Internship
at
National Health Mission,
Madhya Pradesh

By

Swati Mittal

MBA Hospital and Health Management
2014-2016

The IIHMR University, Jaipur
2016

Background

1.1 This Framework for Implementation lays out the broad principles and strategic directions of the National Health Mission (NHM) encompassing two Sub-Missions, National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). It is both flexible and dynamic and is intended to guide States1 towards ensuring the achievement of universal access to health care through strengthening of health systems, institutions and capabilities.

1.2 This Framework draws on several sources. First, it builds on the Framework for Implementation2 approved by the Cabinet in 2006, for the first phase of the NRHM. The second is the learning from NRHM implementation over the past seven years, documented in several evaluation reports and studies3 and the experiences of people and practitioners across the rural areas of the country. Third, the Chapter on Health of the Twelfth Plan provides the broad guidance for this Framework. Finally, it also incorporates the comments and suggestions from the Planning Commission, various Ministries, and state governments.

1.3 This Framework document is intended to lay out the approach for the National Health Mission for the period 2012-2017 and beyond.

1.4 The 2006 Framework for Implementation has served the Mission well and has guided the NRHM so far. The Framework for Implementation of NUHM has been approved by the Cabinet on May 1, 2013. These Frameworks will continue to guide the NRHM and the NUHM in so far as they are not inconsistent with any of the provisions of the NHM Framework.

VISION OF THE NHM

“Attainment of Universal Access to Equitable, Affordable and Quality health care services, accountable and responsive to people’s needs, with effective inter-sectoral convergent action to address the wider social determinants of health”.

CORE VALUES ‹

Safeguard the health of the poor, vulnerable and disadvantaged, and move towards a right based approach to health through entitlements and service guarantees ‹

Strengthen public health systems as a basis for universal access and social protection against the rising costs of health care. ‹

Build environment of trust between people and providers of health services.

Empower community to become active participants in the process of attainment of highest possible levels of health.

Institutionalize transparency and accountability in all processes and mechanisms.

Improve efficiency to optimize use of available resources.

GUIDING PRINCIPLES

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

2.3.2 Ensure coordinated inter-sectoral action to address issues of food security and nutrition, access to safe drinking water and sanitation, education particularly girls education, occupational and environmental health determinants, women's rights and empowerment and different forms of marginalization and vulnerability.

2.3.3 Incentivize states and UTs to undertake health sector reforms that lead to greater efficiency and equity in health care delivery.

2.3.4 Ensure prioritization of services that address the health of women and children and the prevention and control of communicable and non-communicable diseases, including locally endemic diseases.

2.3.5 Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities wherever necessary.

INSTITUTIONL MECHANISM

- At the National level, the Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) are in place. The MSG provides policy direction to the Mission. The Union Minister of Health & Family Welfare chairs the MSG. The convenor is the Secretary, Department of Health & Family Welfare and the co-convenor is the Additional Secretary & Mission Director. Financial proposals brought before the MSG are first placed before and examined by the EPC, which is headed by the Union Secretary of Health and Family Welfare. The composition, role and powers of the MSG and EPC are in accordance with the Cabinet approval of May 1, 2013.
- The Mission is headed by a Mission Director, of the rank of Additional Secretary, supported by a team of Joint Secretaries. The Mission handles not just the day-to-day administrative affairs of the Mission but is responsible for planning, implementing and monitoring Mission activities.
- Upto 0.5% of NHM Outlay is earmarked for programme management and activities for policy support at the national level through a National Programme Management Unit (NPMU).

- The National Health Systems Resource Centre (NHSRC) would continue to serve as the apex body for technical support to the Centre and states. Technical support focuses on problem identification, analysis and problem solving in the process of implementation. It also includes capacity building for district/city planning, organization of community processes and over all dimensions of institutional capacity, of which skills is only a part. NHSRC would also undertake implementation research and evaluation and support the development of State Health Systems Resource Centres (SHSRC) and knowledge networks and partnerships in the states. NHSRC would further provide support for policy and strategy development, through collating evidence and knowledge from published work, from experiences in implementation and serve as institutional memory.
- The National Institute of Health and Family Welfare (NIHFW) is the country's apex body for training. Its main focus is on public health education, development of skills in public health management and all training needs of the health care providers. Training is focused on skill based training of service providers and includes selected aspects of health management training. Its primary accountability is to see that along with its state counterparts, necessary skills for public health management and service provision are in place. One of the major roles of the NIHFW would be to revitalize and strengthen the State Institutes of Health and Family Welfare (SIHFW). Another role would be to develop into a center of e-learning. The NIHFW would also play a leading role in public health research and support to health and family welfare programme

STRENGTHENING STATE HEALTH SYSTEMS

- The NHM shall be a major instrument of financing and support to the states to strengthen public health systems and health care delivery. This financing to the state will be based on the state's Programme Implementation Plan (PIP). The PIP shall have following parts:
  Part I : NRHM RCH Flexipool
  Part II : NUHM Flexipool,
  Part III : Flexible Pool for Communicable Diseases
  Part IV : Flexible Pool for Non Communicable Diseases, Injury and Trauma
  Part V : Infrastructure Maintenance
- Within the broad national parameters and priorities, States would have the flexibility to plan and implement state specific action plans. The state PIP would spell out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes.
- The state PIPs would be an aggregate of the district/city health action plans, and include activities to be carried out at the state level. They would be expected to include the individual district plans particularly of High Priority Districts and City Plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it

would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state.

- The existing Memorandum of Understanding (MOU) signed with the states under NRHM will operate as the MOU under the NHM with modifications as required. The MOU spells out the responsibilities and commitments of the Centre and the state, the outcomes expected from the financial investments and the institutional reforms to strengthen accountability and regulatory frameworks in the state health system. States would be incentivized to undertake governance and institutional reforms for improved health outcomes. The incentive fund approved by the MSG would be used for this purpose. Further, failure to execute fundamental reforms or comply with key conditionalities would attract disincentives. Trust in the state's ability to adhere to rules, norms and procedures in program implementation and the delivery of results is the cornerstone of the relationship between the centre and the state.
- The fund flow from the Central Government to the states would be as per the procedure prescribed by the Government of India.
- The State PIP is approved by the Union Secretary of Health & Family Welfare as Chairman of the EPC, based on appraisal by the National Programme Coordination Committee (NPCC), which is chaired by the Mission Director and includes representatives of the state, Technical and Programme divisions of the MoHFW, National Technical Assistance agencies providing support to the respective states, other departments of the MoHFW and other Ministries as appropriate.
- All existing vertical programmes, shall be horizontally integrated at state, district and block levels. This will mean incorporation into an integrated state, district/city programme implementation plan, sharing data and information across these structures. It shall also mean rationalization of use of infrastructure and human resources across these vertical programmes.