include in-patient care.

### 3. COMMUNITY LEVEL

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#### A. Urban Social Health Activist (USHA):

- A Frontline community worker for each slum/community similar to ASHA under NRHM.
- The USHA would be a woman resident of the slum, preferably in the age group of 25 to 45 years married / widowed/ divorced.
- She would be covering about 1000 – 2500 community level beneficiaries.
- She would be covering between 200-500 households functional at the slum level the door steps.



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- She would serve as an effective link between the Urban Primary Health Centre and the urban slum populations.
  - She would maintain interpersonal communication with the beneficiary families and individuals.
  - She would help the ANM in delivering outreach services in the doorsteps of the beneficiaries.

## Functions:

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- To promote good health services in her area.
- To facilitate awareness on RCH services.
- To motivate all types of family planning methods.
- To register all pregnant mothers and to motivate them for antenatal care.
- To act as a depot for essential provisions like ORS packets, IFA tablets, Chloroquine tablets, oral pills, condoms etc.
- To support ANM in conducting monthly outreach session regularly.
- To escort the patients requiring health services.
- To encourage the community participation in health activities.

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- To maintain the records of vital events in her area.
  - To treat minor ailments with the drug kit provided.
  - Reinforcement of community action for immunization.

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**B. MAHILA AROGYA SAMITI (MAS):**

- It acts as community group involved in community awareness, interpersonal communication, community based monitoring and linkages with the services and referral.
- The MAS may cover around 50- 100 households (HHs 250-500 population) with an elected Chairperson and a Treasurer supported by an USHA Link worker.
- This group would focus on preventive and promotive health care.

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## **Functions of MAS:**

- To focus on preventive and promotive care.
- To act as peer education group.
- To facilitate access to identified facilities.
- Community monitoring and referral.
- Risk pooling fund and health insurance.

## Process of promotion of Mahila Arogya Samiti:

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- Meetings with slum women.
- Identification of active and committed women.
- Suggested group size: The suggested norm for one group is 10-12 members over 50-100 families (250-500 population). The numbers will vary depending on the size of the slum (e.g. in case of a small slum with 50 families, the Committee will be promoted over 50 families).



**C. AUXILIARY NURSE MID-WIFE:**

- Each ANM will organize a minimum of one outreach session every month.
- Outreach Medical Camps – Once in a week the ANMs would organize one Outreach Medical Camp in partnership with other health professionals (doctors/pharmacist/technicians/nurses – government or private).
- Outreach sessions will be planned to focus special attention for slum population, rag pickers, sex workers, street children and rickshaw pullers.

## 4. REFERRAL LINKAGES

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- Existing hospitals, including maternity homes, state government hospitals and medical colleges, apart from private hospitals will be accredited to act as referral points.
- Health care services like maternal health, child health, diabetes, trauma care, orthopaedic complications, dental surgeries, mental health, critical illness, deafness control, cancer management, tobacco counselling / cessation, critical illness, surgical cases etc.

## THE INTERVENTIONS UNDER THE SUB-MISSION WILL RESULT IN

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- Reduce IMR & MMR by 40% (in urban areas).
- Achieve universal immunization in all urban areas.
- Reduce MMR by 50%.
- 100% of ANC coverage.
- Achieve universal access to reproductive health including 100% institutional delivery.
- Achieve all targets of disease control programmes.

# DIFFERENCE BETWEEN NRHM AND NUHM

NRHM	NUHM
▪National rural health mission	▪National urban health mission
▪Improves rural health delivery system	▪Separate mission for urban areas and focus on slums & other urban poor families.
▪Launched on 12 th April, 2005	▪Approved on 1st May 2013
▪Creation of ASHA (Accredited Social Health Activist)	▪Creation of USHA (Urban Social Health Activist)
▪1 ASHA = 1000 population	▪1 USHA= 1000- 2,500 beneficiaries, 200-500 households
▪ PHC / CHC are present to provide health services.	▪PUHC/ CUHC is there to provide health services.

**THANK YOU**