entomological indices of National capital territory of Delhi for *Aedes aegypti* are as below from 2009 & 2010.

Table showing breeding indices of *Aedes aegypti* in NCT Delhi 2008, 2009 and 2010

S.No.	Month	2008			2009			2010*		
		HI	CI	BI	HI	CI	BI	HI	CI	BI
1.	January	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
2.	February	0.04	0.03	0.04	0.02	0.03	0.03	0.03	0.02	0.03
3.	March	0.11	0.13	0.14	0.09	0.07	0.0	90.1	0.1	0.2
4.	April	0.54	0.48	0.56	0.16	0.13	0.16	0.5	1.00.2	0.6
5.	May	1.2	1.1	1.3	0.5	0.4	0.5	1.2	0.81.0	1.6
6.	June	4.8	5.0	5.8	1.0	1.1	1.3	0.9	2.80.8	1.2
7.	July	4.4	5.2	7.7	1.1	1.1	1.3	1.9	9.82.8	4.6
8.	August	4.5	5.2	7.8	3.1	4.1	6.2	6.4	9.79.8	25.0
9.	September	4.1	4.4	5.8	3.2	4.9	8.5	7.6	2.9.7	23.9
10.	October	2.3	2.3	2.1	1.6	1.7	2.3	2.5	2.1	3.1
11.	November	0.5	0.6	0.06	1.1	1.0	1.3			
12.	December	0.04	0.03	0.04	0.4	0.4	0.6			

HI= HOUSE INDEX, CI= CONTAINER INDEX, BI= BRETEAU INDEX
*Provisional up to October 2010

Vector Control Strategy

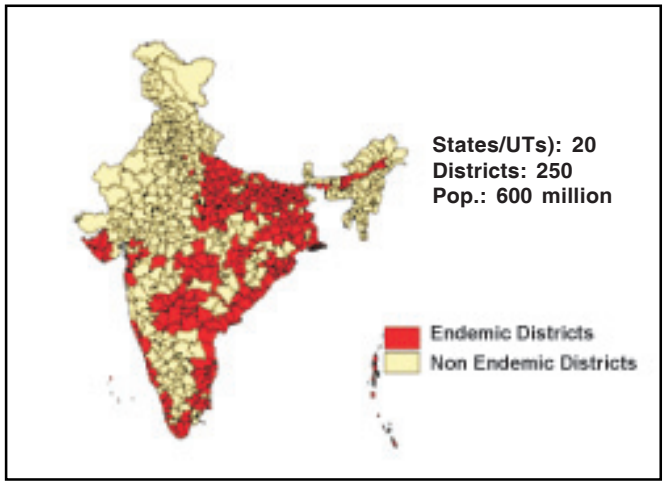
Followings are the vector control strategies for NCT Delhi:

- Weekly recurrent application of larvicides like temephos and mosquito larvicides oil in different breeding habitats.
- Use of Larvivorous fish *Gambusia affinis*, and *Poecila* reticulate (Guppy) in ornamental tanks, ponds and other water collections.
- Filling up of unused well and water pools, desilting and deweeding of the margins of the drains.
- Use of legislative measures and prosecution of defaulters; for creating mosquitogenic conditions in domestic places.
- Spray with pyrethrum in and around 50 house of a positive malaria case.
- Use of fogging in case of very high density of vector mosquitoes (*Aedes aegypti and An. Stephens*i).

6.2.3. Elimination of LymphaticFilariasis

6.2.3.a.Lymphatic Filariasis is transmitted mainly by mosquito *Culex quinquefasciatus* which breeds in polluted water in drains, cesspits etc., in areas with inadequate drainage, sanitation.However, in some parts of Kerala *Mansonia annulifera / M.uniformis* also transmits the disease and the vector mosquitoes breed in water pools with aquatic vegetation. The disease is reported to be endemic in 250 districts in 20 States and UTs. The population of about 600 million in these districts

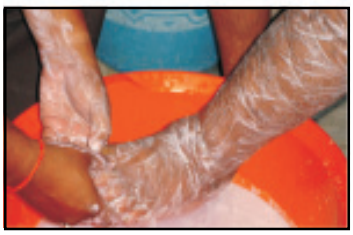
is at risk of lymphatic filariasis. This disease causes personal trauma to the affected persons and is associated with social stigma, even though it is not fatal.



6.2.3.b. The target year for **Global** elimination of this disease is by the year 2020. Government of India is signatory to the World Health Assembly Resolution in 1997 for Global Elimination of Lymphatic Filariasis. The National Health Policy (2002) has envisaged elimination of lymphatic fialriasis in India by 2015. The Elimination is defined as "Lymphatic Filariasis ceases to be a public health problem, when the number of microfilaria carriers is less than 1% and the children born after initiation of ELF are free from circulating antigenaemia (presence of adult filaria worm in human body).

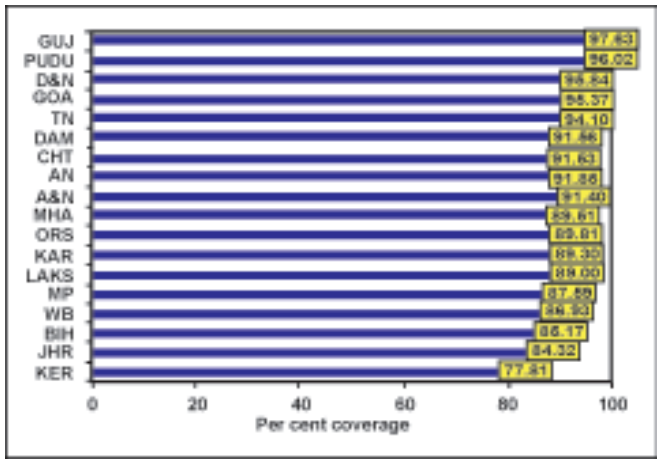
6.2.3.c.The strategy of lymphatic filariasis elimination is through:

- Annual Mass Drug Administration (MDA) of single dose of antifilarial tablets i.e. DEC + Albendazole for 5 years or more to the eligible population (except pregnant women, children below 2 years of age and seriously ill persons) to interrupt transmission of the disease.



- Home based management of lymphoedema cases and up-scaling of hydrocele operations in identified CHCs/ District Hospitals /Medical Colleges.

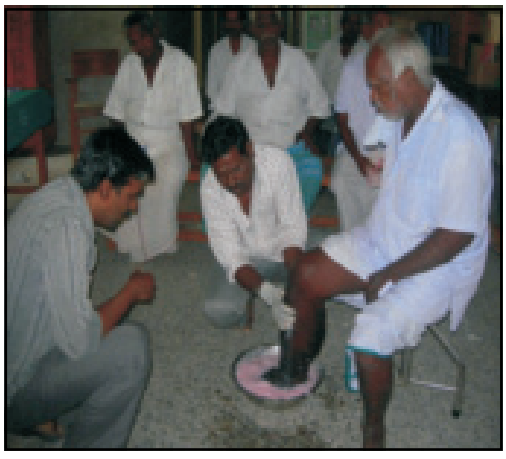
6.2.3.d. To achieve elimination of Lymphatic Filariasis, the Government of India during 2004 launched annual Mass Drug Administration (MDA) with annual single recommended dose of DEC tablets in addition to scaling up home based foot care and Hydrocele operation. The co-administration of DEC+ Albendazole has been upscaled to cover the population at risk. However, Mass Drug Administration (MDA) - 2009 round was observed in 18 States/UTs except Assam and Uttar



Pradesh with co-administration of DEC with Albendazole. The coverage achieved in these states for MDA is 88.6% against the targeted population. The MDA coverage was 72.4% in 2004, 76% in 2005, 82% in 2006, 83% in 2007 and 86% in 2008. The state wise coverage is indicated in **Appendix-2.**

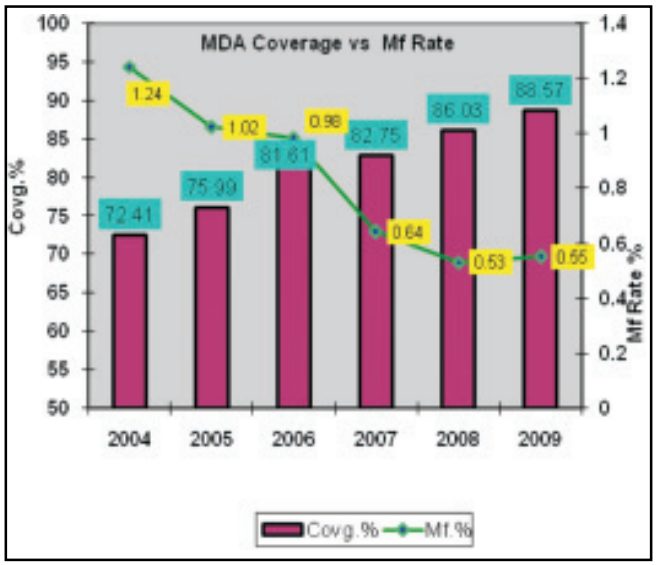
The MDA 2010 round has started from 11th November, 2010.

6.2.3.e. The line listing of lymphoedema and Hydrocele cases were initiated since 2004 by door to door survey in these filaria endemic districts. The enlisted cases are regularly being updated by state health authorities and more cases are being recorded. This increase is mainly due to incomplete surveys during initial years and reluctance on part of



community to reveal their manifestations of lymphoedema and Hydrocele. The updated figure till 2009 revealed that 7.62 lakhs lymphoedema and 3.93 lakhs Hydrocele cases have been enlisted. The initiatives have also been taken to demonstrate the simple washing of foot to maintain hygiene for prevention of secondary bacterial and fungal infection in chronic lymphoedema cases so that the patients get relief from frequent acute attacks. The states regularly update the list and intensify the hydrocele operations in their respective states.

6.2.3.f. The microfilaria survey in all the implementation units (districts) is being done through night blood survey before MDA. The survey is done in 4 sentinel and 4 random sites collecting total 4000 slides (500 from each site). There is definite evidence of microfilaria reduction in the MDA districts. However, the coverage of population with MDA should be above 80% persistently for 5-6 year which would reduce microfilaria load in community and thereby, interrupting the transmission.



6.2.4. Kala-Azar

6.2.4.a.Kala-azar is caused by a protozoan parasite *Leishmania donovani* and spread by sandfly, which breeds in shady, damp and warm places in cracks and crevices in the soft soil, in masonry and rubble heaps, etc. Proper sanitation and hygiene are critical to prevent sand fly breeding. The National Health Policy (2002) of GoI has set the goal for elimination of Kala-azar from the country by 2010. In pursuance to achieve the elimination goal, case detection and treatment compliance has been strengthened and Rapid Diagnostic Test for Kala-azar and oral drug *miltefosine* have been introduced. World Bank is providing assistance in 46 districts in 3 states namely Bihar, Jharkhand and West Bengal.

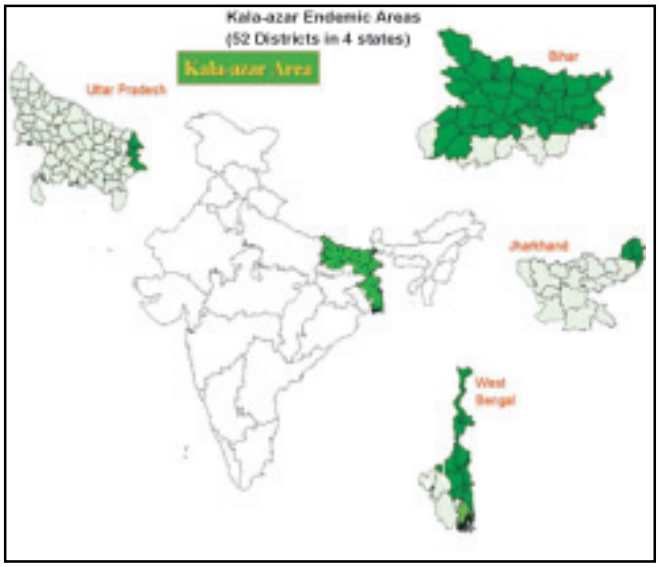
Kala-azar is endemic in 52 districts (31 in Bihar, 4 in Jharkhand, 11 in West Bengal and 6 in UP). The Kala-azar Control Programme was launched in 1990-91. The annual incidence of disease came down from 77,099 cases in 1992 to 33598 cases in 2008 and deaths from 1419 to 151 in 2008 respectively. In the year 2009, 24212 cases and 93 deaths were reported, whereas in 2010 upto October, 23375 cases and 78 deaths have been reported **- Appendix 3.**

6.2.4.b. To realize the goal of elimination of Kala-azar, the Govt. of India is providing 100% support to endemic states since 2003-04.

6.2.4.c. Initiatives undertaken for Kala-azar elimination are as follows:

- **Active Case Search:** The frequency of case searches has been increased, from a single annual case search to quarterly case searches. The active case searches are carried out during a fortnight designated as the **ëKala-azar Fortnightí,** during which the peripheral health workers and volunteers are engaged to make door-to-door search and refer the cases conforming to case definition of kala-azar and PKDL to the treatment centres for definitive diagnosis and treatment.

- **Institutional Surveillance through passive case detection:** Majority of the Kala-azar cases are reported from PHC's and district hospitals.



Many private practitioner, NGO, FBO's have also been advised to report cases to the district health authorities.

- **Treatment:** To ensure complete treatment compliance a patient coding scheme has been put in place in all the treatment cetnres.

- **Vector Control:** Two rounds of DDT spray are undertaken in affected villages of the endemic district, at a dosage of 1g/m^2.

- A **health education programme** with personal contacts as well as through mass media has been initiated to create awareness of the disease amongst the public, emphasizing the need for early case detection, acceptance of a full course of treatment and other control measures.

- Intensive **training** programme for all levels of health staff has been undertaken including one inter-country training and one inter-country training on **Standard Operation Procedures** (SOP).

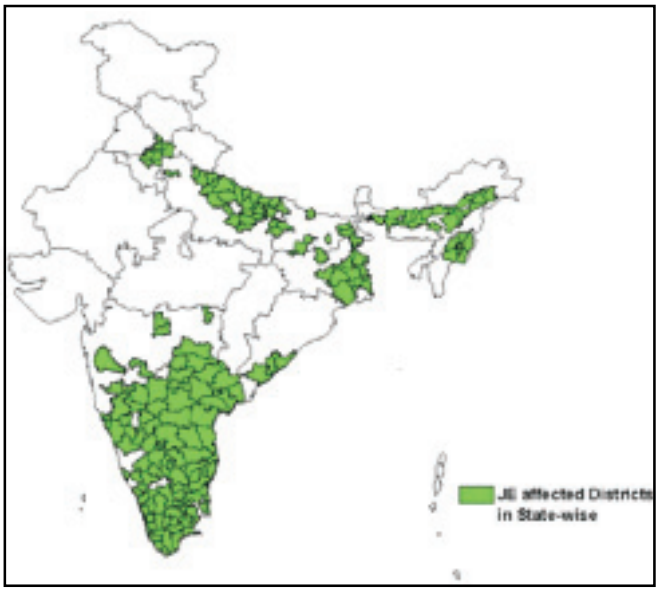
- Introduction of rapid diagnosis test for Kala-azar and oral drug miltefosine in 10 pilot districts of 3 endemic states.

- An incentive for an amount of Rs.200/- is being provided to the Health Workers/ASHAs for referring a susceptive case of kala-azar and to ensure complete treatment after confirmation.

- The kala-azar activist/ Accredited Social Health Activist (ASHA) under the National Rural Health Mission (NRHM) will be provided incentives to involve them in the various activities for control of kala-azar.

6.2.5. Japanese Encephalitis (JE)

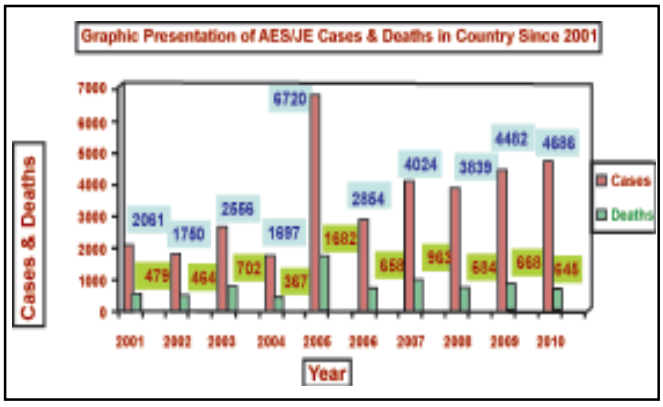
6.2.5.a. Japanese Encephalitis is a zoonotic disease which is transmitted by vector mosquito mainly belonging to *Culex vishnui* group. The transmission cycle is maintained in the nature by animal reservoirs of JE virus like pigs and water birds. Man is the dead end host, i.e. JE is not transmitted from one infected person to other. Outbreaks are common in those areas where there is close interaction between animals/birds and human beings. The vectors of JE breed in large water bodies such as paddy fields. The population at risk is about 300 million.



6.2.5.b. Case definition of AES: Clinically, a case of AES is defined as a person of any age, at any time of the year with the acute onset of fever and a change in mental status (including symptoms such as confusion, disorientation, coma or inability to talk), and/or new onset of seizures (excluding/simple febrile seizures). Other early clinical findings may include an increase in irritability, somnolence or abnormal behaviour greater than that seem with usual febrile illness.

A simple febrile seizure is defined as a seizure that occurs in a child aged 6 months to less than six years old, whose only findings is fever and a single generalized convulsion lasting less than 15 minutes and who recovers consciousness within 60 minutes of the seizure. (Reference – Guidelines for surveillance of Acute Encephalitis Syndrome with special reference to Japanese Encephalitis, Dte. of NVBDCP, Dte. General of Health Services, MOH&FW, November, 2006).

6.2.5.c. Epidemiological Situation: JE has been reported from different parts of the country. The disease is endemic in 14 states of which Assam, Bihar, Haryana, and Uttar Pradesh have been reporting outbreaks. During the year 2008, the reported AES figures indicated 3839 cases and 684 deaths. In the year 2009, 4482 cases and 774 deaths were reported. In 2010 (upto November, 2010) 4686 cases and 645 death were reported. State-wise JE cases and deaths are given in **Appendix - 4.**

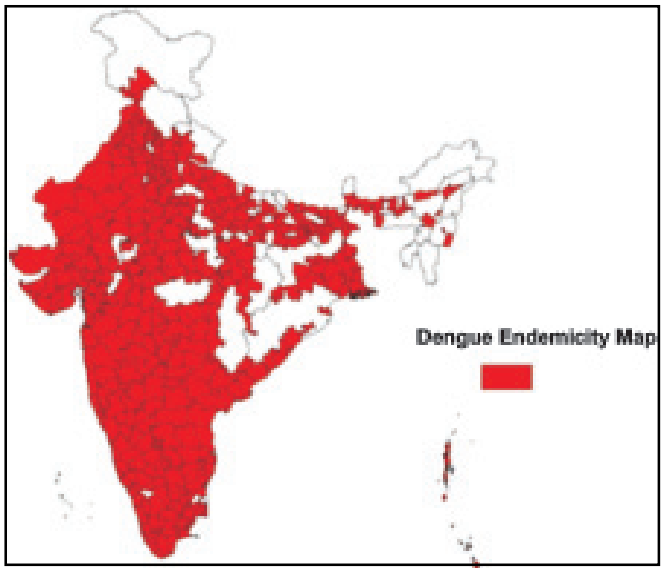


6.2.5.d. There is no specific cure for this disease. Symptomatic and early case management is very important to minimize risk of death and complications. Govt. of India launched JE vaccination programme as an integral component of Universal Immunization Programme (UIP) with single dose live attenuated JE (SA- 14-14-2) in 11 endemic districts of 4 States namely Uttar Pradesh, Assam, West Bengal and Karnataka for children between 1 and 15 years of age and 88.39% coverage was achieved. During 2007, 28 more districts were covered with 84.28% coverage and during 2008 and 2009 children between 1-15 years in 21 and 70 districts respectively vaccinated bringing the total number vaccinated districts to 90. During 2010 out of 19 districts, 5 districts in Manipur, 2 districts in Assam and 1 district in uttarakhand have been covered under vaccination campaign. In addition 7 districts in Uttar Pradesh under special JE vaccination campaign during 2010-11.

6.2.5.e. In addition, implementation of public health measures such as, Health Education through different media like radio, TV including cable network, miking, inter-personal communication, etc for disseminating appropriate messages in the community is crucial. The emphasis is given on keeping pigs away from human dwellings or in pigsties particularly during dusk to dawn which is the biting time of vector mosquitoes. Sensitization of the community regarding avoidance of man-mosquito contact by using bet nets and fully covering the body are also advocated. Since early reporting of cases is crucial to avoid any complication and mortality, community is given full information about the signs and symptoms as well as availability of health services at health centres/hospitals. Besides, the states are advised fogging with malathion (technical) as an outbreak control measure in the affected areas.

6.2.6. Dengue Fever/Dengue Haemorrhagic Fever

6.2.6.a. Dengue Fever is an outbreak prone viral disease, transmitted by *Aedes aegypti* mosquitoes. *Aedes aegypti* mosquitoes prefer to breed in manmade containers, viz., cement tanks, overhead tanks, underground tanks, tyres, desert coolers, pitchers, discarded containers, junk materials etc, in which water stagnates for more than a week. This is a day biting mosquito and prefers to rest in hard to find dark areas inside the houses. The risk of dengue has shown an increase in recent years due to rapid urbanization, life style changes and deficient water management including improper water storage practices in urban, peri-urban and rural areas, leading to proliferation of mosquito breeding sites. The disease has a seasonal pattern i.e., the cases peak after monsoon and it is not uniformly distributed throughout the year. Dengue is a

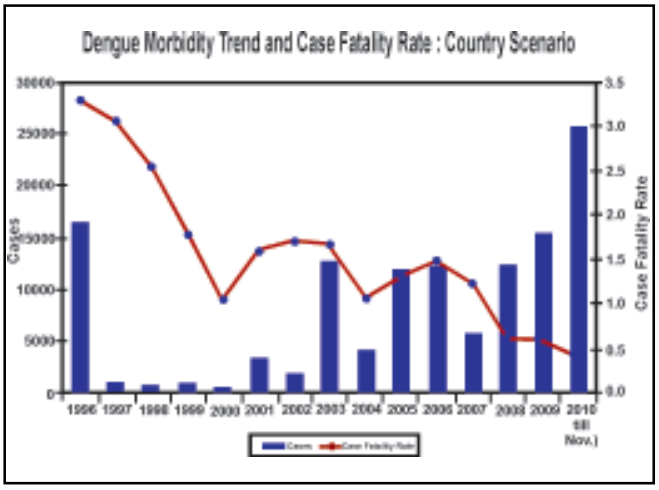


self limiting acute disease characterized by fever, headache, muscle & joint pains, rash, nausea and vomiting. Some infections results in Dengue Haemorrhagic Fever (DHF) and in its severe form Dengue Shock Syndrome (DSS) can threaten the patient's life primarily through increased vascular permeability and shock due to bleeding from internal organs. Though during last 2 years numbers of cases are increasing the deaths are declining. The case fatality rate which was 3.3 % in 1996 had come down to 0.6 in 2009 and 0.4 till November 2010 because of better



management of Dengue cases in the country following National guidelines. The risk of Dengue has been increased in recent year.

6.2.6.b. Epidemiological Situation: Dengue is endemic in 29 States/UTs. After 1996, Outbreak with a total number of 16517 cases and 545 deaths upsurge of cases were recorded in 2003, 2005 and 2008. In 2009 total 15535 cases and 99 deaths have been reported. During 2010, till November 25725 cases and 99 deaths have been reported **(Appendix-5).** Maximum cases were reported by Delhi (6221) followed by Punjab (4022), Kerala (2501), Gujarat (2269) and Karnataka (2177).



6.2.6.c. There is no specific anti-viral drug or vaccine against dengue infection. Mortality can only be minimized by early diagnosis and prompt symptomatic management of the cases. A strategic action plan has been developed for prevention and control of Dengue and issued to the endemic States for implementation. Guidelines for clinical management of dengue fever/ dengue haemorrhagic fever and dengue shock syndrome cases have been developed and sent to the states for wider circulation. Advisories have been sent to the endemic areas for effective vector control through inter-sectoral collaboration and active community involvement, regular monitoring of Dengue cases as well as entomological parameters to forecast likely outbreaks and to take timely remedial measures. The States have been communicated to undertake widespread campaigns for community awareness and mobilization through different media like mass media, miking, inter-personal communication, etc. The emphasis is on elimination of mosquito breeding sources like avoidance of water collection in and around houses, removal of all discarded and disposed/junk materials, keeping all water containers/storage facilities tightly covered and cleaning the water coolers at least once a week before re-filling. Since early reporting of cases is crucial to avoid any complication and mortality, the community is given full information about the signs and symptoms as well as availability of health services at health centres/ hospitals. Alerting the Hospitals for making adequate arrangements for management of Dengue/ Dengue Haemorrhagic Fever cases have also been advised.

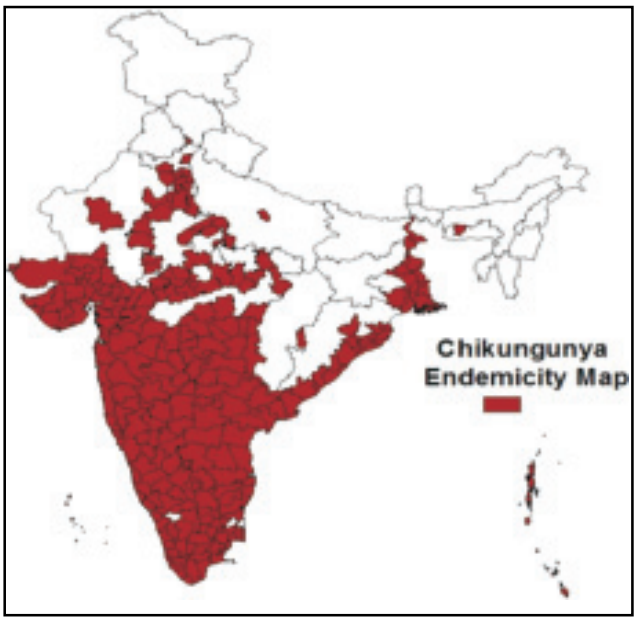
The Directorate of National Vector Borne Disease Control has provided detailed guidelines for the prevention and control of dengue to the affected states. Intensive health education activities through print, electronic and inter-personnel media, outdoor publicity as well as an inter-sectoral collaboration with civil society organization (NGOs/CBOs/Self-Help Groups), PRIs and Municipal bodies have been emphasized. Regular supervision and monitoring is conducted. The Government of India in consultation with States has identified 182 sentinel surveillance hospitals with laboratory support for augmentation of diagnostic facilities in the endemic states. Further, for advanced diagnosis and backup support 13 Apex Referral Laboratories **(Appendix-7)** have been identified and linked with sentinel surveillance hospitals. To make these functional, test kits are provided through National Institute of Virology, Pune free of cost. Contingency grant is also provided to meet the operational costs.

6.2.7. Chikungunya

Chikungunya is a debilitating non-fatal viral illness caused by Chikungunya virus. The disease re-emerged in the country after a gap of three decades. In India a major epidemic of Chikungunya fever was reported during earlier 60s & 70s; 1963 Kolkata; 1965 (Pondicherry and Chennai in Tamil Nadu, Rajahmundry, Vishakapatnam and Kakinada in Andhra Pradesh; Sagar in Madhya Pradesh and Nagpur in Maharashtra) and 1973, (Barsi in Maharashtra). This disease is also transmitted by *Aedes* mosquito. Both *Ae. aegypti* and *Ae.albopictus* can transmit the disease. Humans are considered to be the major source or reservoir of Chikungunya virus. Therefore, the mosquitoes usually transmit the disease by biting infected persons and then biting others. The infected person cannot spread the infection directly to other person (i.e. it is not contagious disease). Symptoms of Chikungunya fever are most often clinically indistinguishable from those observed in dengue fever.

However, unlike dengue, hemmorrhagic manifestations are rare and shock is not observed in Chikungunya virus infection. It is characterized by fever with severe joint pain (arthralgia) and rash. Chikungunya outbreaks typically result in large number of cases but deaths are rarely encountered. Joint pains sometimes persist for a long time even after the disease is cured.

Deaths already occur in Chikungunya infection?(plz. check it)



6.2.7.a. During 2006, total 1.39 million clinically suspected Chikungunya cases reported in the country. Out of 35 States/UTs 16 were affected: Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Madhya Pradesh, Gujarat, Kerala, Andaman & Nicobar Islands, Delhi, Rajasthan, Puducherry, Goa, Orissa, West Bengal, Lakshadweep and Uttar Pradesh. There are no reported deaths directly related to Chikungunya. In 2007, total 14 states were affected and reported 59535 suspected Chikungunya fever cases with nil death. Subsequently in 2008, 95091 suspected Chikungunya fever cases and nil deaths have been reported. In 2009 73288 Suspected Chikungunya fever cases and Nil death have been reported. During 2010, 24364 Suspected Chikungunya fever cases have been reported. Maximum cases were reported from Karnataka (35.01%) followed by Maharashtra (24.26) **(Appendix-6).**

6.2.7.b. As already mentioned, *Aedes* mosquitoes bite during the day and breed in a wide variety of man-made containers which are common around human dwellings. These containers such as discarded tyres, flower pots, old water drums, family water trough, water storage vessels and plastic food containers collect rain water and become the source of breeding of *Aedes* mosquitoes. *Ae.aegypti* played the major role in transmitting the disease in all the states except Kerala, where *Ae. albopictus* played the major role. *Ae. albopictus* breeding was detected in latex collecting cups of rubber plantations, shoot-off leaves of areca palm, fruit shells, leaf axils, tree holes etc.

There is neither any vaccine nor drugs available to cure the Chikungunya infection. Supportive therapy that helps to ease symptoms, such as administration of non-steroidal anti-inflammatory drugs and getting plenty of rest are found to be beneficial.

6.2.7.c. Government of India is continuously monitoring the situation, sending guidelines and advisories for prevention and control of Chikungunya fever to the states. Since same vector is involved in the transmission of Dengue and Chikungunya strategies for transmission, risk reduction by vector control are also same. A comprehensive Long Term Action Plan for prevention & control of Chikungunya and Dengue/Dengue Haemorrhagic Fever has been prepared and disseminated for guidance to the states. Support in the form of logistics and funds are provided to the states. The central teams are deputed to the affected states for technical guidance of the state health authorities. As most transmission occurs at home, therefore, community participation and co-operation is of paramount importance for successful implementation of programme strategies for prevention and control of Chikungunya. Therefore, considerable efforts have been made through advocacy and social mobilization for community education and awareness. For effective community participation, people are informed about Chikungunya and the fact that major epidemics can be prevented by taking effective preventive measures by community itself. For carrying out proactive surveillance and enhancing diagnostic facilities for Chikungunya, the 182 Sentinel Surveillance hospitals involved in dengue **(Appendix-8)** in the affected states also carries Chikungunya tests. Both Dengue and Chikungunya Diagnostic kits to these institutes are provided through National Institute of Virology, Pune and cost is borne by GOI. Further, rapid response by the concerned health

authorities has been envisaged on report of any suspected case from the Sentinel Surveillance Hospitals to prevent further spread of the disease.

6.2.7.d. The overall strategies for prevention and control are same as in Dengue such as symptomatic management of cases, reduction of breeding sources, personal protection and intensive IEC and capacity building. Initiatives undertaken by Govt. of India for prevention and control of Dengue/Chikungunya are as follows:

1. Continuous monitoring of Chikungunya and Dengue situation in states.

2. Circulation of guidelines and advisories for prevention and control of diseases to affected states.

3. Launch of intensive IEC and Behaviour Change Communication activities through print, electronic media, interpersonal communication, outdoor publicity as well as inter sectoral collaboration with civil society organizations (NGOs/CBOs/ Self Help Groups), PRIs.

4. Provision of larvicides and adulticides to affected states.

5. Identification and strengthening of Apex Referral Laboratories and sentinel surveillance hospitals for diagnosis and regular surveillance.

6. NIV, Pune has been entrusted for supply of test kits to the identified institutions free of cost.

7. Contingency grant provided to the Apex Referral Laboratories and sentinel surveillance hospitals to meet the operational cost.

8. Training is imparted on various aspects of prevention and control of Dengue and Chikungunya to programme personnel, Medical Officers on Case Management and laboratory personnel on case diagnosis.

Appendix-1

State-wise Malaria situation in the Country

STATEs/UTs.	2007		2008		2009		2010(till September) updated on 28.08.10)	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Death
Andhra Prd.	27803	2	26424	0	25152	3	25511	20
Arunachal Prd.	32072	36	29146	27	22066	15	12818	0
Assam	94853	152	83939	86	91413	63	52004	30
Bihar	1595	1	2541	0	3255	21	916	1
Chhattisgarh	147525	0	123495	4	129397	11	77553	10
Goa	9755	11	9822	21	5056	10	1753	1
Gujarat	71121	73	51161	43	45902	34	36603	6
Haryana	30895	0	35683	0	30168	0	7286	0
Himachal Prd.	104	0	146	0	192	0	139	0
J&K	240	1	217	1	346	0	504	0
Jharkhand	184878	31	214299	25	230683	28	128452	9
Karnataka	49355	18	47344	8	36859	0	31298	4
Kerala	1927	6	1804	4	2046	5	1756	4
Madhya Pradesh	90829	41	105312	53	87628	26	52828	0
Maharashtra	67850	182	67333	148	93818	227	102822	149
Manipur	1194	4	708	2	1069	1	770	4
Meghalaya	36337	237	39616	73	76759	192	34866	66
Mizoram	6081	75	7361	91	9399	119	12049	18
Nagaland	4976	26	5078	19	8489	35	3744	4
Orissa	371879	221	375430	239	380904	198	279519	161
Punjab	2017	0	2494	0	2955	0	2990	0
Rajasthan	55043	46	57482	54	32709	18	29007	26
Sikkim	48	0	38	0	42	1	32	0
Tamil Nadu	22389	1	21046	2	14988	1	11308	1
Tripura	18474	51	25894	51	24430	62	19941	4
Uttarakhand	953	0	1059	0	1264	0	1097	0
Uttar Pradesh	82538	0	93383	0	55437	0	36155	0
West Bengal	87754	96	89443	104	141211	74	67920	29
A&N Islands	3973	0	4688	0	5760	0	2089	0
Chandigarh	340	0	347	0	430	0	290	0
D & N Haveli	3780	0	3037	0	3408	0	4307	0
Daman & Diu	99	0	115	0	97	0	132	0
Delhi	182	0	253	0	169	0	191	0
Lakshadweep	0	0	0	0	8	0	6	0
Puducherry	68	0	72	0	65	0	97	0
All India Total	**1508927**	**1311**	**1526210**	**1055**	**1563574**	**1144**	**1038753**	**547**

Appendix-2

Population Coverage (%) during Mass Drug Administration (MDA)

Sl. No.	States/UTs	2004	2005	2006	2007	2008	2009
1	Andhra Pradesh	84.78	81.05	89.66	89.13	91.96	91.85
2	Assam	25.42	42.94	67.33	78.32	81.34	**ND**
3	Bihar	81.64	77.82	79.77	77.23	**ND**	85.17 (partial)
4	Chhattisgarh	84.17	82.80	**ND**	89.53	91.30	91.53
5	Goa	97.92	95.33	97.17	97.83	97.46	96.32
6	Gujarat	45.47	98.23	69.60	92.11	93.25	97.63
7	Jharkhand	42.25	74.16	72.75	79.03	84.64	84.32
8	Karnataka	85.22	89.31	90.20	89.67	90.53	89.30
9	Kerala	86.10	90.15	**ND**	92.19	93.67	77.81
10	Madhya Pradesh	73.74	79.29	88.01	88.48	90.14	87.59
11	Maharashtra	78.68	86.48	87.80	88.39	89.71	89.51
12	Orissa	90.11	90.60	87.40	88.47	85.43	89.81
13	Tamil Nadu	95.18	**ND**	**ND**	77.22	87.61	94.1
14	Uttar Pradesh	66.40	71.03	75.97	79.87	81.67	**ND**
15	West Bengal	39.58	51.24	**ND**	76.63	77.79	86.93
16	A&N Islands	85.85	88.31	93.17	98.73	94.10	91.40
17	D & N Haveli	91.13	98.26	94.93	94.16	96.67	95.84
18	Daman & Diu	94.96	73.23	87.17	93.27	91.85	91.56
19	Lakshadweep	64.53	88.23	80.00	86.83	86.32	89.00
20	Puducherry	94.76	96.63	**ND**	96.30	97.01	96.02
	Total	**72.41**	**75.99**	**81.61**	**82.75**	**86.03**	**88.57**

ND: - Not Done
YD: - Yet to do
RN: - Report not received

Appendix-3

State-wise Kala-azar Cases & Deaths

Sl. No	State	2007		2008		2009		2010 (upto Oct. updated on 29.11.10)	
†	†	C	D	C	D	C	D	C	D
1	Bihar	37819	172	28489	142	20519	80	18738	69
2	W. Bengal	1817	9	1256	3	756	0	1146	4
3	UP	69	1	26	0	17	1	12	0
4	Jharkhand	4803	20	3690	5	2875	12	3426	4
5	Delhi*	19	0	34	0	12	0	33	0
6	Assam	0	0	98	0	26	0	12	0
7	Uttarakhand	2	0	0	0	2	0	0	0
8	Sikkim	0	0	4	1	5	0	3	0
9	Gujarat*	4	1	0	0	0	0	0	0
10	M.P	0	0	1	0	0	0	0	0
11.	Himachal Prd.	0	0	0	0	0	0	5	1
	INDIA	**44533**	**203**	**33598**	**151**	**24212**	**93**	**23375**	**78**

C: Cases D: Deaths
*Imported

Appendix-4

STATE-WISE CASES AND DEATHS DUE TO SUSPECTED AES/JE

Sl. No.	Affected States/UTs	2007		2008		2009		2010 (till 30.11.10)	
		C	D	C	D	C	D	C	D
1	Andhra Pradesh	22	0	6	0	14	0	132	5
2	Assam	424	133	319	99	462	92	562	125
3	Bihar	336	164	203	45	325	95	50	7
4	Goa	70	0	39	0	66	3	58	0
5	Haryana	85	46	13	3	12	10	0	0
6	Karnataka	15	3	3	0	246	8	82	1
7	Kerala	2	0	2	0	3	0	19	5
8	Maharashtra	2	0	24	0	1	0	34	17
9	Manipur	65	0	4	0	6	0	116	14
10	Tamil Nadu	42	1	144	0	265	8	290	5
11	Uttarakhand	0	0	12	0	0	0	0	0
12	Uttar Pradesh	3024	645	3012	537	3073	556	3331	460
13	West Bengal	16	2	58	0	0	0	1	0
14	Nagaland	7	1	0	0	9	2	11	6
	Grand Total	**410**	**995**	**3839**	**684**	**4482**	**774**	**4686**	**645**

C : Cases D : Deaths

Appendix-5

State-Wise Dengue Cases And Deaths

Sl. No.	State	2007		2008		2009		2010*	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Andhra Pd.	587	2	313	2	1190	11	728	3
2	Assam	0	0	0	0	0	0	158	2
3	Bihar	0	0	1	0	1	0	287	0
4	Chhattisgarh	0	0	0	0	26	7	1	0
5	Goa	36	0	43	0	277	5	219	0
6	Gujarat	570	2	1065	2	2461	2	2269	0
7	Haryana	365	11	1137	9	125	1	1079	20
8	J & K	0	0	0	0	2	0	0	0
9	Jharkhand	0	0	0	0	0	0	11	0
10	Karnataka	230	0	339	3	1764	8	2177	6
11	Kerala	603	11	733	3	1425	6	2501	17
12	Madhya Pd.	51	2	3	0	1467	5	171	1
13	Meghalaya	0	0	0	0	0	0	1	0
14	Maharashtra	614	21	743	22	2255	20	1116	6
15	Manipur	51	1	0	0	0	0	5	0
16	Nagaland	0	0	0	0	25	0	0	0
17	Orissa	4	0	0	0	0	0	19	0
18	Punjab	28	0	4349	21	245	1	4022	13
19	Rajasthan	540	10	682	4	1389	18	1253	6
20	Sikkim	0	0	0	0	0	0	0	0
21	Tamil Nadu	707	2	530	3	1072	7	1662	8
22	Uttar Pradesh	132	2	51	2	168	2	941	8
23	Uttrakhand	0	0	20	0	0	0	21	0
24	West Bengal	95	4	1038	7	399	0	612	1
25	A&N Island	0	0	0	0	0	0	25	0
26	Chandigarh	99	0	167	0	25	0	163	0
27	Delhi	548	1	1312	2	1153	3	6221	8
28	D&N Haveli	0	0	0	0	0	0	25	0
29	Puducherry	274	0	35	0	66	0	38	0
	TOTAL	**5534**	**69**	**12561**	**80**	**15535**	**96**	**25725**	**99**

*provisional upto November

Appendix-6

Epidemiological Profile Of Chikungunya Fever In The Country

Sl.No	Name of the State	2009				2010*			
		Total Suspected Chikungunya fever cases	No. of Samples tested	No. of confirmed cases	No. of deaths	Total Suspected Chikungunya fever cases	No. of Samples tested	No. of confirmed cases	No. of deaths
1	Andhra Pd.	591	297	117	0	107	107	41	0
2	Goa	1839	1525	685	0	1312	1312	595	0
3	Gujarat	1740	453	169	0	1353	586	248	0
4	Haryana	2	2	0	0	26	26	1	0
5	Karnataka	41230	7714	3164	0	8550	3460	1359	0
6	Kerala	13349	2761	711	0	1521	460	209	0
7	Madhya Pd.	30	30	5	0	31	31	14	0
8	Meghalaya	0	0	0	0	16	16	8	0
9	Maharashtra	1594	766	443	0	5913	1569	768	0
10	Orissa	2306	41	2	0	425	10	4	0
11	Rajasthan	256	256	106	0	365	365	110	0
12	Tamil Nadu	5063	2873	1053	0	4299	3478	736	0
13	Uttar Pradesh	0	0	0	0	1	1	1	0
14	West Bengal	5270	816	338	0	305	305	69	0
15	A&N Island	0	0	0	0	59	0	0	
16	Delhi	18	18	18	0	70	70	70	0
17	Lakshadweep	0	0	0	0	0	0	0	0
18	Puducherry	0	0	0	0	11	11	3	0
	Total	**73288**	**17552**	**6811**	**0**	**24364**	**11807**	**4236**	**0**

*provisional upto November

Appendix - 7

APEX REFERRAL LABORATORIES

(i) All India Institute of Medical Sciences, New Delhi,

(ii) National Institute of Communicable Diseases, Delhi

(iii) National Institute of Virology, Pune,

(iv) National Institute of Mental Health and Neuro-Sceinces, Bangaluru,

(v) Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow,

(vi) Postgraduate Institute of Medical Sciences, Chandigarh,

(vii) ICMR Virus Unit (NICED), Kolkata,

(viii) Kings Institute of Preventive Medicines, Chennai,

(ix) Institute of Preventive Medicine, Hyderabad,

(x) B.J. Medical College, Ahmedabad,

(xi) Kerala State Institute of Virology and infectious diseases, Alleppey,

(xii) Defence Research Development and Establishment, Gwalior.

(xiii) Regional Medical Research Centre (ICMR), Dibrugarh, Assam.

List of the Sentinel Hospitals for Dengue and Chikungunya

Name of the State	Sentinel Hospitals/Institutes
Andhra Pradesh	1. MGM Hospital, Warangal,
	2. Ruya Hospital,Tirupathi,
	3. Govt.Hospital,Guntur,
	4. Govt.Hospital,Vijayawada,
	5. Govt. Hospital,Karimnagar,
	6. Govt. Hospital,Nizamabad,
	7. Govt.Hospital,Annanthpur.
	8. VBRI,Hyderabad.
	9. Medical College, Kurnool
	10. Medical College, Mahboobnagar
Goa	1. Hospicio Hospital, Margoa, South Goa.
	2. Goa Medical College, Goa
	3. Asilo Hospital (North Goa), Mapusa
Maharashtra	1. Govt. Medical Vollege, Nagpur,
	2. B.J. Medical College, Pune,
	3. Govt. Medical College, Aurangabad
	4. District Hospital, Akola
	5. District Hospital, Nashik
	6. Govt. Medical College, Nanded
	7. J.J.Hospital, Mumbai
	8. District Hospital, Chandrapur
	9. Govt. Medical College, Yavatmal
	10. District Hospital, Beed
	11. Govt. Medical College, Kolhapur
	12. Govt. Medical College, Dhule
	13. K.E.M. Hospital, Mumbai
	14. Sion Hospital, Mumbai
	15. District Hospital, Thane
Gujarat	1. N.H.L. Municipal Med. College, Ahmedabad.
	2. Govt. Medical College, Vadodara,
	3. Govt. Medical College,Surat,
	4. Municipal Med. College,Surat,
	5. M.P. Shah Med. College, Jamnagar,
	6. Govt. Med. College, Rajkot,
	7. Govt. Medical College, Bhavnagar.
	8. General Hospital, Palanpur
	9. General Hospital, Dahod
	10. General Hospital, Bhuj
Madhya Pradesh	1. Gandhi Medical College, Bhopal,
	2. G.R.Medical College,Gwalior
	3. S.S. Medical College, Rewa,
	4. N. S.C.B Medical college, Jabalpur
	5. M.G.M. Medical College, Indore
	6. Khandwa district hospital
	7. Betul district hospital
	8. Sagar district hospital
	9. Guna district hospital
	10. Chhindwara district hospital
	11.Satna district hospital
	12. District Malaria Office, Bhopal
Haryana	1. B.K. Hospital, Faridabad.
	2. General Hospital, Ambala

Name of the State	Sentinel Hospitals/Institutes
	3. State Bacteriological Laboratory, Karnal
	4. General Hospital, Gurgaon
	5. General Hospital, Panchkula
	6. Medical College, Agroha
Delhi	1. Swami Daya Nand Hospital, Shahadra, Delhi
	2. Raja Harish Chand Hospital, Narela, Delhi
	3. Hindu Rao Hospital , Delhi
	4. Sanjay Gandhi Memorial Hospital, Mangol Puri, Delhi
	5. Baba Sahib Ambedkar Hospital, Rohini, Delhi
	6. Safdarjung Hospital, New Delhi
	7. Malviya Nagar Hospital, Malviya Nagar, Delhi
	8. SVB Patel Hospital Patel Nagar
	9. ABG Hospital, Moti Nagar, Delhi,
	10.Ram Manohar Lohia Hospital, New Delhi
	11.Lok Nayak Hospital, Jawahar Lal Nehru Marg, Delhi
	12.Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi
	13.GTB Hospital, Dilshad Garden, Delhi
	14.Chacha Nehru Children Hospital, Geeta Colony, Delhi
	15.Lal Bahadur Shastri Hospital, Khichirpur, Delhi
	16.Maharishi Balmiki Hospital, Pooth Khurd, Delhi
	17. Dr. Hedgewar Arogya Sansthan, Karkardooma, Delhi
	18.Lady Hardinge Medical College and its associated hospital Sucheeta Kriplani Hospital
	19.Army Hospital R & R Dhaula Kaun
	20.Central Hospital, Northern Railway
	21.Guru Govind Singh Govt. Hospital, Raghuvir Nagar, Delhi
	22.Babu Jagjivan Ram Memorial Hospital, Jahangirpuri, Delhi
	23.Bhagwan Mahavir Hospital, Pitampura, Delhi
	24.Jag Parvesh Chander Hospital, (JPC) , Shastri Park Hospital
	25.NC.Joshi Memorial Hospital, Karolbagh, Delhi
	26.Kasturba Hospital, Near Jama Masjid, Delhi
	27.Aruna Asaf Ali Hospital, Rajpur Road, Delhi
	28.NDMC Charak Palika Hospital, Moti Bagh, New Delhi
	29.Rao Tula Ram Memorial Hospital,Jaffarpur, Delhi
	30.G.B.Pant Hospital, Jawahar Lal Nehru Marg, Delhi
	31.Base Hospital Delhi Cant.,
	32.Kalawati Saran Children Hospital
	33. ESI Hospital, Basai Darapur
Punjab	1. Civil Hospital, Ludhiana
	2. Govt. Medical College, Amritsar
	3. Govt. Medical Colelge, Patiala
	4. Civil Hospital, Bathinda
	5. Civil Hospital, Jalandhar

Name of the State	Sentinel Hospitals/Institutes
	6. Civil Hospital, S.A.S.Nagar (Mohali)
Rajasthan	1. SMS Hospital, Jaipur
	2. J.K. Lone Hospital
	3. Umaid Hospital,Jodhpur
	4. SMDM, Jaipur
	5. M.B. Hospital, Kota,
	6. S.P. Medical College, Bikaner
	7. RNT Medical College, Udaipur
	8. JLN Medical College, Ajmer
	9. General Hospital Bharatpur
Kerala	1. Govt. Medical College, Kozhikode
	2. Medical College, Kottayam
	3.Medical College, Thiruvanthapuram
	4.Public Health Lab, Thiruvanthapuram
	5. District Hospital, Kollam
	6. THQHThodupuzha, Dist. Idukki
	7. Regional Public Health Laboratory, Ernakulam
	8. District Hospital, Palakkad
	9. District Hospital, Manjeri, Malappuram
	10. District Hospital, Mananthavady, Dist. Wyanad
West Bengal	1. Burdwan Medical College Hospital.
	2. School of Tropical Medicine, Kalkata
	3. Medical College, Kolkata
	4. Nil Ratan Sircar Medical College & Hospital, Kolkata
	5. SSKM Medical College & Hospital, Kolkata
	6. R.G.Kar Medical College & Hospital, Kolkata
	7. National MCH, Kolkata
	8. Midnapore Medical College & Hospital, Midnapur
	9. Bankura Sammilani Medical College & Hospital, Bankura
	10.North Bengal Medical College & Hospital, Siliguri
Karnataka	1. Central Lab. (Hqrs), Bangaluru
	2. Virus Diagnostic Lab, Shimoga
	3. Vijay Nagar Institute of Medical Science, Bellary
	4. District Surveillance Unit, SNR hospital, Kollar
	5. District Surveillance Unit, Belgaum
	6. District Surveillance Unit, Mangalore, D Kanada
	7. Medical College, Hubli
	8. District surveillance Unit Chitradurga
	9. District Surveillance Unit Hassan
	10. District Surveillance Unit Mysore11. District Surveillance Unit Bidar
	12. District Surveillance Unit Raichur
	13. District Surveillance Unit Bijapur
	14. District Surveillance Unit Tumkur
	15. NIV Field Station, Bangaluru
	16. Indira Gandhi Institute of Child Health (IGICH)
	17.National Center for Disease Control (NCDC)

Name of the State	Sentinel Hospitals/Institutes
Tamil Nadu	1. Kanniyakumari Medical College
	2. Tirunelveli Medical College
	3. Thoothukudi Medical College
	4. Thanjavur Medical College
	5. Mohan Kumaramangalam Medical College, Salem
	6. Coimbatore Medical College
	7. K.A.P.Viswanathan Medical College, Trichy
	8. Theni Medical College
	9. Chengalpattu Medical College
	10. Madurai Medical College
	11.Vellore Medical College
	12. Madras Medical College
	13.Institute of Vector Control and Zoonoses, Hosur
Bihar	1.Patna Medical college & Hospital
Uttar Pradesh	1. Regional Lab. Swasthya Bhawan, Lucknow.
	2. District Hospital, Ghaziabad,
	3. L.L.R.M., Medical College, Meerut,
	4. M.L.B. Medical College, Jhansi,
	5. M.L.N.,Medical College, Allahabad.
	6. Institute of Medical Sciences, B.H.U., Varanasi.
	7. S.N., Medical College, Agra.
	8. G.S.B.M., Medical College, Kanpur.
	9. K.G.M.U., Lucknow.
	10. Authority Hospital, Noida
Orissa	1. S.C.B. Medical College, Cuttak
	2. VSS Medical College, Burla, Sambalpur
	3. MKCG, Medical College, Berhampur, Ganjam
A&N Islands	1.GB Pant Hospital, Port Blair
Lakshadweep	1.Indira Gandhi Hospital, Kavaratti
Manipur	1. Regional Institute of Medical Sciences, IMPHAL
Puducherry	1. JIPMER, Puduchery
	2. General Hospital, Puduchery
Jammu & Kashmir	1.Govt. Medical College, Jammu
Chattishgarh	1. Pt. J.N.M Medical College, Raipur,
	2. Sardar Vallabh Bhai Patel District Hospital, Bilaspur
Jharkhand	1.Rajendra Institute of Medical Science (RIMS), Ranchi
	2. MGM Medical College, Jamsedpur
Assam	1. Gauhati Medical College, Guwahati
	2. Assam Medical College, Dibrugarh
Uttarakhand	1. Doon Hospital, Dehradun
	2. Susheela Tiwari Medical College, Haldwani, Nainital
Total	182

6.3. NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

The National Leprosy Control Programme was launched by the Govt. of India in 1955. Multi Drug Therapy came into wide use from 1982 and the National Leprosy Eradication Programme was introduced in 1983. Since then, remarkable progress has been achieved in reducing the disease burden. India achieved the goal of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population, at the National level in the month of December 2005 as set by the National Health Policy, 2002. The National Leprosy Eradication Programme is 100% centrally sponsored scheme. MDT is supplied free of cost by WHO.

Following are the programme components –

(i) Decentralized integrated Leprosy services through General Health Care System.

(ii) Training in Leprosy to all General Health Services functionaries.

(iii) Intensified Information, Education & Communication (IEC).

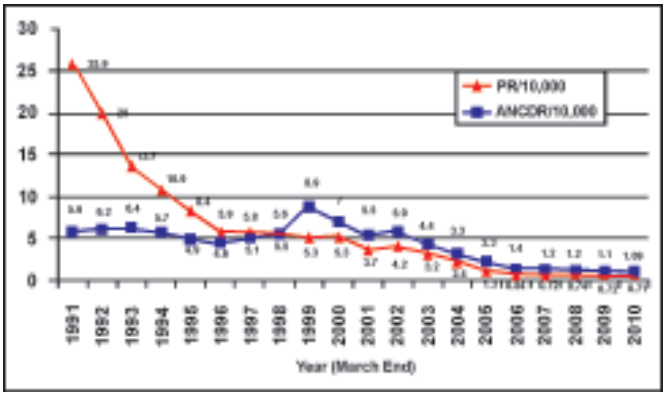
(iv) Renewed emphasis on Prevention of Disability and Medical Rehabilitation and

(v) Monitoring and supervision.

6.3.1. Epidemiological Situation

- 32 States/UTs have achieved leprosy elimination status. Only 3 States/UT viz. Bihar, Chhattisgarh and Dadra & Nagar Haveli are yet to achieve elimination. Further, out of 633 districts, 510 (80.57%) have also achieved elimination level.
- At the end of March 2010, there were 87,190 leprosy cases on record (under treatment).
- In 2009-10, total 1,33,717 new leprosy cases were detected and put under treatment as compared to 1,34184 leprosy cases detected during corresponding period of previous year giving Annual New Case Detection Rate (ANCDR) of 10.93 per 1,00,000 population.
- Among the new cases detected in 2009-10, the proportions were- MB cases (54.43%), female (35.42%), children (9.97%) and grade II disability (3.08%).
- Out of 1,47,642 leprosy cases discharged during the year, 1,33,822 cases (90.6%) were released as cured after completing treatment.
- 2856 reconstructive surgeries were conducted in 2009-10 for correction of disability in leprosy affected persons.

The declining trend of Prevalence and Annual New Case Detection Rate per 10,000 population since 1991-1992 is shown in the diagram below:



6.3.1. Activities under NLEP:

6.3.2.a.Diagnosis and treatment of leprosy- Services for diagnosis and treatment (Multi Drug Therapy) are provided by all primary health centres and govt. dispensaries throughout the country free of cost. Difficult to diagnose and complicated cases and cases requiring reconstructive surgery are referred to district hospital for further management. ASHAs under NRHM are being involved to bring out leprosy cases from villages for diagnosis at PHC and follow up cases for treatment completion. ASHAs are being paid incentive for this activity from the programme budget.

6.3.2.b. Training: Training of general health staff like medical officer, health workers, health supervisors, laboratory technicians and ASHAs are conducted every year to develop adequate skill in diagnosis and management of leprosy cases. Training of State & District Leprosy Officers organized at schieffline Institute of Health Research & Leprosy Centre Vellore, Tamil Nadu and RLTRI Raipur.

6.3.2.c.Urban Leprosy Control: To address the complex problems in urban areas, the Urban Leprosy Control activities are being implemented in 422 urban areas having population size of more than 1 lakh. These activities include MDT delivery services & follow up of

patient for treatment completion, providing supportive medicines & dressing material and monitoring & supervision.

6.3.3. Involvement of NGOs

Non Governmental Organizations (NGOs) have been involved in the programme for many decades and have provided valuable contribution in reducing the burden of leprosy. NGOs serve in remote, inaccessible, uncovered, urban slums, industrial / labour population and other marginalized population groups. IEC, Prevention of impairments and disabilities, Case Detection & referral and follow-up for treatment completion are some important activities undertaken by NGOs. Under SET scheme, Rs. 2.10 crores have been allocated to NGOs in 2010-11 and Grant-in-Aid to NGOs is routed through State Leprosy Societies.

6.3.4. ILEP Agencies

The International Federation of Anti-leprosy Associations (ILEP) is actively involved as partner in NLEP. In India, ILEP is constituted by 10 Agencies viz. The Leprosy Mission, Damien Foundation of India Trust, Netherland Leprosy Relief, German Leprosy Relief Association, Lepra India, ALES, AIFO, Fontilles – India, AERF - India and American Leprosy Mission.

ILEP is providing support in the form of planning, monitoring & supervision of the programme, capacity building of GHC staff, IEC, providing re-constructive surgery services and socio economic rehabilitation of persons affected with leprosy. 36 NGOs conducting re-constructive surgeries for disability correction in leprosy affected persons are also supported by ILEP.

6.3.5 WHO Support

WHO support the programme in the form of providing financial assistance for conducting annual review meetings at national level and technical support through State/Zonal NLEP Coordinators in the high endemic states. WHO continues to provide requirement of anti-leprosy MDT drugs to the country free of cost with assistance from NOVARTIS.

6.3.6 Information, Education & Communication (IEC)

Intensive IEC activities are conducted for awareness generation and particularly reduction of stigma and discrimination against leprosy affected persons. These activities are carried through mass media, outdoor media, rural media and advocacy meetings. More focus is given on inter personnel communication. Intensive IEC Campaign with a theme 'Towards Leprosy Free India' is being carried out towards further reduction of leprosy burden in the community, early reporting of cases & their treatment completion, provision of quality leprosy services and reduction of stigma & discrimination against leprosy affected persons. Mass media campaign during the period October, 2010 and January-February 2011, have been planned through the Prasar Bharati to spread awareness about leprosy in the General Public.

6.3.7 Disability Prevention and Medical Rehabilitation

For prevention of disability among persons with insensitive hands and feet, they are given dressing material, supportive medicines and micro-cellular rubber (MCR) footwear. The patients are also empowered with self care procedure for taking care of themselves.

More emphasis is being given on correction of disability in leprosy affected persons through reconstructive surgery (RCS). To strengthen RCS services, GOI has recognized 83 institutions for conducting RCS based on the recommendations of the state government. Out of these, 42 are Govt. institutions and 41 are NGO institutions.

6.3.8 Supervision and Monitoring

Programme is being monitored at different level through analysis of monthly progress reports, through field visits by the supervisory officers and programme review meetings held at central, state and district level. For better epidemiological analysis of the disease situation, emphasis is given to assessment of New Case Detection and Treatment Completion Rate and proportion of grade II disability among new cases. Independent Programme evaluation is also been conducted through an independent agency.

6.3.9 Initiatives:

6.3.9.a. An amount of Rs. 5000/- is provided as incentive to leprosy affected persons from BPL family for undergoing per major reconstructive surgery in identified Govt./NGO institutions to compensate loss of wages during their stay in hospital. Support is also provided to Government institutions in the form of Rs. 5000/- per RCS

conducted, for procurement of supply & material and other ancillary expenditure required for the surgery.

6.3.9.b.Involvement of ASHAñ A scheme to involve ASHAs was drawn up to bring out leprosy cases from their villages for diagnosis at PHC and follow up cases for treatment completion. To facilitate the involvement of ASHA, they are being paid an incentive as below**:**

(i) On confirmed diagnosis of case brought by them – Rs. 100/-

(ii) On completion of full course of treatment of the case within specified time- PB leprosy case – Rs. 200/- and MB Leprosy case – Rs. 400/-

4,22,638 ASHAs have been trained in leprosy and involved in leprosy work 4572 ASHAs received incentive for the above said activity during 2009-10.

6.3.9.c. Discriminatory laws relating to leprosy– There are certain provisions under laws / acts which are discriminatory in nature against leprosy affected persons. The Ministry of Health & Family Welfare has taken up the matter with concerned Ministries/Departments/State Governments for their consideration and action on various such discriminatory acts/laws. These Acts and Laws are being modified or repealed, which will help the persons affected by leprosy live a dignified life.

6.3.10 National Sample Survey

The 131st report of the Committee on Petitions of Rajya Sabha, 2008, recommended that "the final survey, involving Panchayati Raj Institutions (PRI) may be undertaken, so that the Government can have realistic figures of Leprosy Affected Persons (LAPs) to devise a national policy. The Ministry of Health & Family Welfare informed the Committee that a multi – centric study to assess the burden of active leprosy cases, leprosy persons with grade - I & II disability and the magnitude of stigma & discrimination prevalent in the society, will be carried out. The National JALAMA institute Agra (an ICMR instt.) has been entrusted with the above task.

The house to house survey was started in States/UTs as below, which was preceded by training of the survey team member and IEC campaign in the concerned Block and Urban areas.

(i) Six States/UTs viz. Arunachal Pradesh, Gujarat, Rajasthan, Manipur, Sikkim and D&N Haveli started in **May 2010.** Arunachal Pradesh, Sikkim & D&N Haveli reported completion of the Survey.

(ii) Twenty States/UTs viz. Andhra Pradesh, Assam, Chhattisgarh, Goa, Himachal Pradesh, Jharkhand, J&K, Karnataka, Madhya Pradesh, Kerala, Meghalaya, Mizoram, Nagaland, Orissa, Punjab, Tamil Nadu, Tripura, Uttarakhand, Chandigarh and Daman & Diu started in **June 2010.** Goa, Chandigarh, Uttarakhand and Daman & Diu reported completion of the Survey.

(iii) Six States/UTs viz. Uttar Pradesh, West Bengal, Maharashtra, Haryana, A&N Islands and Puducherry started in **July 2010**. Maharashtra, A&N Islands and Puducherry reported completion of the Survey.

(iv) Delhi and Bihar have started survey in August 2010.

The final report of National Sample Survey is expected by July 2011.

6.3.11 Budget: Budget allocation under NLEP for for 2009-10 was 44.50 crores and expenditure of 35.12 crores was incurred during the year. Budget allocation under NLEP for 2010-11 is 45.32 crores. 26.85 crores expenditure has been incurred till date.

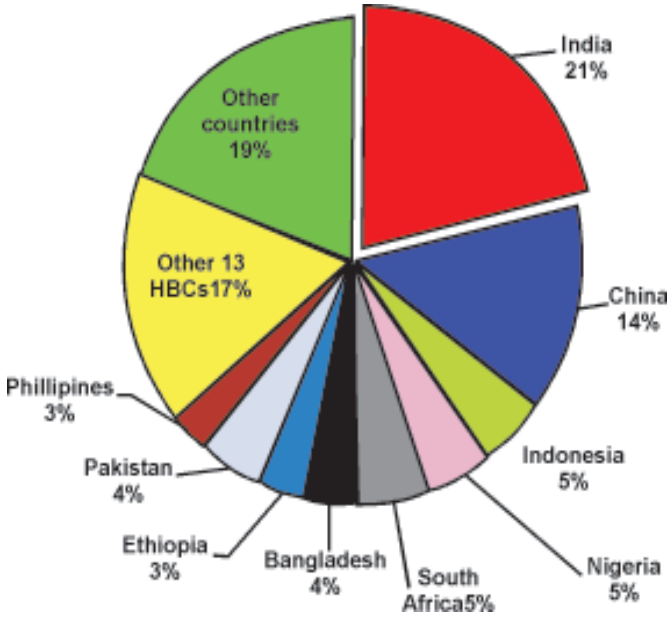
6.4 REVISED NATIONAL TB CONTROL PROGRAMME (RNTCP)

Tuberculosis is a major public health problem in India. The burden of TB in India (Prevalence) as in the year 2000 was 8.5 million total cases of which 3.8 million were bacillary pulmonary cases, 3.9 million abacillary cases and 0.8 million extra-pulmonary cases.

India accounts for nearly one-fifth of the global incidence. In 2009, out of the global annual incidence of 9.4 million TB cases, 2 million were estimated to have occurred in India. In the year 2009, India reported a total case notification of 1.3 million (all forms of TB), of which 0.62 million were reported as sputum positive cases which are infectious.

An infectious case if not treated on an average infects 10-15 persons in a year. Annual risk of becoming infected with TB is 1.5% and once infected there is 10% life-time

risk of developing TB disease. About one person dies from TB in India every two minutes; ~ 760 people every day and almost 2.8 lakh every year.

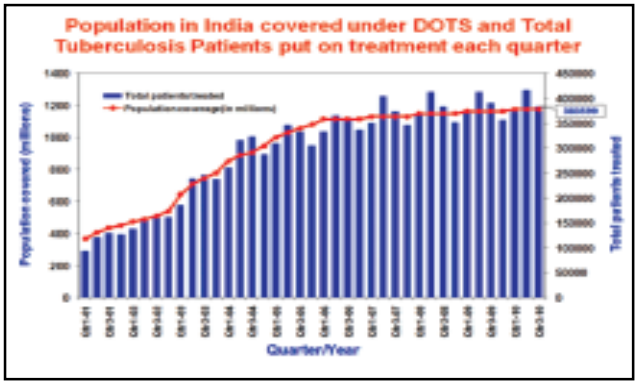


HBC: High burden countries

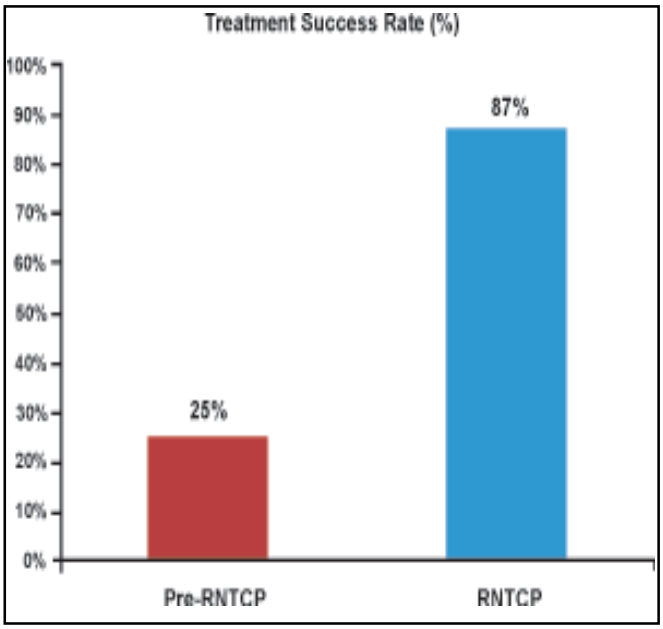
Source: WHO Geneva; WHO Report 2010: Global Tuberculosis Control; Surveillance, Planning and Financing.

Revised National TB Control Programme, an application in India of the WHO-recommended Directly Observed Treatment, Short Course (DOTS) strategy to control TB with the objective of curing at least 85% of new sputum positive TB patients and detecting at least 70% of such patients, was launched in the country in March 1997 and was implemented in a phased manner. By March 2006, entire population (1114 million) of the country in all 632 districts had been covered under the Programme.

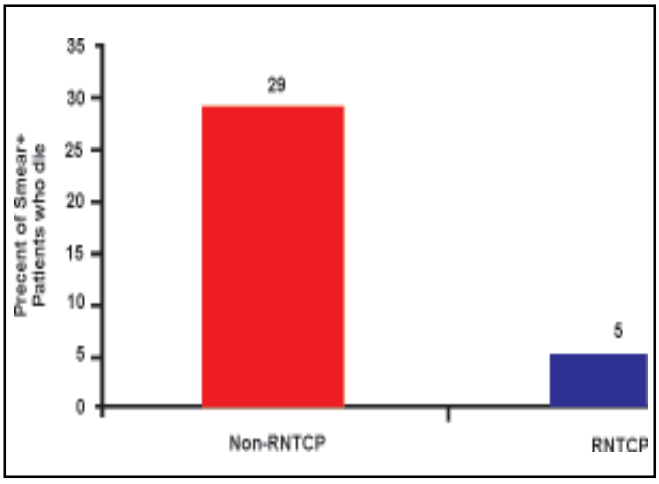
6.4.1. Achievements of RNTCP

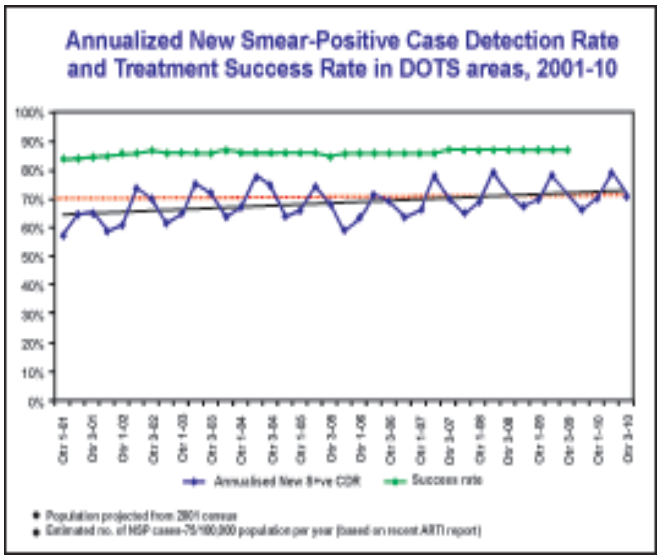


- Since its inception, the programme has initiated nearly 1.24 million patients on treatment, thus saving more than 2.2 million additional lives. In 2009 over 1.53 million TB patients have been initiated on treatment. In 2010, 1.17 million patients have been registered for treatment till 30th September.
- India has contributed to approximately 24% of the total global new cases detection during the year 2009 as per the WHO Global Report 2010.
- Treatment success rates have tripled from 25% in the pre-RNTCP era to 87% presently.



- TB death rates have been cut 7-fold from 29% in the pre-RNTCP era to 4% presently.





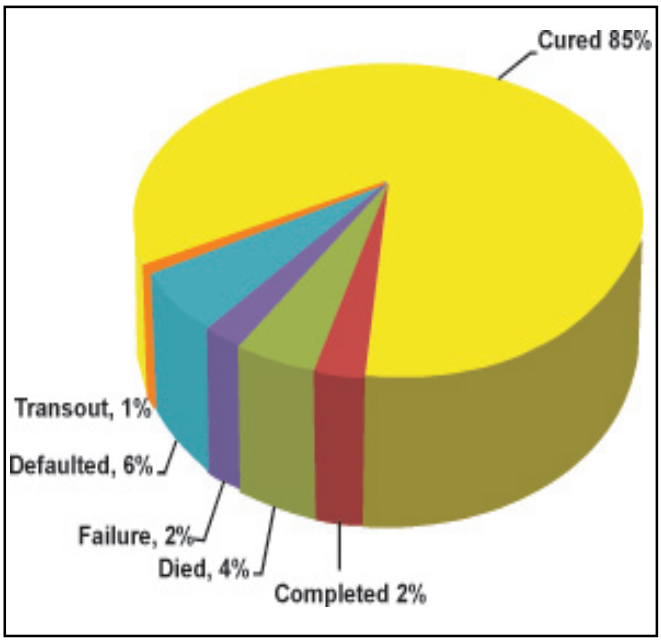
- The programme has consistently maintained the treatment success rate >85% and new sputum positive (NSP) case detection rate more than the global target of 70%.

- All states are currently implementing the 'Supervision and Monitoring strategy' – detailing guidelines, tools and indicators for monitoring the performance from the PHI level to the national level. The programme is focusing on the reduction in the default rates amongst all new and re-treatment cases and is undertaking steps for the same.

- Quality assured Sputum Microcopy diagnostic facilities are available through more than 12,700 laboratories across the country. To ensure quality, external quality assurance of sputum microscopy is being routinely conducted throughout the country. This includes onsite evaluation, panel testing and blinded crosschecking.

- To improve access to tribal and other marginalized groups the programme has developed a Tribal action plan which is being implemented with the provision of additional TB Units and DMCs in tribal/difficult areas, additional staff, compensation for transportation of patient & attendant in tribal areas and higher rate of salary to contractual staff etc.

  The latest treatment outcome under RNTCP for the patients' registered in 2009 (Jan – Sept) is represented as a pie chart



- Involvement of other sectors: Over 3000 NGOs, 30,000 Private practitioners, and 200 corporate houses have been involved in the provision of RNTCP services. Presently, 282 medical colleges (including private colleges) have been involved in RNTCP and are estimated to contribute nearly 10-15% of case detection in the districts that have medical colleges. Health facilities in government sectors outside Health Ministry have been involved viz. ESI, Railways, Ports and the Ministries of Mines, Steel, Coal, etc. Collaboration for increased participation of all sectors in RNTCP is being strengthened through constant interaction with all stake holders, including professional bodies like the Indian Medical Association, and Faith Based Organisations such as Catholic Bishops Conference of India.

- **Drug Resistance Surveillance:**

  To estimate the prevalence of drug resistance amongst new cases and re-treatment cases, state wide community based surveys have been carried out in the states of Gujarat and Maharashtra. These surveys estimate the prevalence of Multi-drug resistant TB (MDR-TB) to be ~3% in new cases and 12-17% in retreatment cases. These surveys also indicate that the prevalence of MDR-TB is not increasing in the country. Two more surveys are underway in the states of AP and western UP and there is a plan to undertake a survey in Orissa in near future.

- **DOTS Plus for management of Multidrug Resistant TB (MDR-TB):**
    - The programme is in the process of establishing a network of 43 accredited Culture and Drug Susceptibility testing laboratories (DST) across the country in a phased manner for diagnosis and follows up of MDR TB patients.
    - Currently, 14 Culture and DST Laboratories in government sector are accredited under RNTCP including-

- 4 National Reference Laboratories (NRLs) that includes TRC Chennai, LRS Delhi, NTI Bangalore and JALMA Agra,
- 10 State level Intermediate Reference Laboratories (IRLs) at Gujarat, Maharashtra, Andhra Pradesh, Kerala, Delhi, West Bengal, Tamil Nadu , Rajasthan, Orissa and Jharkhand have been accredited; and
- Another 11 IRLs are under the accreditation process. The remaining IRLs will be accredited in 2011.
    - To supplement and support the IRL network the programme is also involving Mycobacteriology laboratories of Government Medical Colleges as well as laboratories in the NGO and Private Sector. Till date, five such labs (CMC-Vellore; BPRC-Hyderabad, Hinduja Hospital- Mumbai, SMS-Jaipur and RMRCT-Jabalpur) have been accredited and another 9 are under the accreditation process.
    - DOTS Plus services for management of MDR TB have been rolled out in the 10 states of Gujarat, Maharashtra, Andhra Pradesh, Haryana, Delhi, Kerala, West Bengal, Tamil Nadu, Rajasthan and Orissa. Services are available in 136 districts covering a population of 281 million. Till 30th September 2010, ~15700 MDR suspects were examined and a total of 2975 patients were initiated on treatment in these states.
    - The State of Jharkhand, Uttar Pradesh, Madhya Pradesh, Uttarakhand, Karnataka and Himachal Pradesh are in advanced stage of preparation and will initiate identification of MDR suspects shortly. DOTS Plus services in the remaining states will be initiated in 2010-11.

- Advocacy, Communication and Social Mobilization (ACSM):
    - RNTCP has ACSM Strategicic framework that clearly identifies:-
- Objectives (Communication needs)
- Target Groups (Communication players) i.e.(i) Patients and Communities; (ii) Health care providers, public and private; and (iii) Influencers and opinion makers
- Media options to reach target groups (Communication tools)
    - ACSM strategy has been modified for including and addressing newer thrust areas as MDR- TB, TB HIV co-infection, and Infection control. These areas has been identified as important areas to be addressed by the media agency at the national level .
    - ACSM is integral part of planning at national, state and district levels, and annual action plans.
- Format for development of ACSM Annual Action Plan has been modified to included monitoring indicators (outcome and output).
- Quarterly reporting of ACSM activities by the districts and states
    - Six national level ACSM capacity building trainings workshops organized for State TB Officers, State IEC Officers and Communication Facilitators are currently going.
    - Partnership developed with the other donor and bilateral agencies to strengthen Center's capacity for ACSM
    - Formative research for development of communication material on MDR TB, TB HIV and Infection control completed.
- Impact of the programme:
    - TB mortality in the country has reduced from over 42/lakh population in 1990 to 23/lakh population in 2009 as per the WHO global report 2010.
    - The prevalence of TB in the country has reduced from 586/lakh population in 1990 to 249/lakh population by the year 2009 as per the WHO global TB report, 2010

- Programme is currently undertaking repeat ARTI survey (2007-09), disease prevalence surveys (2007-09) to additionally monitor the progress towards MDGs.

6.4.2. RNTCP Phase II

The RNTCP Phase II of the World Bank project has been approved by the Government for the period Oct 2006 to Sep 2011 for a total outlay of Rs 1,156 crore (USD 256.9 million) which includes credit from World Bank of Rs 765 crore (USD 170 million) and commodity assistance of anti-TB drugs from DFID through WHO for Rs 287 crores (USD 63.7 million) with balance of RS 191 crore (USD 42.5 million) will be given by GoI. In addition, 215.81 million US dollars is available for six years (2009 – 2015) through GFATM RCC mechanism (Global Fund for AIDS, Tuberculosis, Malaria – Rolling Continuation Channel) for 27 districts of Uttar Pradesh, and states of Bihar, Andhra Pradesh, Orrisa, Chattisgarh, Jharkhand, Uttarakhand and Haryana. GFATM RCC will also cater through CBCI (Catholic Bishop Conference of India) in 19 states and in 11 states through IMA (Indian Medical Association).

The second phase of the RNTCP is consolidating, maintaining and further improving the achievements of the first phase. Phase II of the RNTCP is a step towards achieving the TB-related Millennium Development Goal (MDG) targets. DOTS remain the core strategy. In addition to the ongoing activities, the following new activities have been envisaged in the second phase.

- the scaling up of the State-level intermediate referral laboratories (IRL) capacity for nation-wide implementation of external quality assessment (EQA) of sputum smear microscopy services and provision of culture and drug sensitivity testing.
- Implementation of DOTS-Plus for multi-drug resistant TB cases will occur in a phased manner.

6.4.3. Major Initiatives

6.4.3.a.Public Private Mix in RNTCP: The RNTCP employs the Public Private Mix (PPM) which is the strategy to diagnose and treat TB patients reporting to all sectors of health care under RNTCP through a mix of different types of health care providers.

6.4.3.b. NGO/PPs: Currently, for enhancing the involvement of NGOs and PPS under RNTCP, the guidelines have been revised with enhanced financial outlays. The programme has entered into a memorandum of understanding with large NGOs/Professional Associations like RK Mission, World Vision, Christian Medical Association of India, Catholic Health Association of India, Indian Medical Association etc. In addition, many local NGOs support programme activities to improve access of RNTCP in difficult and uncovered areas.

6.4.3.c.Medical colleges/TB Hospitals and others: Medical colleges are being provided with manpower and logistic support to facilitate their participation in the programme. The involvement of medical colleges is monitored by the Task Force mechanism at the State/ Zonal and National levels.

6.4.3.d.Other sectors: - All the 16 centrally owned ESI hospitals, Zonal Railway Hospitals, Coal, Steel and Mines health facilities, Port trust hospitals, CGHS hospitals and 200 corporate hospitals are involved in RNTCP services. Four regional workshops were conducted by Confederation of Indian Industry (CII) to sensitise and promote about workplace interventions in RNTCP at Chandigarh, Mysore, Ranchi and Pune .

6.4.3.e.Urban TB for slum dwellers†:- Recognizing the problem and impact of TB on urban slum population RNTCP intends to provide greater levels of access to its services to the urban slum population. In addition, a special PPM scheme for Urban Slum dwellers has been introduced under the recently revised PPM schemes.

6.4.4 Other initiatives-

The IMA has formed a National Working Group for RNTCP and has selected National and State coordinators. National, State and Local workshops are being organized by the IMA to sensitize the private practitioners. The PPM project assisted by GFATM under RCC is being implemented in 16 States - Andhra Pradesh, Chandigarh, Haryana, Maharashtra, Punjab, Uttar Pradesh, Bihar, Chhattisgarh, Gujarat, Jharkhand, Kerala, Orissa, Rajasthan, Tamil Nadu, Uttaranchal, and West Bengal .

There has also been a professional coalition against TB by IMA with IAP(Indian Academy of Paediatrics),NCCP (National College of Chest Physicians),ICS (Indian Chest Society),FPAI (Federation of Family Physicians Association Of India) as its members.

The RNTCP has adopted the recently published "International Standards for TB Care" (ISTC) document to improve the standards of TB management across all sectors of health care in India, and to recruit and involve additional health care providers in RNTCP activities. As the RNTCP conforms to all standards laid down in the ISTC, the central government has urged all providers of health care to adopt RNTCP to ensure adherence to the internationally recognized standard of care for TB.

The Revised National TB Control Programme has signed a MOU with the Catholic Bishops Conference of India, for the involvement of Catholic Health Institutions under RNTCP in 19 states - Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh ,West Bengal , Kerala, Tamil Nadu, Gujarat, Maharashtra, Goa, Meghalaya, Manipur and Nagaland .The Catholic Healthcare network is the largest in the NGO sector with more than 5,500 health care facilities.

Global Fund has also approved the Round 9 Grant for TB to the three Principal Recipients, namely Central TB Division , the Union and World Vision India (WVI) for a period of 5 years (starting 1st April 2010) with the following objectives:

1. Establish and enhance capacity for quality assured rapid diagnosis of Drug Resistant-TB in 43 Culture and DST laboratories in India by 2015;
2. Scale-up care and management of DR-TB in 35 States/Union Territories of India resulting in the initiation of treatment of 55,350 additional cases of Drug Resistant TB (DR-TB) by 2015;
3. Improve the reach, visibility and effectiveness of RNTCP through civil society support in 374 districts across 23 states by 2015; and
4. Engage communities and community-based care providers in 374 districts across 23 states by 2015 to improve TB care and control, especially for marginalized and vulnerable populations including TB-HIV patients.

6.4.5 TB/HIV coordination: Globally, the HIV epidemic is worsening the TB situation, by increasing the number of tuberculosis cases and accelerating the spread of the disease. HIV increases a person's susceptibility to TB infection and Tuberculosis increases morbidity and mortality in HIV infected persons. HIV is the most potent risk factor for progression of TB infection to disease. Since 2001, Government has been implementing a joint action plan in co-ordination with National AIDS Control Programme (NACP), to counter the growing incidence of the HIV-TB co-infection, initially in the six high HIV prevalence States of Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur and Nagaland. Services for HIV infected TB patients are provided through linkages between the Integrated Counseling and Testing Centre (ICTC) supported by the HIV/AIDS Programme and Designated Microscopy Centres (DMCs) supported by RNTCP, joint IEC activities and infection control measures.

In 2007, the national action plan for TB/HIV was revised. RNTCP & NACP have formulated a National framework for joint TB/HIV Collaborative activities which replaces the action plan. The document elaborates the various activities that need to be undertaken at the National, State & district level and provides the guidelines for the same. Under the National framework there is enhanced focus on the provision of HIV care including ART, for all known HIV infected TB patients in order to reduce mortality in this group of TB patients. With the formulation of National framework, the TB/HIV collaborative activities are being extended to the entire country. The framework looks to establishing mechanisms for coordination between the two programmes at all levels. Technical working groups with the key staff of both the programmes as members have been established at the National and State level which are meeting on a periodic basis. The framework was revised in 2008 and an "Intensified HIV-TB Package" of services which give opportunity to all TB patients to know their HIV status and linking of all HIV+TB patients to HIV care and support for ART and Cotrimoxozole prophylaxis therapy (CPT), was rolled out to offer these additional services in states with the higher burden of HIV-TB.

The 2009 revision of the National Framework establishes uniform activities at ART centers and ICTCs nationwide for intensified TB case finding and reporting, and set the ground for better monitoring and evaluation jointly by the two programmes. The HIV-TB performance indicators and performance targets act as a guide to channelize the HIV-TB interventions in the right direction at all the levels. In addition to this, the revised reporting formats and mechanisms have been incorporated in the National Framework to develop a common understanding on the monitoring system.

In 2010, "Intensified TB-HIV package" of services has been rolled out in 11 more states totalling to 29 States &UTs in which this package of services has already been rolled out with the vision to scale up Intensified TB-HIV package in the entire country by 2012

ART- DOTS linkages are being established at all the ART centres of the AIDS control programme to ensure optimal access to TB diagnostic and treatment services to the HIV positives at advanced stage of disease. A new TB/ HIV module for ART centre staff has been created and ART staff have been trained in this module. In addition, joint training modules on TB/HIV have been formulated for various categories of staff of RNTCP and NACP and the training activities are being scaled up. TOTs have been conducted for State and District level trainers and the training of field staff is on-going and is at various stages in the different States. IEC materials regarding TB are being made available at NACP facilities. Selective IEC material on HIV is displayed at RNTCP facilities.

6.4.6 MDR-TB: Another challenge to TB control in India is the MDR-TB. The data available to date shows that levels of MDR-TB remain relatively low, at around 3% amongst new patients and 12-17% in re-treatment cases. However, these relatively low percentage figures translate into large absolute number of MDR-TB cases, which increase the magnitude and severity of TB epidemic and pose a major threat to TB control. Guidelines for management of MDR TB cases (DOTS Plus) have been formulated and published. The Programme Division has an ambitious plan to scale up services for management of MDR-TB patients in the country and is in the process of securing funding for the same. DOTS Plus services for management of MDR TB have been rolled out in the ten states presently i.e. in the states of Gujarat, Maharashtra, Andhra Pradesh, Haryana, Delhi, Kerala, West Bengal, Tamil Nadu, Rajasthan and Orissa. Till date a total of over 2975 MDR-TB patients are on treatment in these states.

Information, Education and communication (IEC) or Advocacy, Communication and Social Mobilization (ACSM) continue to be an important component of the programme. In line with the stop TB strategy, replacement of the terminology with 'Advocacy, Communication, and Social Mobilization' (ACSM) is being promoted, as the term ACSM has advantage over IEC as it clearly defines the components and initiatives.

6.4.7 The IEC strategy in RNTCP envisages that:

1. IEC is a long term commitment where in IEC is a process and not product oriented. Implementing IEC activities is based on analysis of the needs, and developing strategy to plan need based, locally appropriate activities. Communication strategies for TB control takes care of opportunities for interactive communication, such as engaging cured patients to convince and support others, group meetings to discuss all aspects of TB control, including the social aspects.

2. It focuses on decentralized planning, choice of communication channels and monitoring to ensure contextual relevance and wide reach of information. The states and districts have to take active part in this process while Centre continues to provide leadership, develop core messages, mass media and advocacy events.

3. IEC takes care to address social issues related to TB such as stigma and gender, and special communication initiatives to address the needs of the special groups and 'hard to reach populations'

   RNTCP emphasizes on decentralized planning and implementation of health communication initiatives. States and districts develop need based annual action plans and implement activities using local popular media. To support the districts in planning and implementing, Communication Facilitators have been engaged who identify opportunities and network through which communication activities are undertaken to spread information about TB and availability of free diagnosis and DOTS treatment. Other important role of Communication Facilitators is to integrate communication about TB within the context of other health programmes and NRHM.

RNTCP encourages states to: i) systematic planning and implementation of communication activities based on the needs, knowledge of target groups, using the local appropriate media; ii) to undertake IEC activity for maintaining desired level of awareness, motivation, support and services in patient friendly environment; and iii) monitor IEC activities regularly like other components of the programme.

RNTCP is also working to i*ncrease in state and district level capacity to plan and execute IEC activities. For this purpose, e*ach state has undertaken an IEC audit to take stock of its current capacity. This was done with a standardized format and procedure.

The objective is to assess the existing capacity in states and districts for planning and implementing IEC activities. In many case IEC planning and implementation is individual driven depending upon the leadership role taken by the programme manager or the designated person. There is need to institutionalize these processes and IEC capacity audit is a step in this direction to document that exists at this point of time.

6.4.8 Web-based Resource Centre for IEC: A web-based resource Centre for IEC is being used by the States and Districts for reproduction of material. The Resource Centre is available on the Programme's web site:www.tbcindia.org

6.4.9 Quality Control of diagnosis and drugs: A protocol for External Quality Assurance (EQA) of sputum microscopy of slides by different level of staff at the Microscopy Centres (MCs), Districts, Intermediate Reference Laboratories and National Reference Laboratories have been operationalised. Similarly, an independent agency had been contracted to test quality of RNTCP drugs at various points.

6.4.10 Research activities: The RNTCP encourages Operational Research (OR) and has provision for funding such studies. Funds have also been made available to States for inviting proposals and funding research activities in their respective States. The OR priority research areas as well as formats for the proposals are available on the RNTCP websitewww.tbcindia.org. The aim of the research is to improve DOT services to make them more patient- friendly, ensure that treatment is directly observed and increase detection of smear positive cases. A number of studies have been done in this field. Some of these have been and are being initiated/sponsored and funded by the Central TB Division, some have been undertaken by the States and National/Central institutes, and others have been carried out by the teaching and training institutes.

6.4.11 Physical Performance:

Comparative statement of achievements under RNTCP during the last 8 years.

Indicators	2002	2003	2004	2005	2006	2007	2008	2009	2010 (Jan-Sep)
Population coverage, (millions)	530	775	947	1080	1114 [1]	1131	1148	1164[2]	1176
Total number of cases put on DOTS	622873	906472	1187353	1293083	1397498	1475587	1517333	1533309	1173992
New smear positive patients put on treatment	245051	358496	465331	506193	553660	592635	616016	624617	485018
Cure rate (expected 85%	84%	86%	86%	84%	84%	84%	84%	85%	85%
No. of NGOs involved (approx)	410	650	1011	1600	2263	2400	2524	2291	3000

[1]Entire country covered under RNTCP in March 2006

[2] Projected populations in 2009

6.4.12 Financial Performance

Year	Outlay as budgeted (Rs. in Crores)	Actual expenditure (Rs. in Crores)
2006-07	202.17	220.97
2007-08	267.00	262.12
2008-09	275.00	279.90
2009-10	312.25	233.43 (till 30.09.2010)

6.5 NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020. Rapid Survey on Avoidable Blindness conducted under NPCB during 2006-07 showed reduction in the prevalence of blindness from 1.1% (2001-02) to 1% (2006-07).

Main causes of blindness are as follows: - Cataract (62.6%) Refractive Error (19.70%) Corneal Blindness (0.90%), Glaucoma (5.80%), Surgical Complication (1.20%) Posterior Capsular Opacification (0.90%) Posterior Segment Disorder (4.70%), Others (4.19%) Estimated National Prevalence of Childhood Blindness / Low Vision is 0.80 per thousand.

The Pattern of Assistance for National Programme for Control of Blindness during the 11th Five Year Plan has been approved by the Cabinet Committee on Economic Affairs. The Pattern of Assistance for the 11th Five Year Plan is effective from 16th October, 2008.

The allocation for the 11th Plan (2007-12) is Rs.1250.00 crore. The allocation for the current financial year (2010-11) is Rs.260.00 crore.

6.5.1. Main objectives of the programme:

a) to reduce the backlog of blindness through identification and treatment of blind;

b) to develop Comprehensive Eye Care facilities in every district;

c) to develop human resources for providing Eye Care Services;

d) to improve quality of service delivery;

e) to secure participation of Voluntary Organizations/ Private Practitioners in eye care;

f) to enhance community awareness on eye care.

6.5.2. Salient features/strategies adopted to achieve the objectives:

- Provision of assistance to make eye care programme comprehensive by covering diseases other than cataract like diabetic retinopathy, glaucoma, corneal transplantation, vitreo-retinal surgery, treatment of childhood blindness etc.
- Reduction in the backlog of blind persons by active screening of population above 50 years, organizing screening eye camps and transporting operable cases to fixed eye care facilities
- Coverage of underserved area for eye care services through public-private partnership.
- Capacity building of health personnel for improving their skill, enhancing their knowledge in delivery of high quality eye services
- Community awareness/information education communication (IEC) activities for creating awareness on eye- care. Major events include eye donation awareness fortnight (25th August to 8th September) and World Sight Day (2nd Thursday of October) each year in addition to ongoing activities.
- Screening of children for identification and treatment of refractive errors and provision of free glasses to those affected and belonging to poor socio-economic strata.
- Development of regional institute of ophthalmology and medical colleges in a phase manner to be centre of excellence in retina units/low vision units/ paediatric eye units.

6.5.3. New Initiatives introduced during 11th Plan

- Construction of dedicated Eye Wards & Eye OTs in District Hospitals in North-Eastern States, Bihar, Jharkhand, J&K, Himachal Pradesh, Uttarakhand and few other States where dedicated Operation Theaters are not available as per demand.

- Appointment of Ophthalmic manpower (Ophthalmic Surgeons, Ophthalmic Assistants and Eye Donation Counsellors) in States on contractual basis.
- Grant-in-aid to NGOs for management of other Eye diseases other than Cataract like Diabetic Retinopathy, Glaucoma Management, Laser Techniques, Corneal Transplantation, Vitreoretinal Surgery, Treatment of childhood blindness etc. The assistance would be upto Rs. 750 per case for Cataract/IOL Implantation Surgery and Rs.1000 per case of other major Eye diseases.
- Development of Mobile Ophthalmic Units in NE States, Hilly States & difficult terrains for diagnosis and medical management of eye diseases.
- Involvement of Private Practitioners in Sub District, Blocks and Village level.
- Maintenance of Ophthalmic Equipments supplied to Regional Institutes of Ophthalmology, Medical Colleges, District/Sub-District Hospitals, PHC/ Vision Centres.

6.4.7 Major events during 2010-11:

- Annual review meeting of NPCB with State Programme Officers was held on 8-9 April, 2010 as a part of review of the programme at the central level.
- Meetings of Technical Committee to formulate revised duties of Ophthalmic Assistants under NPCB were held on 1.9.2010 and 8.11.2010.

Budget Allocation and expenditure:

(Rs. in crore)

Year	Budget allocated (BE/FE)	Expenditure
2006-07	111.87	111.53
2007-08	171.87	164.95
2008-09	250.00	249.49
2009-10	250.00	252.89
20010-11 (as on 30.11.2010)	260.00	125.00

Cataract Operations:

Year	Target	Cataract operations performed	% surgery with IOL
2006-07	45,00,000	50,40,089	93
2007-08	50,00,000	54,04,406	94
2008-09	60,00,000	58,10,336	94
2009-10	60,00,000	59,06,016	95
2010-11(as on 30.11.2010)	60,00,000	23,11,000	95

School Eye Screening Programme:

Year	No. of free spectacles provided to school age group children with refractive errors	
	Target	Achievement
2006-07	70,000	4,56,634
2007-08	3,00,000	5,12,020
2008-09	3,00,000	10,21,082
2009-10	4,73,472	5,05,843
2010-11 (as on 30.11.2010)	3,00,000	85,000

Collection of donated Eyes:

Year	Collection of donated eyes	
	Target	Achievement
2006-07	45,000	30,007
2007-08	40,000	38,546
2008-09	50,000	41,780
2009-10	55,000	46,589
2010-11 (as on 30.11.2010)	60,000	14,481

Training of Eye Surgeons:

Year	Target	No. of eye surgeons trained
2006-07	250	250
2007-08	400	300
2008-09	400	450
2009-10	400	400
2010-11(as on 30.11.2010)	400	300

6.6 National Iodine Deficiency disorders Control Programme (NIDDCP)

6.6.1 Iodine an essential micronutrient required daily at 100-150 micrograms for normal human growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, stillbirth, deaf mutism, squint & various types of goiter.

The sample surveys conducted in 325 districts covering all the States/Union Territories have revealed that 263 districts are endemic as the prevalence of Iodine Deficiency Disorders is more than 10%. It is also estimated that in the country more than 71 million persons are suffering from goiter and other Iodine Deficiency Disorders.

The objectives of the programme is to (a) survey to assess the magnitude of the Iodine Deficiency Disorders, (b) supply of iodated salt in place of common salt, (c) resurvey to asses iodine deficiency disorders and impact of iodated salt after every 5 years, (d) health education and publicity (Information, Education & Communication, IEC), (e) laboratory monitoring of iodated salt and urinary iodine excretion.

6.6.2. Initiatives and Progress

6.6.2.a. Salt Commissioner has issued licenses to 824 salt manufacturers out of which 532 units have commenced production. These units have an annual production capacity of 120 lakh metric tonnes of Iodated salt.

6.6.2.b. Production of iodated salt of 45.90 lakh metric tonnes was recorded during the period from April 2010 to August 2010 against 55.00 lakh metric tonnes target for the year 2010-11.

6.6.2.c. The Ministry of Health & Family Welfare has issued notification (with effect from 17th May, 2006 under the Prevention of Food Adulteration (PFA) Act 1954) banning the sale of non-iodized salt for direct human consumption.

6.6.2.d. For effective implementation of National Iodine Deficiency Disorders Control Programme 31 States/UTs have established Iodine Deficiency Disorders Control Cells in their State Health Directorate.

6.6.2.e. In order to monitor the quality of iodated salt and urinary iodine excretion, 28 States/UTs have already set up Iodine Deficiency Disorders monitoring laboratories while the remaining States are in the process of establishing the same.

6.6.2.f. During the year 2010-11, to ensure the quality of iodated salt at consumption level, a total of 17426 salt samples were analyzed out of which 16239 (93%) salt samples were found confirming to the standard (as per the report - till October 2010).

6.6.2.g. Urine samples were collected and analyzed for estimation of urinary iodine excretion for bio-availability of iodine 6581, out of which 6173 samples were found confirming to the standard (94%).

6.6.2.h. Global IDD Prevention day was observed throughout the country on 21st October, 2010. On Global IDD Prevention Day messages on benefits of consumption of iodated salt in prevention and control of IDD were published in National & Regional newspapers. A two day national workshop on National Iodine Deficiency Disorders Control Programme was also organized at New Delhi

6.6.2.i. Visible goitre and cretinism has reduced significantly in the country.

6.6.2.j. Information, Education & Communication Activities

- In 16 States song and drama division through their field units have been carrying out special interactive programmes/ activities.
- The Directorate of Field Publicity through their 207 regional units in 29 States have carried out extensive IEC campaigns in the country regarding consumption of iodated salt for prevention and control of IDDs. The activities include film shows, group discussion and other special programmes.

- IDD spots containing messages on consequences of Iodine Deficiency Disorders and benefits of consuming iodated salt are being telecast through the National Network of Doordarshan daily. In Kalyani Programme the IDD messages are telecasted thrice a week in regional languages from 8 regional Kendras of Doordarshan.
- IDD spots containing messages on consequences of iodine deficiency disorders and benefits of consuming iodated salt are broadcast by the All India Radio through its 40 regional channels, 133 primary channels and 22 FM channels from April 2010.
- State Governments have also been provided grants for undertaking IEC activities at the local level in their regional languages that includes celebration of Global IDD Prevention Day in all districts.

Information, Education And Communication

7.1. INTRODUCTION

Public policy and communication strategies influence both individual and collective change. The interface between these two components provides the framework to position behavior change. In other words, the balance between communication and policy facilitates health seeking behavior. Over the years the thrust of the Department has been to place IEC as an intervention tool to generate demand for the range of services under National Rural Health Mission (NRHM) and various schemes under public health being undertaken by the Government of India.

The Communication Strategy aims to facilitate awareness, disseminate information regarding availability of and access to quality health care within our Public Health System. The key objective of the strategy is to encourage a health seeking behavior that is doable in the context in which people live. The strategy views recipients of health services as not merely users of services but key participants in generating demand for services.

During the year, the communication strategy has focused on sustaining behavior change on key health issues through multimedia tools. This implies that it was not enough to just give information and raise awareness about a particular health issue. Awareness and information dissemination should be used as tools to provide tools to the community to press for changes to improve access to health service provisions.

For making health care accessible to the general public and to spread awareness on health issues, norms have also been outlined for supporting IEC activities. The framework incorporates a variety of activities involving communities and also the media.

Panels inside Delhi Metro Trains highlighting health issues as a part of the IEC campaign.

Major IEC initiatives undertaken during the year :

- Integration of various IEC activities
- MOU signed with NFDC to scale up communication interventions in NE states.
- A series of press advertisements released in national dailies across the country highlighting achievements of the Ministry
- A magazine based programme, Kalyani-1 and 2 telecast in eight states and also all NE states.
- Awareness campaign on Delhi Metro trains highlighting preventive and curative aspects of various health issues.
- Capacity building workshops organized in states to build capacities of state IEC personnels
- Health Pavilion at India International Trade Fair wins gold medal for best display.
- Close monitoring of actual media utilization and behavioral outcomes along with financial allocations
- Presented a tableau on 'Healthy Living ' at the Annual Republic Day Parade, 2011
- National Immunization Day (NID) held in Jan.-Feb. 2011.

The following tools were used during the year:

- Interpersonal Communication
- Community Channels
- Mass Media
- Folk and Traditional Media
- Outdoor Media
- Advocacy
- Events, Image management, PR and Publicity

The target audiences included:

* Citizens of India in various age groups
- Direct Healthcare Providers (ANM, ASHA, AWW)
- Healthcare Managers/Administrative functionaries
- Health Communicators
- Grass-root functionaries
- Other Govt. Departments, e.g. Panchayati Raj, WCD, Water & Sanitation
- NGOs, Civil society stake holders and Media

During the year, the following issues were being highlighted through multi-media tools:

- Janani Suraksha Yojana
- ASHA
- Age At Marriage
- Routine Immunization
- PNDT and Girl Child
- Contraceptive choice and spacing
- Breast Feeding
- Use of Iodized Salt
- Care of New born
- Institutional delivery
- Maternal Care, Positioning of ASHA, Village and Health Nutrition Day, JSY, IMNCI and also awareness campaign on age at marriage, PNDT, spacing and contraception.
- Adolescent health
- RCH and HIV/AIDS
- Communicable and non communicable diseases platform for integration

A Budget allocation of Rs. 204.94 Crores was provided for IEC activities for the year 2010-11.

Major achievements during 2010-11 were as under:

- Reinforcing the brand identity for NRHM.
- Innovations at State level for NRHM advocacy.
- Intra Communication strategies for implementation at State level
- New content for multi-media tools.
- Integrated IEC management through Kalyani Programme News Magazine format through Prasar Bharati being telecast from EAG States and Assam.

- Special publications on achievements under health programmes
- Reinforced presence in Cable and Satellite TV channels and Private FM Radio.
- Special theme based issues for NRHM Newsletter.

Facade of the health pavilion with 'Population Stabilisation' theme. The pavilion won the Gold Medal among Central Government pavilions for its thematic display.

The IEC strategy of the Department has undergone a strategic shift. The communication challenge today is not only demand generation, creating awareness, but at the same time initiating a comprehensive understanding of behavior change communication in the socio-cultural framework of our Public Health System. A number of initiatives were taken to professionalize IEC activities and emphasis was laid on intensive media planning and inter-personal techniques for effective rollout of programmes and messages.

7.2. ACTIVITIES THROUGH MEDIA UNITS OF I & B MINISTRY

The Media Units of the Ministry of Information and Broadcasting provide communication support to the FW Programmes as per the requirements and guidelines of the IEC Division of MOHFW. The focus is on mother and child health issues, population growth, status of women, small family norms, the Community Needs Assessment Approach and also other issues related to health programmes such as Ophthalmology, Cancer, Tobacco etc.

7.3. DOORDARSHAN

i. Doordarshan telecast video spots at prime time on NRHM, RCH issues through its National Network as well Regional Kendras of Doordarshan, Prasar Bharati.

ii. Doordarshan has also telecast programmes including panel discussions, interviews etc. from time to time related with NRHM.

iii. A half an hour Kalyani-I and II magazine based programme was also telecast in 9 States including North-Eastern-States twice a week. Kalyani also repeated on DD Bharati. The proposal for telecast of Kalyani-I and II from North-East are also in the pipeline.

iv. The spots in regional languages of north-east region were also dubbed for telecast for a special campaign. Video Spots on emergency contraceptive pill, NSV and CuT-380-A were also telecast.

7.4. DAVP

DAVP has produced video/ audio spots on NRHM for telecast/broadcast. The programme proposed by DAVP for broadcast through AIR was also approved by the Ministry of Health & Family Welfare to propagate the messages on maternal health, child health and family planning and other critical issues of NRHM. The agency was also engaged in putting up exhibition during IITF-2010 at Pragati Maidan in the capital on November 14 this year which won the Gold Medal in its category.

7.5. NFDC

i. An MOU has been signed between Department of Health & Family Welfare and NFDC, a public sector company under the Ministry of Information & Broadcasting for telecast of Audio/Video spots through satellite channels as well as private FM Channels in the North Eastern region. These programmes were dubbed in regional languages through NFDC for distribution in the states.

ii. The approved spots were also telecast through all satellite channel as well as FM Channels in north-eastern states.

iii. NFDC is also conducting radio programmes based on all issues of maternal health including Janani Suraksha Yojana. They are also producing folk music programme in local dialect in EAG States.

7.6. ALL INDIA RADIO

i. The spots approved were telecast through national network at 7:59 AM before the National News at 8.00 AM and before the evening national news at 8.45 PM.

ii. AIR is broadcasting 15 minutes programme based on NRHM through 189 primary channels, 42 Vivid Bharati stations once a week on every Sunday at 7.00 PM. The programme are based on true successful stories as well as questions and answers through telephone as well as e-mail.

iii. A contract has also been signed with AIR, Mumbai for broadcast of the spots on NRHM 3-4 times daily in each popular programme (film music, rural programme, woman's programme) and also before and after regional news in 18 high focused stations.

iv. Department of Health & Family Welfare, Govt. of India has also supported kendras like AIR, Patna for telecast of the spots in their popular programme like Munshi Prem Chand and special radio serial titled "Cine Profile".

v. AIR, Munbai also telecast spots on NRHM in the North-Eastern States from the fund available under RCH budget.

7.7. SONG AND DRAMA DIVISON

To educate the people about Family Welfare issues, Song & Drama Division organized live entertainment programmes like puppet shows, dance, dramas, folk shows, during India International Trade Fair 2010.

7.8. PRESS INFORMATION BUREAU

It provided media coverage on important occasions, events, activities, policies and programmes of the Department. PIB arranged coverage of Family Welfare Melas, World Population Day functions, Pulse Polio Programme and other important events.

7.9. PRINT MEDIA/PRINT PUBLICITY

Press Advertisement:

The IEC Campaign through Press Advertisement enabled the division to highlight key initiatives in both national and regional media. A number of campaigns were launched through the national and regional press. Especially designed half page colour advertisement on the occasion of and World Population Day was released in the newspapers all over the country to generate mass awareness toward stabilization of population. Colourful advertisements highlighting various achievements on National Rural Health Mission were also released to the newspapers on the occasion of World Health Day, Independence Day, Sadbhavana Divas, Children's Day, achievements of five years of NRHM, Immunization, Dengue, Chickungunya etc.

The most intensive print media campaign was for the national/sub-national rounds of Pulse Polio Programme which was done systematically through a series of press advertisements in major newspapers all over the country.

The IEC Division also released advertisements based on focused theme such as Maternal & Child Health Care, Health & Family Welfare Pavilion in IITF- 2010 etc. The Division as part of an integrated IEC campaign covered a range of issues on NRHM related themes which provided a platform for information dissemination , awareness building and advocacy through the print media.

Printed Publicity Material:

In order to highlight the Ministry's consistent efforts, a series of documents were published. Each document reflected critical areas of NRHM and related programmes. These documents were distributed at major advocacy meeting and programmes to all stake-holders in States/UTs. The prominent documents published during the year were:

i) Book on 'Five years of NRHM'

ii) Book on 'Comprehensive Abortion Care'

iii) Booklet on Achievement of one year of New Government

iv) Bulletin of Rural Health Statistics in India

v) Book on Family Welfare Statistics in India

vi) Training Module for ASHA on NCD

vii) Operational Guidelines for promotion of Menstrual Hygiene

viii) Training Module for ASHA on Menstrual Hygiene

ix) Reading Material for AHSA on Menstrual Hygiene

x) Flip Book on Menstrual Hygiene

xi) Book on 'Hospital Housekeeping Guidelines'

xii) Folders on Family Planning methods (multi-languages)

a) "Hamara Ghar" an established house journal of the Department of Health & FW is being published for the last 39 year for promotion of Health and Family Welfare programmes for grass root level workers.

b) "Gagar Me Sagar" is a selected slogans booklet in Hindi being brought out as supportive material for Health and Family Welfare workers for publicity of Health & FW programmes to grass root level.

NRHM Newsletter:

The NRHM Newsletter is now established as an important publication for promotion of the programmes under National Rural Health Mission. The NRHM Newsletter is being published in Hindi, English, Assamese, Urdu, Oriya, Punjabi, Marathi, Kannada, Tamil & Bengali for NGOs and health functionaries working at the Sub-Centre, PHC, CHC and District level. The Newsletter publishes view points of all development partners, viz. NGOs, donor agencies etc.

A special issue of newsletter on 'Population Stabilization' was brought out during the year. This issue highlighted the discussions in the lower house of the Parliament on 'Population Stabilization'. Other important issue of newsletter published in the year was 'Operational Plan for Mother & Child Tracking System'.

There has been tremendous response to the Newsletter, especially from the grass root health workers from different regions. A number of health related issues, in the form reader's response have been discussed through these Newsletter editions.

Annual Wall Calendar:

Special efforts were made to publish the Wall Calendar 2011 of the Ministry on integrated themes with poster value. The Calendar has come out with innovative designs highlighting initiatives taken on various health and family welfare issues. Special efforts were also made through visual publicity like this year's Calendar for spreading message on health issues as an integrated theme of the Ministry. The Calendar was distributed to various health set ups.

Outdoor Publicity Campaign:

An awareness campaign was launched in Delhi Metro trains through panels inside train compartments highlighting various issues like – New born care, Spacing methods, Population Stabilization, Female feticide, Small family, Right age of marriage, Emergency Contraception, Hand washing, T.B., Anti Tobacco etc. The IEC Division also conducted an outdoor publicity campaign by installing hoarding, unipole on various health issues like – Dengue, Chikungunya, Swine-flue, Maternal & Child Health, Immunization etc.

The MOHFW tableau during the Republic Day Parade, 2011

Mass Mailing Unit(Press)

The Mass Mailing Unit's (Direct Mail Communication) main objective is to build up an effective mailing list of opinion leaders from different parts of the country with a view to utilize their services to bring awareness and attitudinal change among common people.

At present, Mass Mailing Unit, Department of Health & Family Welfare is disseminating the Ministry's regular journals, NRHM newsletter in English, Hindi and several regional languages on a quarterly basis and wall calendars on an Annual Basis. Apart from this regular dispatch, the Mass mailing Unit has mailed various types of publicity materials like posters, leaflets, pamphlets on Health and Family Welfare programmes provided by various divisions of the Ministry to the Health Functionaries at grass root level all over the country.

7.10. IEC WORKSHOP

During the year, Capacity Building IEC Workshops were organised for the District IEC Officers/District Community Mobilizers in two phases in Uttar Pradesh covering all the 80 districts. The purpose of the workshop organised at Allahabad and Agra was to enhance the skills of the officers. The workshops stressed on prioritizing the health issues according to the need of the districts, budgeting exercise, preparing IEC material and stressed Inter-Personal Communication to spread Behaviour Change messages to the general public etc.

7.11. WORLD POPULATION DAY

Like every year, the World Population Day was observed on 11th July, 2010. On this occasion, a population run was organized jointly by the Ministry and Jansankya Sthirtha Kosh at New Delhi in which the Union Health & Family Welfare Minister Ghulam Nabi Azad, Chief Minister of Delhi,Smt Sheila Dikshit and Common Wealth Games Gold Medalist Saina Nehwal participated along with school children to create awareness about population stabilization.

7.12. HEALTH PAVILION AT IITF-2010

The main theme of the Annual Health & Family Welfare Pavilion at Pragati Maidan in the capital was "Population Stabilization". The Ministry has renewed and stepped up its focus on this issue and used various forums to highlight the importance of the theme. The Pavilion won the Gold Medal for its display in its category.

Like every year, free health check-ups, i.e. Cancer detection, Blood test, Eye Test, Height and weight measurement, Family Planning counseling and services for male with various family spacing methods, treatment for communicable and non-communicable diseases were arranged by the Deptt. of AYUSH through its Councils of Ayurveda, Unani & Homeopathy and allopathic clinic of CGHS.

Folk Dance/Nukkad Natak were organized by the Song & Drama Division to spread health and social messages. A small amphitheatre was also established to educate people through showcasing documentary films. Painting Competition was organized for the Children in two age groups and first three entries were awarded with prizes and certificate. NACO, JSK, HSCC, HLL, Rajiv Gandhi Cancer Research Hospital, Heart Care Foundation & VHAI etc also participated in the exhibition.

7.13. REPUBLIC DAY TABLEAU-2011

The Ministry of Health & Family Welfare presented a tableau at the Republic Day Parade, 2011. The theme of the Tableau was **HEALTHY LIVING** with emphasis on preventive and curative health care including Yoga, regular exercise and healthy food.

The tableau also highlighted the adverse effects of tobacco use and substance abuse.

Partnership With Non-Government Organisations

8.1 INTRODUCTION

The National Rural Health Mission (NRHM) seeks to build greater ownership of the program among the community through involvement of Non-Government Organizations. Promotion of Public Private Partnership for achieving public health goals is one of the strategies initiated by the department in this regard. This partnership will reinforce the strategy of involvement of NGOs already spelt out in the National Population Policy 2000.

The Government of India is committed to voluntary and informed choice in family planning, reproductive and child health care services. Towards this end, the Government, the corporate sector, voluntary and non-voluntary sector are expected to work together in partnership. The professional bodies like Indian Medical Association, Federation of Obstetrician & Gynecologist are also involved in the partnership to achieve the desired goal.

8.2 PARTNERSHIP WITH NON-GOVERNMENT ORGANIZATIONS

The Government of India envisages collaboration with NGOs through enhanced participation by the State Government also. Under RCH-II, the ownership of the program has been decentralized to the State Governments. The planning process now starts from the district level. The scheme has been included in the State PIP for NRHM under RCH II.

NGOs in particular, have been assigned supplementary or complementary role to that of the Government health care delivery, thus aiding them in reaching the masses meaningfully. They have a comparative advantage of flexibility in procedures, rapport building with communities and are at the cutting edge of program implementation. NGOs will be involved in ASHA's training, activities relating to National Disease Control Programmes, PNDT related activities and service delivery in addition to health education and awareness programme.

8.3 NEW GUIDELINES

According to the guidelines of NGO Scheme, the States have been given an important role in selection/approval of the NGOs and overseeing implementation of the projects undertaken by them. An inbuilt mechanism of monitoring the working of the NGOs and various activities undertaken under the project, in addition to the mid-term appraisal, etc. by the designated evaluating agencies/ organizations has been built into the guidelines:

The key features are: -

- Decentralization of the schemes to the State and District level.
- Integration with National Rural Health Mission.
- Training of ASHA
- Activities relating to various National Disease Control Programme.
- Awareness relating activities concerning PNDT Act.
- Shift from exclusive IEC and awareness generation to Service Delivery.
- Delivery of RCH services by NGOs in un-served and under served areas.
- Clearly defined eligibility criteria for Registration, Experience, Assets and jurisdiction.
- Rationalization of the jurisdiction area serviced by the NGO to provide in depth service and optimize resources.
- Mainstreaming gender issues in all intervention areas.
- Enhanced male participation and involvement in delivery of all RCH services.

- Emphasis on measurable qualitative and quantitative performance indicators.
- Selection, approval, funding and monitoring of Mother NGO/Service NGO projects by State and District RCH Committees.
- Increased interface of NGOs with local government bodies.

8.4 MOTHER NGO (MNGO) SCHEME

The underlying philosophy of the Mother NGO (MNGO) Scheme is one of nurturing and capacity building through partnership. In accordance with the National Population Policy 2000, National Health Policy (NHP) 2002 and 10th plan document that places emphasis on decentralization of program management and RCH service delivery using a gender sensitive approach, the NGO guidelines were revised in accordance with the RCH II approach.

The objectives of the MNGO scheme, are to improve RCH indicators in the under served and unserved areas, with specific focus on Mother & Child Health, Family Planning, Immunization, Institutional delivery, RTI/STI and adolescent reproductive health care. It is expected that the gender concerns and male involvement will be addressed across all the interventions.

The un-served areas specifically include hilly, desert and mountainous regions, SC/ST habitats, urban slums and in areas where the government infrastructures are functioning sub optimally. Under the revised mode, NGOs are expected to facilitate RCH service delivery in addition to addressing the awareness, education and advocacy requirement.

The overall approach has shifted from a project to a program mode (from one-year cycle to 3-5 year cycle). Rationalization of NGO jurisdiction (reducing coverage from 5-8 districts or more to 1-2 only), and each Mother NGO to work with only 3-4 Field NGOs (FNGOs) from each district, encouraging each Mother NGO to identify the un-served and under served pockets within the districts in consultation with District Health Officials, identification of Field NGOs from the same pockets to serve populations covering 1-2 sub centers in the provision of RCH service delivery related to NRHM Family Planning, Immunization, Mother & Child Health and access to institutional delivery. RTI/STI, adolescent reproductive health care, implementation of Janani Suraksha Yojana (JSY) are some of the salient features. Currently, 310 existing Mother NGOs are working in all the States of the Country.

8.5 SERVICE NGO (SNGO) SCHEME

The Service NGOs (SNGOS) are, those, who are expected to provide clinical services and other specialized aspects such as Dai training, MTP, male involvement, covering 1,00,000 populations, contributing to achieving the RCH objectives.

NGOs with an established institutional and infrastructure for service delivery are encouraged to compliment the public health care delivery system in achieving the goals of RCH-II program. These SNGOs will cover an area co-terminus to that of a CHC/block PHC with approximately 1,00,000 population or around 100 villages. Service NGOs are expected to provide a range of clinical and non-clinical services directly to the community as an integrated package of RCH-II services. Some of the services expected to be provided by Service NGOs include safe deliveries, neo natal care, treatment of diarrhoea and ARI, abortion and IUD services, RTI/STI etc.

8.6 INSTITUTIONAL FRAMEWORK FOR PROGRAM MANAGEMENT

The program management under the revised scheme is decentralized to the State and district Authorities. The State Government forms State RCH society, which has the responsibility for the overall management of the scheme. The State NGO Selection committee will be responsible for MNGO selection, recommendation of projects for GOI approval, fund disbursement, capacity building, monitoring and evaluation. The District RCH society is responsible for all the operational aspects of the program management at the district level. The district NGO committee holds the responsibility for recommendation of MNGO composite proposals to State RCH Society, facilitating the signing of MOU with the MNGO and passes it on for fund release to state RCH society. The State RCH society undertakes review meetings and periodic monitoring in the field for assessing Field NGO/Mother NGO performance.

Role of Government of India is related to provision of policy guidelines, final approval of proposals, and technical support for capacity building of NGOs and fund release to State governments.

8.7 STATE NGO COORDINATORS (SNGOCs)

The SNGOCs are responsible for monitoring the implementation, facilitating timely submission of NGO reports to the state government, providing government feed back to NGOs, communicating government policies and programs and facilitating NGO dialogue with the district health system. Presently there are 15 selected Service NGOCs are in position.

8.8 INSTITUTIONAL FRAMEWORK FOR NGO CAPACITY BUILDING

The Regional Resource Centres (RRCs) is the institutional mechanism available to support this program. There are 11 RRCs covering the programme all over the country. NGOs with expertise and experience in Reproductive Child Health (RCH) and having national level stature are identified as RRCs.

The RRCs are playing an important role to be a catalyst, advocacy and net working with state governments, strengthen managerial and technical competencies of the Mother NGOs, support and oversee Field NGO training, document and disseminate best practices, collect and disseminate RCH policies, laws, and program from the respective states where they work and for maintenance of database on technical and human resources related to RCH.

Family Planning

9.1 INTRODUCTION

In 1952, India launched the world's first national programme emphasizing family planning to the extent necessary for reducing birth rates *"to stabilize the population at a level consistent with the requirement of national economy"*. Since then, the family planning programme has evolved and the program is currently being repositioned to not only achieve population stabilization but also to promote reproductive health and reduce maternal, infant & child mortality and morbidity.

17% of the world population. Even a cursory look at following figure will give a broad idea of the demographic scenario of India, where population of each state is equivalent to one major country in the world. India has been showing a slow but steady decline in population growth. India's annual population growth rate during 1991-2001 decade was 1.93%, a decrease of over 15% from the previous decade. Similarly, Total Fertility Rate (TFR) in the country has recorded a steady decline to the current levels of 2.6 (SRS 2008), a 42% decline from mid-1960s.

Table.1. Stated goals in recent National Population and Health Policies related to Family Welfare and their current status

Program/Policy Goals	X Five Year Plan(by 2007)	NPP (by 2010)	NRHM (by 2012)	MDG (by 2015)	Current Status (Reference Year)
Infant Mortality Rate	45	<30	30	27	53 (2008)
MaternalMortality Ratio	200	<100	100	100	254(2005)
Total Fertility Rate	NA	2.1	2.1	NA	2.6(2008)

The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others) (see Table 1).

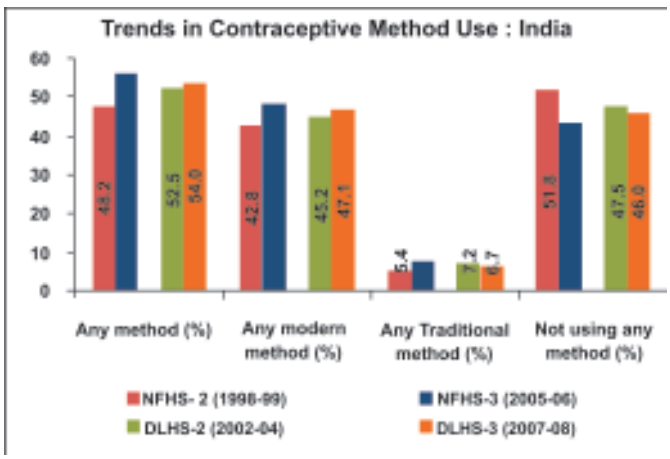
9.2. CURRENT SCENARIO OF POPULATION AND FAMILY PLANNING IN INDIA

9.2.1 Demographic Scenario:

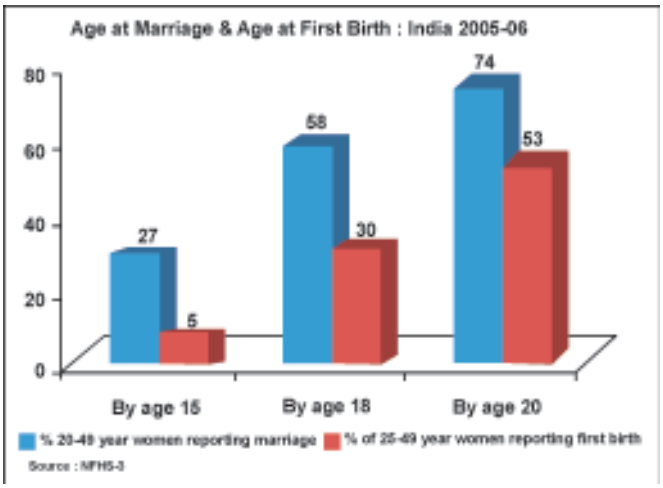
India's population as per 2001 census was 1.028 billion, second only to China in the world. India which accounts for 2.4% of the land area is already supporting around

9.2.2. Family Planning Scenario:

Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9: NFHS-3) and the general awareness of contraception is



almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure). Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase



of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). The proximate determinants of fertility like age at first marriage and age at first childbirth (which are societal preferences) are also showing good improvements at the national level and adjoining figure indicates the current position of social determinants of fertility in the country.

9.3 CURRENT FAMILY PLANNING EFFORTS

The Family Planning (FP) Division is involved in the development, implementation and monitoring of strategic interventions for fulfilling the twin objectives of population stabilization and promoting reproductive health within the wider context of sustainable development. The interventions, activities and performance in the area of family planning over the year 2010-11 are as follows:

9.3.1. Contraceptive services under the National Family Welfare Programme:

The public sector provides a wide range of contraceptive services for limiting and spacing of births at various levels of health system as described in Table 2:

Table 2: Family Planning Services in Public Health Sector

Family Planning Method	Service Provider	Service Location	Service Strategy* & Promotional Schemes
LIMITING METHODS			
Minilap	Trained & certified MBBS Doctors & Specialist Doctors	PHC & higher levels	• FDS: Fixed Day • Static Approach
Laparoscopic Sterilization	Trained & certified Specialist Usually Doctors (OBG & General Surgeons)	CHC & higher levels	• Camp Approach • Revised Compensation Scheme
NSV: No Scalpel Vasectomy	Trained & certified MBBS Doctors & Specialist Doctors	PHC & higher levels	• National Family Planning • Insurance Scheme
SPACING METHODS			
IUD 380 A	Trained & certified ANMs, LHVs, SNs and Doctors	Sub centre & higher levels	• On demand • Camp Approach • Revised Compensation Scheme
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and Doctors	Village level Sub centre & higher levels	• On demand • VHNDs: Village Health Nutrition Days
Condoms	Trained ASHAs, ANMs, LHVs, SNs and Doctors	Village level Sub centre & higher levels	• On demand • VHNDs
EMERGENCY CONTRACEPTION			
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and Doctors	Village level Sub centre & higher levels	• On demand • VHNDs

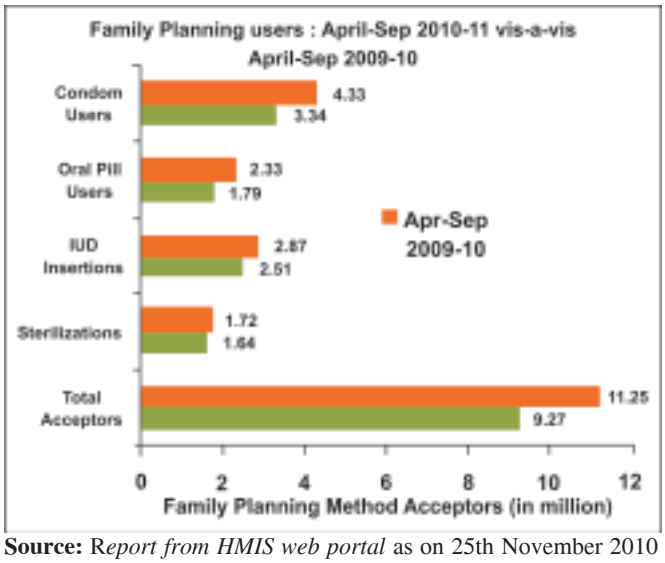
Legends: *ANM: Auxiliary Nurse Midwife; LHV: Lady Health Visitor; SN: Staff Nurse; ASHA: Accredited Social Health Activist*
Note: ** extensive IEC is key component of all the strategies of Family Planning Programme*

The salient features of the family planning services are as follows:

- Counselling, access to and provision of good quality services and follow-up care.
- 'Fixed Day Static Services' (FDS) approach in sterilization services to increase access.
- Continuation of sterilization camps in the states with high fertility till the time FDS is implemented effectively.
- Revised compensation scheme for sterilization acceptors.
- 'National Family Planning Insurance Scheme' (NFPIS) to cover service providers in both public and accredited private facilities, where the clients are insured in the eventualities of deaths, complications and failures in sterilization and the providers/ accredited institutions are indemnified against litigations in those eventualities.
- 'Quality Assurance Committees' (QACs) have been constituted at state and district levels.
- The division has repositioned IUD as short and long term spacing method.
- Guidelines have been developed and disseminated regarding use of Emergency Contraception Pills (ECPs).

Achievements in 2010-11:

The performances of family planning services are showing a marginal decline in all methods (refer Annex-1 for details) for the year 2010-11 compared to the corresponding period in 2009-10.



Source: R*eport from HMIS web portal* as on 25th November 2010

This decline could be because of incomplete data uploaded by most states and it is assumed that once complete data is entered an improved performance would be reflected. However, anecdotal evidences suggest that another reason for declining performance could be attributed to better quality of data entered in HMIS web portal.

9.3.2. Increasing male participation in Planned Parenthood, including ëNo Scalpel Vasectomyí (NSV):

- Increasing male participation in 'Planned Parenthood' is one of the major strategic themes of NPP-2000.
- Promotion of NSV acceptance is one of the most important & visible component of increasing male participation in RCH towards addressing the gender equity issues.
- The No Scalpel Vasectomy (NSV), a modified male sterilization technique, was introduced in 1997.
- Camp approach for male sterilization was adopted initially to re-popularize male sterilization method. Based on the experiential lessons from male sterilization camps in certain states a strategy on advocacy and community mobilization for increasing NSV acceptance through camps was introduced in 2005.
- Human resource development with a three pronged strategy for training surgical faculty from Medical colleges, district NSV trainers and service providers is in place.

Achievements in 2010-11:

- The camp approach was continued in most states across India (http://mohfw.nic.in/NRHM/FP/Revised_Budget_ Guidelines_CSS.pdf)
- Training in NSV, was continued on a priority basis. As on September 2010:
  - As per the latest report (HMIS) there are 9239 facilities in the country with trained NSV providers.
  - Most districts in the country have district NSV trainer/s.
  - Surgical faculty training is being continued in 2010-11 across five regional training centres and funds for the same are being disbursed.

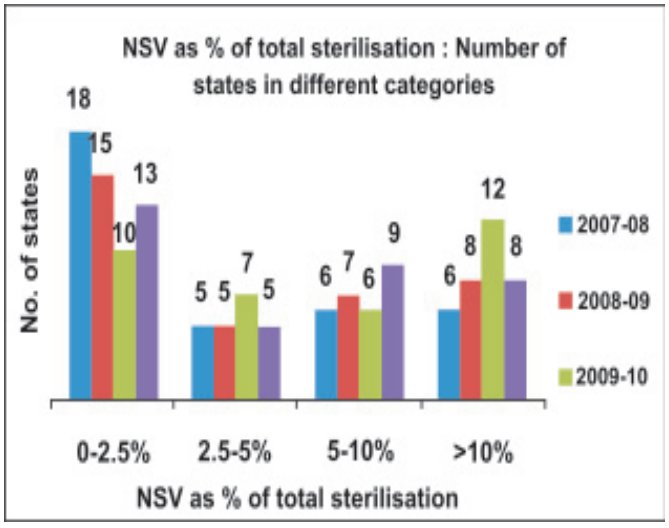
- The annual 'National NSV Review Workshop' was held in September 2009 to review states' performance in NSV, and top three performing states for the year 2008-09 (West Bengal, Punjab & Maharashtra) were felicitated.
- NSV performance has continued its positive trend and has shown an increase in 2009-10:
- From above figure, it is evident that NSV as a percentage of total sterilization is increasing across the country and more and more states are moving in the positive direction.

Table 3: Achievements in Male Sterilization, Nationwide

Period†	April ñ March*			April-September^
Contraception	2008-09 (lakhs)	2009-10 (lakhs)	Annual Change (%)	2010-11 (lakhs)
Male Sterilizations	2.52	2.74	8.7	0.77
Male Sterilization as % of Total Sterilization	5.2	5.5		4.7

*Source: * MIS for NRHM as on November 2010*
^ HMIS RCH Reports accessed on 25th November 2010

- Male sterilization as a percentage of total sterilization had reached a low of 1.89% in 1999 and was hovering around 2.5% until 2006 without much improvement. As a result of intensive efforts to increase male participation, the proportion of male sterilization rose to 4.3% in 2007-08 and 5.5% in the year 2008-09 and it has further improved to 5.6% in 2009-10. Number of NSVs for the period ending September 2010-11 is 4.7%.



Source: 2006-2009: *MIS for NRHM as on 30th April 2009*
2009-10 & 2010-11: *HMIS Standard RCH Reports*

9.3.3. Promotion of IUDs as a short & long term spacing method:

In 2006, GOI launched "Repositioning IUCD in National Family Welfare Programme" (http://mohfw.nic.in/NRHM/FP/Repositioning_IUCD.pdf) with an objective to improve the method mix in contraceptive services and has adopted diverse strategies including advocacy of IUCD at various levels; community mobilization for IUCD; capacity building of public health system staff starting from ANMs to provide quality IUCD services and intensive IEC activities to dispel myths about IUCD.

ìAlternative Training Methodology in IUCDî using anatomical, simulator pelvic models incorporating adult learning principles and humanistic training technique was started in September 2007 to train service providers in provision of quality IUCD services. It was started in twelve districts across twelve states of India on a pilot basis and based on the success of the pilot phase and lessons learned it was expanded to cover the entire country in 2008-09.

Achievements in 2010-11:

- **As on September 2010:**
  - GOI has trained state trainers from all the states at the National level

- Anatomical simulator pelvic models have been distributed to all the districts
- All the states have started district trainers' and service providers' trainings.
- Approximately 35,000 service providers (MOs, SNs, LHVs, & ANMs) have been trained till date.

- **Rapid assessment** of the IUCD training is almost complete (final report awaited).
- In order to increase basket of contraceptives in spacing methods, decision to introduce **Multi Load Copper 375** has been taken and an **operations research study** has been completed in 6 states. The report/ recommendations of the study is awaited. Requirement for **Multi Load IUD** to be launched in the programme is being worked out.

9.3.4. Addressing the unmet need in contraception through assured delivery of family planning services:

9.3.4.a *Fixed Day Static Services in Sterilisation at facility level***:**

- Operationalization of FDS has following objectives (http://mohfw.nic.in/NRHM/FP/Fixed_Day_Static_ Guidelines.pdf):
  - To make a conscious shift from camp approach to a regular routine services.
  - To make health facilities self sufficient in provision of sterilization services.
  - To enable clients to avail sterilization services on any given day at their designated health facility.

Table 4: FDS Guidelines for sterilization services

Health Facility	Minimum frequency of sterilization
services	
District Hospital	Weekly
Sub District Hospital	Weekly
CHC / Block PHC	Fortnightly
24 7 PHC / PHC	Monthly

Note: Those facilities providing more frequent services already must continue to do so

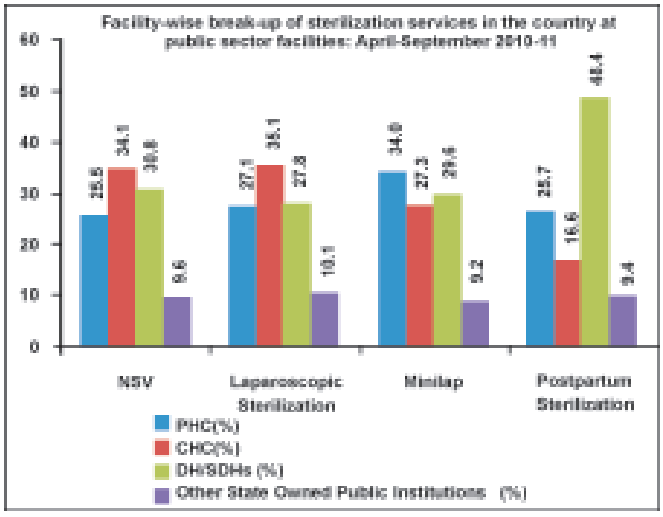
9.3.4.b*. Camp approach for sterilization services* is continued in those states where operation of regular fixed day static services in sterilization takes longer time duration.

9.3.4.c*. Training of service providers* for full operationalization of FDS is continued across all the states for all sterilization services (NSV, minilap abdominal tubectomy and laparoscopic tubectomy) and IUD services.

9.3.4. d. *Rational placement of trained providers* at the peripheral facilities for provision of regular family planning services.

Achievements in 2010-11:

- FDS guidelines have been disseminated to all the states.
- Most states have operationalized FDS in sterilization at the district level and few states like Andhra Pradesh and Tamil Nadu have opertaionalized FDS up to the PHC level.
- Guidelines for "Standard Operating Procedures for sterilization services in camps" were developed, printed and disseminated to all the states.
- "Guidelines for Clinical Skill Building Trainings in Male and Female Sterilization Services" was (http://mohfw.nic.in/NRHM/FP/Scan_Clinical_Skill_Building. pdf) developed and disseminated to all states.
- Analysis of the data available from HMIS under



Source: Data accessed from HMIS on 25th November, 2010 and analyzed in-house

NRHM for the period April-September 2010-11 reveals that around 60% of NSV, Minilap and even laparoscopic sterilization (which requires specialist training and expensive instruments) procedures and approximately 42% of postpartum sterilizations are being conducted at PHC and CHC level, indicating that FDS approach in sterilization is taking root in the country (See figure).

- Expert committee meetings have been convened to standardize trainings in female and male sterilization services.

9.3.5. Quality Assurance in Family Planning:

Quality assurance in family planning services is the decisive factor in acceptance and continuation of contraceptive methods and services.

The guidelines for 'Quality Assurance and Standards' in place.
The Quality Assurance Committees (QACs) set up at the State and District level, following the Supreme Court directives. At the Central level, these activities are monitored through reports and field visits.

Up-to-date guidelines on quality of services are now available for

- Male and female sterilization services: (http://mohfw.nic.in/NRHM/FP/Quality_Assurance.pdf)
- Sterilization services in camps (http://mohfw.nic.in/NRHM/FP/SOP_Book.pdf)
- IUCD services(http://mohfw.nic.in/NRHM/FP/medical_ officer.pdf &
- http://mohfw.nic.in/NRHM/FP/nursing.pdf)
- ECP administration (http://mohfw.nic.in/NRHM/FP/ECP_Book_Final.pdf), the division has developed reference manuals on:
- Minilap tubectomy
- Post partum family planning
- Immediate post partum insertion of IUCD
- Guidelines for training in female sterilisation

Achievements in 2010-11:

- Divisional workshops (5) on "Quality Assurance in Family Planning" were held in the high focus state of Uttar Pradesh.
- Another workshop was conducted in Bihar to orient the newly appointed district nodal officers of family planning.
- Almost all states have reported the constitution of the "SQACs" and of 'DQACs".

9.3.6. Post-partum Family Planning (PPFP) services:

- Institutional deliveries in India have increased significantly since the launch of NRHM which gives an opportunity to offer family planning counselling and contraceptive services.
- PPFP services are not being offered uniformly at all levels of health system across different states of India resulting in missed opportunities.

Achievements in 2010-11:

- The division has undertaken advocacy for strengthening PPFP services, at all levels; further, it was ensured that PPFP is included in PIP for 2010-11 under NRHM.
- Training of Trainers for immediate PPIUCD have been organised in medical colleges and district hospitals of 18 states.
- PPS is showing increasing trends at the National level. The proportion of PPS out of total female sterilization has recorded an impressive 8.1 percentage points increase for the period April-March 2009-10 (32.1%) compared to the period April-March 2008-09 (24%). Further, this remains static during the corresponding period of 2010-11 at 32.2%.
- Hand book on Post- partum family planning has been developed.

9.3.7. Promotion of Emergency Contraceptive Pills (ECPs):

ECPs are effective for preventing conception due to unplanned/ unprotected sex. This helps to reduce unwanted pregnancy and associated abortions, maternal mortality and morbidity.

- ECPs have been included in National Family Welfare Programme and efforts are being made to utilize them at all levels of public health system.

- ECP has been included in the ASHA kits to address the issue of unwanted pregnancy at the community level.

9.3.8. Assisted Reproductive Technologies (ART) for infertility:

As per WHO data, the incidence of infertility in various countries including India is around 10-15% which has created demand for assisted reproduction. In order to ensure quality in ART services and for regulating and supervising the functioning of ART clinics, the National Guidelines on ART has been developed by ICMR and National Academy of Medical Sciences for GOI.

Achievements in 2010-11:

- The Draft bill on ART has been updated by incorporating comments from various stakeholders including the Law Commission and general public. The draft Bill has been sent to the Law Ministry for examination..

9.3.9. New contraceptive methods and contraceptive services:

It has been documented worldwide that introduction of a new contraceptive method increases the CPR by approximately 3%. The division is taking proactive approach to introduce new contraceptive methods and services in family welfare programme.

Achievements in 2010-11:

- Post- Partum IUCD (PPIUCD) has been introduced as a contraceptive technique in the programme. Training of service providers and trainers has been done in 18 states – 32 Gynaecologists and 30 (as state trainers) have trained more than 100 Gynaecologists and nurses at the district level who will be further train medical officers from FRUs. 2000 anatomical pelvic models with post-partum uterus procured with the support of UNFPA and distributed to the states.
- Decision to introduce Multi Load Copper 375 has been taken and operation research study for the introduction of the same in National Family Welfare Programme has been completed and the final report/ recommendation is awaited.
- Funds have been released to ICMR for Post Marketing Surveillance study in Centchroman (a non steroidal oral contraceptive developed indigenously by CDRI, Lucknow).
- RISUG is an indigenously developed intra-vasal male contraceptive. It is under Phase 3 clinical trial which is funded by the ministry.
- A 3 year pre-introductory study on Net-EN, Cyclofem and hormonal Implants is in progress. ICMR is conducting the research study in HRRCs and Medical Colleges prior to its introduction in the National Programme.

9.3.10. Other promotional schemes:

***9.3.10.a**. Revised compensation scheme for acceptors of sterilization:*

GOI has been providing compensation to the acceptors of sterilization for their loss of wages for availing the services as per the revised rates since September 2007 and all the states are covered under this scheme. Funds in the scheme have also been earmarked for the compensation for sterilization in accredited private health facilities and empanelled private healthcare providers.

The detailed scheme is available on the ministry's website at http://mohfw.nic.in/NRHM/FP/ Revised_compensation.pdf .

***9.3.10.b.**National Family Planning Insurance Scheme (NFPIS):*

GOI launched the NFPIS Scheme in November 2005 to compensate for the acceptors of sterilization or his/her nominee in the unlikely event of failure or complications or his/ her death, following a sterilization operation. The scheme also provides for indemnity insurance cover to the medical officers and the health facilities for up to four cases of litigations per year that the healthcare provider or the facility may face as a consequence of performing sterilization operations.

- The Insurance scheme has been renewed with the ICICI Lombard Insurance company for the year 2009-10
- The manual for NFPIS is available on the ministry's website at http://mohfw.nic.in/NRHM/FP/ FP_Manual_ 2008-Final.pdf

***9.3.10.c**.Public Private Partnership (PPP):*

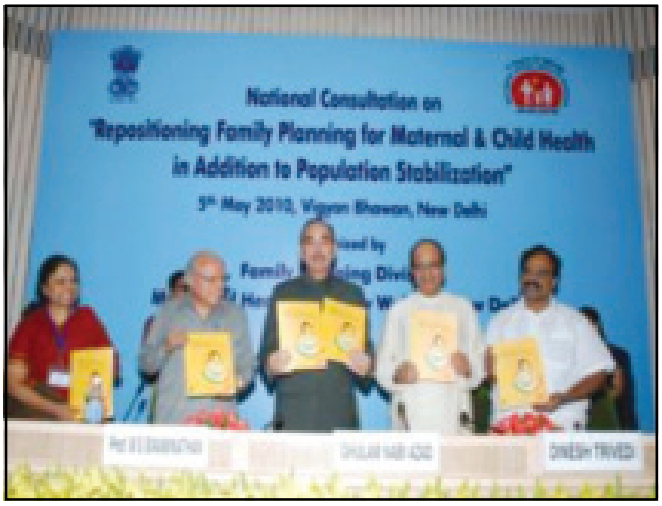
- PPP in family planning services are intended to utilize the reach of private sector in increasing the access to family planning services. In order to promote PPP in family planning services, accredited private facilities and empanelled private

healthcare providers are covered under revised compensation scheme for sterilization and NFPIS.

- Accreditation and empanelment of private health facilities /healthcare providers is decentralized to districts.
- However, PPP in family planning has not been adequately promoted. The division is addressing this issue by increasing advocacy for PPP at all forums including Indian Medical Association (IMA). Nearly 100 workshops have been conducted for private practitioners through funding to IMA.

9.3.11. Some major activities during the year:

9.3.11.a. *National consultation on Repositioning Family Planning for Maternal & Child Health in Addition to Population Stabilisation (May 05, 2010):*



- The consultation was inaugurated by the Hon'ble Minister of Health and the key note address was delivered by Hon'ble Member of Parliament Shri M S Swaminathan.
- Various experts from across the globe & from various international organisations like UNFPA, UNICEF, DFID, USAID, WHO, World Bank and representatives from lead NGOs participated in the consultation.

9.3.11.b. *Celebration of World Population Day & Week (July 11 – 17, 2010):*

- World Population Day was celebrated for the first time in all districts of the high focus states (304 districts) to generate awareness about population issues.
- At the central level the Hon'ble Union Minister of Health and Family Welfare Shri Ghulam Nabi Azad flagged off a 'Population Run' from Vijay Chowk to India Gate. The gathering was also addressed by the Hon'ble Chief Minister of Delhi Smt. Sheila Dixit.
- Similar functions were also held not only in all the 9 high focus states' capital but also in all their districts. In all the states two days' district level *melas* were also held where stalls were set up for RCH services including counselling, IUD services, other spacing methods and enlisting for clients for sterilisation.

Key findings:

- During the population week over 90,000 sterilisations were performed; this was a result of concerted IEC/BCC efforts and provision of quality services.
- With meticulous micro planning the available service providers could be judiciously distributed to make more facilities functional and thereby provide service to the clients nearer their place of residence. Further, it was observed that those states showed better performance where top bureaucratic leadership was actively involved.

9.3.11.c. *Debate on Population Stabilisation in Parliament (August 04, 2010):*

- The Hon'ble Minister of Health and Family Welfare, Shri Ghulam Nabi Azad, piloted a debate in Parliament – "That this house consider the issue of Population Stabilisation in the country"
- It was a historic debate as the subject was debated in Parliament after 33 long years. The debate lasted almost 7 hours and more than 34 members spoke in the debate. Cutting across party lines all members appreciated the gravity of the subject and urged the government to take all necessary steps to contain the rising population.

9.3.11.d. *Meeting of the National Commission on Population (October 21, 2010) :*

- The second meeting of the National Commission on Population (NCP) chaired by Hon'ble Prime

Minister, Shri Manmohan Singh was held on October 21, 2010.

- The meeting was attended by Chief Ministers of high focus states, health ministers of the states and members of the NCP.

9.4. KEY CHALLENGES & OPPORTUNITIES

9.4.1. Demographic challenges:

- It has been estimated that with current trends, the population in India will increase from 1.029 billion to 1.4 billion during the period 2001-2026, an increase of 36% in twenty-five years at the rate of 1.2% annually.

- There are substantial differences in TFR in between and within states and the national progress must be seen in the context of these striking differences e.g. Kerala, Tamil Nadu, Andhra Pradesh & Karnataka with TFR at or below replacement levels and states like Uttar Pradesh, Bihar, Madhya Pradesh, Chhattisgarh, Uttarakhand, Rajasthan, Jharkhand and Orissa, with an estimated combined TFR of 4.2 in 2000. Table 5 gives the estimated year by which some selected HFS will reach replacement fertility if the current trends continue and it will delay the attainment of replacement level of fertility in India until 2021:

Table 5 Projected Year to reach Replacement-level Fertility

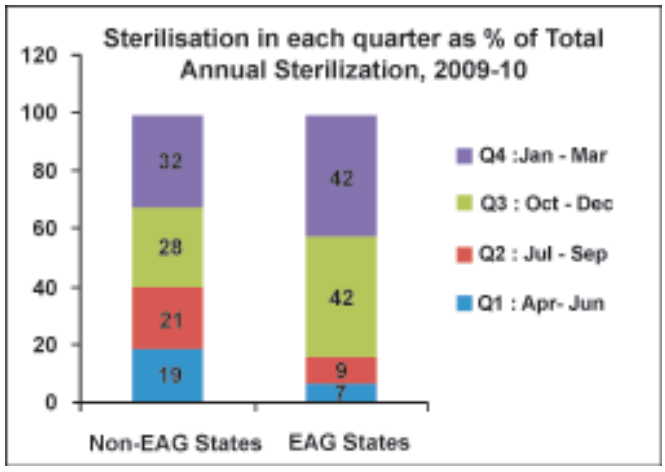
Sl. No.	Name of the State	Year
1	Uttar Pradesh	2027
2	Madhya Pradesh	2025
3	Chhattisgarh	2022
4	Uttarakhand	2022
5	Bihar	2021
6	Rajasthan	2021
7	Jharkhand	2018
	INDIA	**2021**

Source: *Report of the technical group on population projections commissioned by the National Commission on Population, May 2006*

9.4.2. Programmatic and service delivery challenges in family planning:

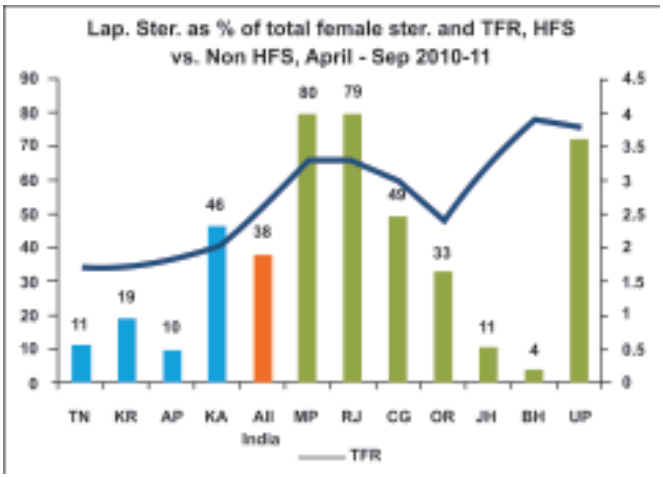
- **Unavailability of regular sterilization services:** The access to sterilization services at sub-district levels is restricted due to poor implementation of FDS approach, especially so in high focus states with high TFR and high unmet need due to:
  - lack of trained service providers specially in minilap & NSV at the CHCs and PHCs
  - poor facility readiness

High **seasonal variation** in sterilisation services is evident in high focus states (84% sterilization in last 6 months and 42% in last three months) compared to a more uniform performance throughout the year in non-EAG states (see adjoining figure). This reflects the lack of regular service provision rather than the 'acceptors preference', as frequently claimed by many service providers.



Source: *Data accessed as on November 25, 2010 from HMIS web*

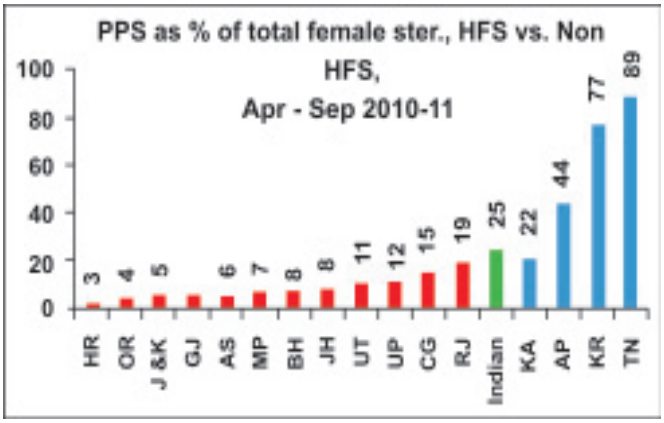
- **Heavy reliance on expensive, technically and logistically high-demanding laparoscopic sterilizations**: As evidenced by adjoining figure, the southern states (blue bars), except Karnataka,



Source: *Data accessed as on November 25, 2010 from HMIS web portal*

show a high proportion of minilap sterilizations (75 to 89% out of total female sterilization). However, in most of the high focus states (green bars), with the exception of Bihar and Jharkhand, laparoscopic female sterilization remains the predominant procedure. Laparoscopic sterilization services can be provided by trained gynaecologists/surgeons only; the procedure requires expensive instruments with high maintenance and sophisticated infrastructure including basic OT. Hence, heavy reliance on it would limit service provision in these states where the availability of specialists and facility readiness is still low. Promoting the simpler, safer and easy-to-provide minilap would be a better proposition for increasing the access to sterilization services and reduce the unmet need in limiting methods in high focus states.

- The huge potential for **post-partum contraception** offered by the increasing number of institutional deliveries has not been tapped adequately due to lack of planning, lack of trained post-partum family planning service providers and lack of infrastructure in most of the high focus states. This is evident

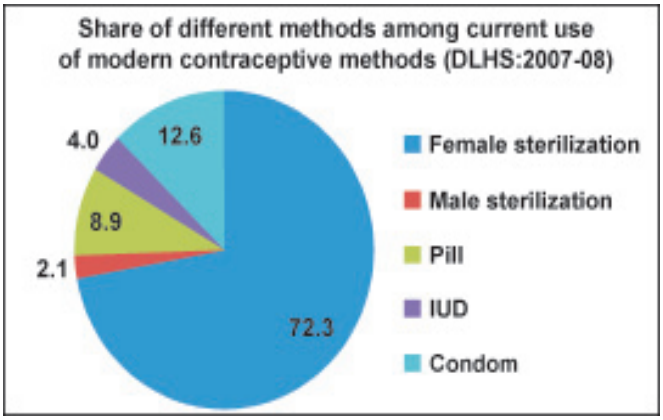


Source: *Data accessed as on November 25, 2010 from HMIS web portal*

from above figure which shows that in high focus states like Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Uttarakhand and Orissa postpartum sterilization accounts for a very lowly 3-19% of total female sterilization as compared to 75-90% in non-high focus states like Kerala and Tamil Nadu.

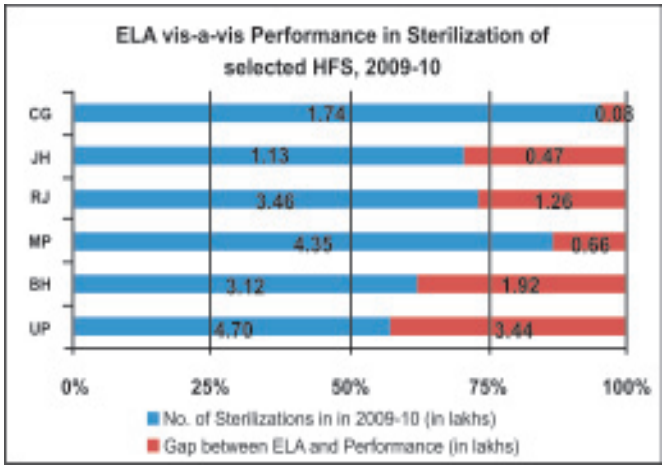
- **Human resource development** for minilap, laparoscopic sterilization & NSV to operationalize FDS in sterilization is picking up. However, the quality of training, post-training follow-up and support for adherence to standard service delivery protocols are poor. More importantly, there is a lack of rational human resource development plan in the states where selection of trainees, post-training placement and post-training infrastructure & logistic support are not given adequate importance leading to loss of trained service providers to the system and wasted resources.

- **Lack of regular contraceptive updates** at state/ district level for all categories of service providers is limiting the service providers' knowledge level and skills to provide quality contraceptive services according to the latest service delivery protocols.



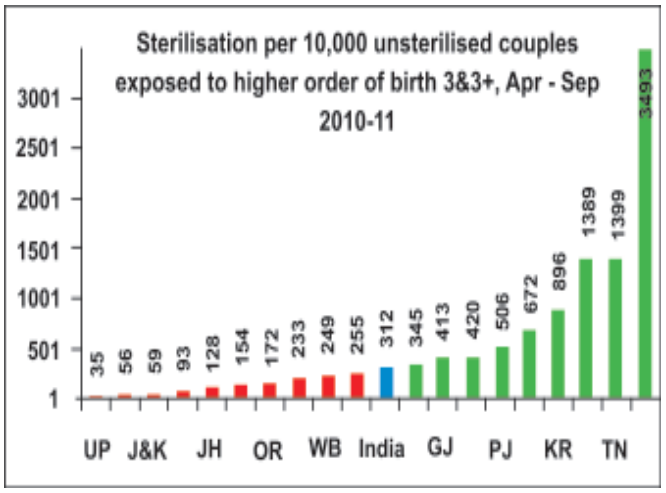
- **Inadequate attention to spacing methods** is evident by consistently low use of spacing methods across most states of India, despite high unmet need in spacing. According to DLHS 3, all the spacing methods together account for just around 25.5% of the current contraceptive use compared to 74.5% by female & male sterilizations put together as evidenced in adjoining pie chart.

- **Inter-State variation in access to and use of family planning services:** The access to and use of family planning services shows wide inter-state variations. The performance of HFS in family planning services, though improving, remains much below expected levels and needs to be stepped up considerably. Adjoining chart shows the gap between the ELA (Expected Level of Achievement) and actual performance in 2009-10 in sterilization services in select HFS and the gaps range from of 3.44 lakhs in UP and 1.92 lakhs in Bihar to 8 thousands in Chhattisgarh. The data on



Source: *Data accessed as on November 25, 2010 from HMIS web portal*

sterilizations per 10,000 unsterilized couples exposed to higher birth order of 3 and 3+ further highlights the poor performance of HFS. The sterilization rate for 10,000 unsterilized couples exposed to high birth order ranges from a lowly 35 in Uttar Pradesh, 56 in Bihar & 59 in J&K to a high of 1,399 in Tamil Nadu and 3,493 in Andhra Pradesh as shown in the figure.



- The demand from the states for contraceptives and survey findings on contraceptive use are in variance. To address this issue, the logistics of procurement **and supply** of contraceptives has to be rationalized to reflect the actual requirement and usage.
- **Public Private Partnership (PPP)** in family planning has not been adequately promoted across most states in India and there is a reluctance to accredit private providers at state/district level which is adversely affecting the widest possible access of family planning services to clients.
- **Community based family planning services** (including counselling, contraceptive distribution, referral services) utilizing ASHAs, VHNDs and VHSCs have not yet been opertaionalized effectively.

9.5. FUTURE STRATEGIES

The ministry has set in motion new approaches to sustain the momentum gained in the sphere of family planning and population stabilization this year, some of which are as follows:

- Advocacy for repositioning the Family Planning Program at all levels, for achieving population stabilization and reducing the maternal, infant and child mortality and morbidity.
- Ensuring the Fixed Day Static Services round the year.
- Rolling out the comprehensive training plan for development of trained human resources in family planning services which has been an area of concern for a long time.
- Promoting male participation
- Increasing the thrust on Post-partum Family Planning services.
- Organizing state Family Planning dissemination workshops countrywide.
- State wide dissemination of IEC/BCC and advocacy materials.
- Increasing the basket of choices in contraceptives offering more options to the clients.
- Strengthening contraceptive logistics (Decentralization of procurement): allowing state/ districts to procure NSV instruments / IUD kits/ Laparoscopes through the flexi pool
- Revised monitoring strategy is being put in place with a clear road map for states to achieve dual goals of population stabilisation and better reproductive health:

  a. Development of key performance indicators for input, process and output

  b. Categorisation of states based on TFR

  c. Analysing states' performance on the basis of

information available through survey, HMIS, review mission reports etc.

d. Conducting visit to states to corroborate the findings of above analysis and analysing underlying causes for poor performance which would lead to the way forward.

e. Analysis of information with implication for follow-up action.

9.6 CONTRACEPTIVES IN THE NATIONAL FAMILY WELFARE PROGRAMME

The Department of Health and Family Welfare is responsible for implementation of the National Family Welfare Programme by interalia, encouraging the utilization of contraceptives and distribution of the same to the States/UTs through Free Supply Scheme and Public-Private Partnership (PPP) under Social Marketing Scheme. Under Free Supply Scheme, contraceptives, namely, Condoms, Oral Contraceptive Pills, Intra Uterine Contraceptive Device (IUCD), Emergency Contraceptive Pills and Tubal Rings are procured and supplied free to the States/UTs.

9.6.1. The channel for supply of these contraceptives under Free Supply Scheme is Government network comprising Sub-Centers, Primary Health Centres, Community Health Centres and Govt. Hospitals, State AIDS Control Societies throughout the country.

9.6.2. Procurement procedures: Orders are placed on HLL Life Care Ltd. and IDPL (both PSUs) for procurement of contraceptives being manufactured by them as per Govt. instructions. For the remaining quantities, tenders are solicited from the firms through advertisement of Tender Enquiries for concluding Rate Contracts. Rate Contracts are concluded with the manufacturers and Supply Orders are placed upon them as per their competitive rates and the capacity to manufacture the items.

9.6.3. Quality Assurance: Manufacturers do in-house testing of stores before offering them for inspection. At the time of acceptance of stores, all the batches are tested and thereafter, stores are supplied to the consignees.

9.6.4. The quantities given to the States under Free Supply Scheme during the last two years and the current year (upto November, 2010) along with the budget utilized are given in the following tables:

Quantities supplied to States/UTs

Contraceptives	2008-09	2009-10	2010-11 (upto Nov. 10)
Condoms(In million pieces))	320.322	642.427	389.030
Oral Pills(In lakh cycles)	616.677	123.000	255.000
IUDs (In lakh pieces)	41.686	31.000	72.510
Tubal Rings (In lakh pairs)	16.32	13.744	15.470
ECP(in lakh packs)	6.59	45.000	21.540
Pregnancy Test Kits(in lakhs)	217.48	217.48	78.500

Budget Utilization

(Rs. in Crore)

Contraceptives	2008-09	2009-10	2010-11 (up to Nov.,10)
Condoms	170.30	98.79	60.54
Oral Pills	11.90	4.12	8.54
IUDs	6.48	6.13	14.28
Tubal Rings	1.50	1.07	1.97
ECP	0.44	3.60	1.72
Pregnancy Test Kits	24.47	24.47	8.4460

9.7 SOCIAL MARKETING SCHEME

The National Family Welfare Programme initiated the Social Marketing Programme of Condoms in 1968 and that of Oral Pills in 1987. Under the Social Marketing Programme, both Condoms and Oral Pills are made available to the people at highly subsidized rates, through diverse outlets. The extent of subsidy ranges from 70% to 85% depending upon the procurement price in a given year. Both these contraceptives are distributed through Social Marketing Organizations (SMOs).

The SMOs are given Deluxe Nirodh condom at Rs.2.00 per packet of 5 pieces and this is sold @ Rs.3/- per packet of 5 pieces to the consumer. One cycle of Oral Pills, which is required for one month, is given to the SMOs @ Re.1.60/- and it is sold to the consumer @ Rs.3/- per strip (cycle) under the brand name-"Mala –D". Under the Social Marketing programme, currently three

Government brands and fourteen different SMOs brands of condoms are sold in the market. Similarly for Oral Pills, one Government brand and seven SMOs brands of Pills are sold. Based on the recommendation of the Working Group on Social Marketing of Contraceptives, SMOs have the flexibility to fix the price of branded condoms and OCPs within the range fixed by the Government.

9.8. AREA SPECIFIC PROJECTS FOR SOCIAL MARKETING

With a view to providing impetus to Social Marketing in selected regions/districts, area specific projects are initiated under the Social Marketing Programme. This endeavour has been undertaken in the States of Madhya Pradesh, Haryana, Andhra Pradesh, Bihar, Jharkhand and Orissa. During the year 2010-11, till November, 2010 no project under the scheme could be approved.

9.9. SALE OF CONDOMS (QUANTITY IN MILLION PIECES)

Sl. No.	Social Marketing Organisation	2008-09	2009-10	2010-11 (upto Nov., 2010)
1.	HLL Lifecare Ltd, Thiruvananthapuram	223.54	185.50	105.41
2.	Population Services International, Delhi	176.87	189.41	50.77
3.	Parivar Seva Sanstha, Delhi	61.19	34.32	11.95
4.	DKT, India, Mumbai	114.36	105.62	25.50
5.	World Pharma, Indore	11.60	3.60	0.00
6.	Janani, Patna	25.19	29.23	8.95
7.	Pashupati Chem. and Pharmaceutical Ltd., Kolkata	10.57	4.96	0.00
8.	Population Health Services(India)	75.71	97.34	21.68
9.	Sanskar Shiksha Samiti, Bhopal	…	…	…
	Total	**699.03**	**649.98**	**224.26**

9.10. SALE OF ORAL CONTRACEPTIVE PILLS (QUANTITY IN LAKH CYCLES)

Sl. No.	Social Marketing Organisation	2008-09	2009-10	2009-10 (Upto Nov. 2010)
1.	HLL Lifecare Ltd, Thiruvananthapuram	122.00	66.21	58.01
2.	Population Services International, Delhi	69.01	63.40	54.17
3.	Parivar Seva Sanstha, Delhi	30.66	25.00	7.86
4.	World Pharma, Indore	15.86	4.00	0.00
5..	DKT, India, Mumbai	102.54	120.50	30.08
6.	Eskag Pharma (Pvt.) Ltd., Kolkata	62.51	75.68	0.00
7.	Janani, Patna	21.43	22.90	7.58
8.	Population Health Services, Hyderabad	51.62	45.30	33.31
9	Sanskar Shiksha Samiti, Bhopal	0.10	0.00	0.00
10	PCPL, Kolkata	19.40	10.05	0.00
	Total	**495.13**	**433.04**	**191.01**

9.11. CENTCHROMAN (ORAL PILLS)

Since December 1995, a non-steroidal weekly Oral Contraceptive Pill, Centchroman (Popularly known as Saheli & Novex), to prevent pregnancy is also being subsidized under the Social Marketing Programme. The weekly Oral pill is the result of indigenous research of CDRL, Lucknow. The pill is now available in the market at Rs.2.00 per tablet. The Government of India provides a subsidy of Rs.2.59 per tablet towards product and promotional subsidy.

9.12. PERFORMANCE OF SOCIAL MARKETING PROGRAMME IN THE SALE OF CONTRACEPTIVES

Contraceptives	2008-09	2009-10	2010-11 (Upto Nov., 2010)
Condoms(Million pieces)	699.03	649.98	224.26
Oral Pills (lakh cycles)	495.13	433.04	191.01
Centchroman (Saheli/ Novex) Weekly Oral Pills (lakh tablets)	181.07	203.94	32.94

9.13. EMERGENCY CONTRACEPTIVE PILLS[ECP]

Department of Health &Family Welfare introduced 'Emergency Contraceptive Pills' (E- pills) in the National Family Welfare Programme during the year 2002-03. This contraceptive is used within 72 hours of un-protected sex. The following quantities of E-pills were procured during the years 2008-09, 2009-10 & 2010-11 (upto Nov.2010).

Quantity procured (in lakh packs)			
Item	2008-09	2009-10	2010-11 (Nov.2010)
ECP	5.50	45.000	21.54

9.14. PREGNANCY TEST KITS

Orders have been placed on HLL Lifecare Ltd, (a PSU under the Ministry), for procurement of 2,17,48,200 Pregnancy Test kits each during the year 2008-09, 2009-10 and 2010-11 for free-of-cost supply for timely and early detection of pregnancy. The kits are home-based and easy to use.

9.15 COPPER-T

Under the National Family Welfare Programme, Cu-T-200B was being supplied to the States/UTs. From 2003-04, advanced version of Intra Uterine Contraceptive Device i.e.IUCD-380-A has been introduced in the Programme. This Cu.-T has longer life of placement in the body and thus provides protection from pregnancy for a period of about 10 years. Now the advanced version of IUCDs i.e.IUCD-380A is being procured and supplied to the States/UTs.

ANNEXURE 1:

Number and percentage of family planning users, by states: 2010-11

State/UT/ Agency	Total Sterilization acceptors during April to September		IUD Insertions during April to September		OCP Users during April to September		Condom Users during April to September	
	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10
I. High Focus North-East								
Arunachal Pradesh	528	46.7	1,277	4.8	1317	20	679	57
Assam	28,544	32.5	18,664	14.5	65,821	25	52,680	44
Manipur	640	79.8	2,490	-6.5	3,904	103	2442	-8
Meghalaya	1,033	6.3	1,777	62.6	5,446	9	3,756	3
Mizoram	1,359	-2.2	1,625	56.6	6,909	17	4,801	26
Nagaland	643	-10.4	781	-32	575	-5	706	93
Sikkim	71	.	1,017	52.7	4,406	-1	2383	-36
Tripura	1,540	-15.3	822	-47.1	4,245	-70	6,770	-8
II. High Focus Non North-East								
Bihar	38,035	12.5	93,454	9.4	48,083	15	81,918	31
Chhattisgarh	28,077	5.3	50,659	1.4	98346	-16	159,055	-23
Himachal Pradesh	1,821	-10.8	10,140	-13.8	23,282	-19	81,908	-21
Jammu & Kashmir	3,287	-8.7	9,216	-14.4	16,338	24	25,921	7
Jharkhand	26,665	118.1	59,460	35.1	92560	7	134,974	-16
Madhya Pradesh	112060	77.8	175876	-24.7	400672	-16	664511	-33
Orissa	29,300	62.4	58,283	-5.1	136736	-25	178,024	-30
Rajasthan	86,725	-1.4	258264	3.8	700969	-19	1,326,489	-18
Uttar Pradesh	53,377	-25.6	575094	-25.3	249664	-66	580,930	-41
Uttarakhand	3,939	-26.7	31,907	-39.1	20,181	-58	38,591	-44
III. Non-High Focus Large								
Andhra Pradesh	391607	-8.4	177431	-11.2	301685	-9	701091	-12
Goa	1954	-18.2	1088	0.6	3903	17	1598	10
Gujarat	87879	-13	256110	-9.8	255353	-12	660135	-35
Haryana	37210	-3.6	85784	-5.6	54337	-38	132796	-56
Karnataka	166709	-16.4	113211	-17.6	117126	-28	227275	-2

State/UT/ Agency	Total Sterilization acceptors during April to September		IUD Insertions during April to September		OCP Users during April to September		Condom Users during April to September	
	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10	2010-11	% Change from 2009-10
Kerala	52544	4	29418	-4.2	10071	-61	83478	-24
Maharashtra	163432	-24.9	153529	-14.8	190143	-32	308440	-29
Punjab	43044	12.6	105769	-22.9	78100	-22	388956	-3
Tamil Nadu	169890	-2.5	172911	10.1	107647	-3	169734	3
West Bengal	88523	-11.6	34269	-15.7	586412	-4	516323	-6
IV. Non-High Focus Small & UTs								
A &N Islands	224	-43.1	80	-85.7	416	-76	203	-90
Chandigarh	1024	15.4	1,727	-11.6	699	-32	13,064	-9
Dadra & Nagar Haveli	250	-51.7	71	14.5	183	-16	1162	39
Daman & Diu	55	.	39	.	118	.	457	.
Delhi	8,522	3.3	21,680	41.7	16,540	17	106,266	6
Lakshadweep	14	366.7	10	-50	3	.	76	-35
Puducherry	5,604	11.9	1,143	-21	2,280	-11	9,006	-12
V. Other Agencies								
M/O Defence	1,279	-69.1	1,127	-59.2	1,128	-65	8,448	-69
M/O Railways	1,466	-14.2	1,123	-20.1	2,354	-30	17,584	-32
All India	**1,638,874**	**-4.8**	**2,507,326**	**-12.8**	**3,607,952**	**-23.2**	**6,692,630**	**-23.2**

Note: Collated from HMIS Periodic RCH Reports (accessed on 29th November 2010), Provisional Figures (Status as on: Oct 28, 2010)

Training Programme

10.1 INTRODUCTION

One of the key components of the "architectural correction" envisaged under the NRHM is to strengthen community participation in all health programmes. Community participation is not to be limited to the community acting only as beneficiaries, but rather playing an active role in the design, implementation and monitoring of health programmes.

The major schemes through which community processes are strengthened are:

a. ASHA programme;

b. Village Health and Sanitation Committee (VHSC);

c. Un-tied fund provided to the sub-center and VHSC;

d. Rogi Kalyan Samitis (RKS) (or Hospital management committees) as a vehicle for public participation in facility management and the provision of un-tied funds for this purpose;

e. District health societies and the district health planning process;

f. Community monitoring programme and

g. Involvement of NGOs/private sector in the mother NGO programme and public- private partnerships.

10.2 ASHA UNDER NRHM

The National Rural Health Mission initiated in 2005, rolled out the ASHA programme in a 'Mission Mode', scaling up simultaneously in several states.

Of the community based programmes, NRHM's most well known and talked about face, is undoubtedly the ASHA programme. Going by national and international experience, community health worker programmes have the potential to make a significant, if not massive, positive contribution to community health and awareness and to impact favourably on major MDG indicators like child survival. There is a need, therefore, to strengthen the ASHA programme and other communitisation initiatives so that much greater outcomes are realized.

All reports and evaluations show that the ASHA programme appears to be making a positive impact. However most assessments also show that there are significant gaps in the implementation of each of these programmes in the states and some process of active support to address these gaps is essential.

10.3 SELECTION OF ASHAS

The general norm for selection is 'one ASHA per 1000 population'. In tribal, hilly and desert areas the norm may be relaxed to one ASHA per habitation.

ASHAs are necessarily a woman resident in the village, preferably married and in the age group of 25 to 45 yrs. ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class, which can be relaxed if suitable women with this qualification are not available. Selection of ASHAs are done by the community, and actively facilitated to ensure that weaker sections participate in the selection. Selection has to be endorsed by the gram panchayat.

10.4 PROGRESS MADE IN SELECTION OF ASHAS

Of the targeted 8,99,986 ASHAs in the country; 8,42,654 (93.6%) ASHAs have been selected. Progress made in selection and training of ASHAs (as on December 2010) is given in table-1.

Table-1: State wise status of ASHA selection and training of ASHAs up to Dec. 2010

	Name of states	Selection Target of ASHA	ASHA selected	Percentage of selection	ASHA Training					
					† Module I	Module II	Module III	Module IV	Module V	Module VI
EAG	**Bihar**	87,135	78,973	90.63	69402	52859	52859	52859		TOT Done
States	**Chhattisgarh**	60092	60092	100.00	60092	60092	60092	60092	60092	
	Jharkhand	40964	40964	100.00	40115	39482	39214	35675	40964	TOT Done
	MP	52117	50113	96.15	48159	44938	44518	42426	808	TOT Done
	Orissa	41,102	40932	99.59	40765	40763	40763	40763	39657	TOT Done
	Rajasthan	48372	43787	90.52	40310	33811	32652	35499	TOT Done	TOT Done
	UP	136268	136182	99.94	135130	128434	128434	128434	TOT Done	
	Uttarakhand	11086	11086	100.00	11086	11086	11086	11086	8978	8750
NE										
	Arunachal	3862	3629	93.97	3426	3305	3324	2906	2497	756
States										
	Assam	29693	28798	96.99	26225	26225	26225	26225	23271	
	Manipur	3878	3878	100.00	3878	3878	3878	3878	3878	TOT Done
	Meghalaya	6258	6258	100.00	6175	6175	6175	6175	3427	
	Mizoram	987	987	100.00	987	987	987	987	987	TOT Done
	Nagaland	1700	1700	100.00	1700	1700	1700	1700	1700	TOT Done
	Sikkim	666	666	100.00	666	666	666	666	666	TOT Done
	Tripura	7367	7367	100.00	7367	7367	7367	7367	7362	TOT Done
Non-EAG	**Andhra Pradesh**	70700	70700	100.00	70700	70700	70700	70700	70700	TOT Done
	Delhi	5400	3200	59.26	2680	2138	2075	1276	0	

	Name of states	Selection Target of ASHA	ASHA selected	Percentage of selection	ASHA Training					
					† Module I	Module II	Module III	Module IV	Module V	Module VI
	Gujarat	31438	29675	94.39	28809	28052	26373	24201	13589	TOT Done
	Haryana	14000	13098	93.56	12825	12169	12169	12169	5097	
	Himachal Pradesh	18248	16888	92.55	16888	0	0	0	0	
	J & K	9764	9500	97.30	9500	9000	9000	9000	5711	TOT Done
	Karnataka	39195	32939	84.04	32939	32939	32939	32939	32939	TOT Done
	Kerala	32854	31868	97.00	30719	29223	25534	20544	697	
	Maharashtra	60457	58954	97.51	56854	46580	8464	8038	7029	TOT Done
	Punjab	17360	17014	98.01	15481	14026	14026	14026	0	
	Tamil Nadu	6850	2650	38.69	2650	2650	0	0	0	
	West Bengal	61008	39736	65.13	29552	25465	21666	19663	17195	TOT Done
UTs										
	Andman & Nicobar	407	407	100.00	407	407	184	49	49	
	Chandigarh	423	423	100.00	-	-	-	0		
	Dadra and Nagar Haveli	250	107	42.80	85	85	85	85	85	
	Lakshadweep	85	83	97.65	83	83		0	0	
	Daman & Diu	NA								
	Goa	NA								
	Pondichery	NA								
Total	†	**8,99,986**	**8,42,654**	**93.60**	**8,05,655**	**7,35,285**	**6,83,155**	**6,69,428**	**3,47,378**	**9,506**

As one can see from the above Table-1, high focus states has selected over 90% of proposed number of ASHAs. The lower figure in MP is as a result of a recent modification to one ASHA per Anganwadi centre (AWC) instead of previous one ASHA per thousand populations. In the north east the figures are even better with the entire process being complete and with much better densities as appropriate to the low population density.

Chhattisgarh has a widely dispersed population and had therefore, opted for one Mitanin per habitation- a total of 54,000 habitations. This gives a ratio of one per just 300 population. GOI agreed to finance the programme using

29347 as the number of ASHAs – as this was the number of anganwadis in place.

In other states and union territories till the beginning of 2009, ASHAs were sanctioned only for tribal areas, which were less than 10% of the blocks. Since January 2009, the programme has been expanded to the whole nation. Some states have availed of this and others have not. It is worth noting that Tamilnadu and Himachal Pradesh which had not opted for this scheme so far have done so this year –leaving only Goa and a couple of Union territories without the ASHA programme.

10.5 TRAINING OF ASHAS

Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives. Training of ASHA is thus a continuous process. ASHAs are trained by block trainers who mostly are women- who are chosen at block level are trained by a district training team who in turn are trained by the state training team.

Considering the range of functions and tasks to be performed, induction training is imparted over in 23 days spread over a period of 18 months. After the induction training, periodic refresher training is planned for about 12 to 24 days per year. In many states, existing NGOs, especially those working on community health issues at the district / block level, have been entrusted with the responsibility for identifying trainers and conducting of TOTs. Progress in Training varies across the states. Most states have completed an average 16 to 19 days of training, and few states are working on the sixth round of training.

10.6 ASHA SUPPORT STRUCTURE

The success of ASHA scheme depends upon how well the scheme is implemented and monitored. It is also depends crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme. It is therefore, necessary that well defined and yet flexible and participatory institutional structures are put into place at all levels from state to village.

(1) The District Health Society under the chairmanship of the District Magistrate/President Zila Parishad oversees the selection process. The Society had designated a District Nodal Officer and a Block Nodal Officer. The job of the Nodal Officers at the District and Block are to facilitate the selection process by involving the Gram Sabha and Gram Panchayat, holding of training for ASHA and for trainers as per the guidelines of the scheme.

(2) At the village level- women's committees (like self help groups or women's health committees), Village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training are major source of support to ASHA.

(3) District ASHA training team/resource centre. There are full time staff hire to play this role.

(4) Block coordinators and sub-block facilitators: For every 15-20 ASHAs one facilitator is deployed and to coordinate 10 such facilitators a block coordinator is deployed.

District mobilisers are in place in Orissa, Uttarakhand, UP and Jharkhand and almost there in Rajasthan and Madhya Pradesh. Rest of the states are yet to start, Sub-district facilitators are in place in Uttarakhand and Orissa only.

State ASHA Resource Centers or equivalent institution has been established in Uttarakhand, Jharkhand, Orissa Assam, Jharkhand and Rajasthan. Chhattisgarh has the SHRC playing this role. Other states have to start this up and there is a long way to go to make it effective.

10.7 ASHA MENTORING GROUP

The Government of India has set up an ASHA Mentoring Group comprising of leading NGOs and well known experts on community health.

There are 17 members in National ASHA Mentoring Group representing renowned NGOs across the country. Each member of National Mentoring Group has designated for particular states where they are making visit and providing guidance and advice on matter related to selection, training, payment of incentives etc. National Health Systems Resource Centre is secretariat for National ASHA mentoring group. Similar mentoring groups at the State level has been to provide guidance and advise on matter relating to selection, training and support for ASHA

State ASHA mentoring group is functional in Uttarakhand, Chhattisgarh, Orissa, Madhya Pradesh, Uttar Pradesh, Jharkhand, Rajasthan, Kerala, Assam, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Sikkim, and Tripura. The administration has to recognize the need for bureaucracy to be guided by the best of civil society in theory and practice of community health worker programmes.

10.8 PERFORMANCE BASED INCENTIVES

Responsibilities of ASHAs that currently are incentivized includes; promoting institutional delivery, promoting immunization, DOT provider, Malaria slide collection.

Most states have an integrated list of incentive package for ASHAs with information on various activities of ASHAs with amount of incentive attached to it. In most States, the bulk of ASHAs' incentive are from JSY and immunisation. It has been suggested to the States to expand the activities and attached incentive to it. The mode of payment by cheque has been operationalise in most of the states. The major reason for success in streamlining ASHA incentive payment in some states are ; payment by cheque, a designated point person at district, block and sector level reviews to handle issues relating to ASHA incentive payment, and tight monitoring, and certification of those PHCs having no backlog of incentive payment to ASHAs.

10.9 ASHA DIARY & VILLAGE HEALTH REGISTER

Two simple tools essential for strengthening the ASHA programme, which all states are putting in place are the ASHA diary and the other is the village health register. The ASHA diary is a simple record of all the works she does, as and when she does it. It is a useful tool for supportive supervision of her work, a data source for village health planning and an important tool for performance.

The Village Health Register (VHR) is an important tool for ensuring access and completion of service delivery, and a major source of information for village level health planning. The Village Health Register provides household and family level data. The VHR is a vehicle for tracking eligible couples, children below 3 (for immunization) and pregnant women to ensure that they receive the services they need. It can also record incidents of serious illness in each family.

10.10 ASHA DRUG KITS

In almost all states, drug kits have been distributed to ASHAs. Across the country, 6, 11,821 ASHAs have received drug kit till Dec. 2010. States are now moving on mechanisms of drug kit replenishment. Govt. of India has recently issued a guideline for regular refilling drug kits and maintaining stock card.

10.11 VILLAGE HEALTH & NUTRITION DAY

Monthly Health and Nutrition day is expected to be organized in every village (Anganwadi centers) with the help of AWW/ANM. ASHA along with AWW mobilizes women, children and vulnerable population for the monthly health day activities like immunization, careful assessment of nutritional status of pregnant/lactating women, newborn & children, ANC/PNC and other health check-ups of women and children, taking weight of babies and pregnant women etc. and all range of other health activities. A total of 23619245 monthly village health and nutrition days has been organized till September 2010 across the country.

10.12 ASHA INNOVATIONS

There is a wide variety of state specific innovations in this programme. To name a few; ASHA gruha (rest house in Orissa), Mitanin help desk (in Chhattisgarh), ASHA Diwas (monthly review meeting- in UP), ASHA radio programme (in Assam, Chhattisgarh, Manipur and Tripura), bicycles for ASHA, Swasth Chetan Yatra (in Rajasthan) and so on.

10.13 COMMUNITY MONITORING PROGRAMME

Community-based Monitoring of health services is a key strategy of National Rural Health Mission (NRHM) to ensure that the services reaches to those for whom they are meant for, especially for those residing in rural areas, the poor, women and children. Community Monitoring is also seen as an important aspect of promoting community led action in the field of health. The provision for Monitoring and Planning Committees has been made at Primary Health Centre (PHC), Block, District and State levels. Community monitoring is to review the progress to ensure that the work is moving towards the decided purpose. Community monitoring helps in identifying and meeting the challenges in the field. The process of Community Monitoring is taking place across nine states (Assam, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan, Maharashtra, Tamil Nadu, Karnataka and Orissa).

10.14 CENTRALLY SPONSORED SCHEME OF ìBASIC TRAINING OF ANM/LHVî

ANMs/LHVs play a vital role in MCH and Family Welfare Service in the rural areas. It is therefore, essential that the proper training to be given to them so that quality services be provided to the rural population.

For this purpose 319 ANM/Multipurpose Health Worker (Female) schools with an admission capacity of approximately 13,000 & 34 promotional training schools for LHV/ Health Assistant (Female) with an admission capacity of 2600 are imparting pre-service training to prepare required number of ANMs and LHVs to man the Sub centres, Primary Health Centres, Community Health Centres, Rural Family Welfare Centres and Health posts in the country. The duration of training programme of ANM is one and half years and minimum admission requirement for this course is 10th pass. Senior ANM with five years of experience is given six months promotional training to become LHV/ Health Assistant (Female). Health Assistant(Female) provides supportive supervision and technical guidance to the ANMs in sub-centres. Curricula of these training courses are provided by the Indian Nursing Council.

The staffing pattern of the school for, which financial assistance is provided by the Department of Family Welfare, varies according to the annual admission capacity of the school. The financial pattern of assistance has been revised w.e.f. 7.2.2001. Other approved costs besides salary to staff are stipend to trainees, contingency and rent.

Item	Norm (in Rupees)	
1.	Salary & allowances of staff	As per State Government
2.	Stipend for trainees	500/- per month/trainee
3.	Contingency	10,000/- per annum /school
4.	Rent*	60,000/- per annum/school

* Rent payable in respect of such schools, which are functioning in rented buildings

Funds under the scheme are released by Family Welfare Budget Section on the basis of audited accounts submitted by States and unspent balance with states. Under the scheme during 2010-11 under BE Rs.8517.95 lakhs were available.

10.15 CENTRALLY SPONSORED SCHEME OF ìBASIC TRAINING FOR MULTI PURPOSE HEALTH WORKER (MALE)î

The Basic Training of Multi Purpose Health Worker (Male) scheme was approved during 6th Five-Year Plan and taken up since 1984, as a 100% Centrally Sponsored Scheme. This training is provided through forty nine basic training schools of Multipurpose Health Workers (Male). The training is of one-year duration and on successful completion of the training, the Male Health Worker is posted at the sub-centre along with an ANM/Health Worker (Female).

The financial pattern of assistance for this scheme has been revised since 7.2.2001. Under the scheme the **salary of the staff**, rent for school and hostel, stipend for trainees, educational aids and training material, transportation and contingency are supported.The financial norms are as follows:

Item	Norm
Rent (for basic schools)	Rs. 10,000 / month
Rent for hostel (for basic schools)	Rs. 250 / month per candidate
Stipend	Rs. 300 / month / candidate
Educational Aids and Training Material	Rs. 15,000 per annum
Transportation (for hiring bus)	Rs. 30,000 per annum
Contingency	Rs. 50,000 per annum

Funds under the scheme are released by Family Welfare Budget Section on the basis of audited accounts submitted by States and unspent balance with states. Under the scheme during 2010-11 under BE Rs.1233.97 lakhs were available.

10.16 MAINTENANCE OF HEALTH AND FAMILY WELFARE TRAINING CENTRE

49 Health and Family Welfare Training centres were established in the country in order to improve the quality and efficiency of the Family Planning Programmes and to bring the changes in the attitude of the personnel

engaged in the delivery of health services through in service training programmes. These training centres are supported under Centrally Sponsored Scheme of "Maintenance of Health and Family Welfare Training Centre".

These training centres are now conducting various in-service training programmes of Department of Family Welfare. Apart from in-service education some of the selected centres are also responsible for conducting the basic training of Male Health Worker's course of one year.

Apart from the salary of the staff of the training centres, other assistance under the scheme includes contingency for purchase of educational material, rent for training centres and payment to guest faculty. The financial pattern of assistance for this scheme has been revised since 7.2.2001. The details of the financial norms are as follows:

Item	Norms
Contingency	Rs. 15,000 per annum
Rent*	Rs. 40,000 per annum
Payment to Guest Faculty	Rs. 50,000 per annum

*Rent payable in respect of such centres that are functioning from rented buildings.

Funds under the scheme are released by Family Welfare Budget Section on the basis of audited accounts submitted by States and unspent balance with states. Under the scheme during 2010-11 under BE Rs.1905.00 lakhs were available.

10.17 TRAINING ACHIEVEMENT

Details regarding the total number of persons trained since beginning of the programme under each of the above training activities reported up to 31 December 2010 are given in the consolidated table below:-

Type of Training		Cumulative Progressup to 31/12/2010
Integrated Service Delivery under NRHM	National Level	280
	State Level	393
PDC	National & State	1366
PMU	National Level	305
	State Level	2606
	Workshop	324
SBA	National Level	121
	State Level	6528
	District Level	40182
BEmOC	State and District Level	351
Contraceptive Update	National Level	133
	State Level	13506
IUD – 380 A Training	National Level	164
	State & Dist. Level	23789
NSV	Dist. Level	2220
Laparoscopic sterilization	State Level	4259
Minilap	District Level	9617
MTP	State and District Level	8886

Type of Training		Cumulative Progressup to 31/12/2010
IMNCI	State & District Level	191249
F-IMNCI	State Level	648
	District Level	2418
NSSK	State Level	519
	District Level	21217
SNCU	District Level	168
RTI\STI	State & District Level	4372
Anesthesia	State Level	1140
	District Level	193
EmOC	State & District Level	2584
Blood Storage		785
Immunization	State Level	774
	District Level	22648
ARSH	District Level	6351
Specialized Clinical Skill Training	National Level	91
	State and District Level	64643
Other Disease Control Programme		
NVBDCP	MOs	10089
	Lab. Techns.	1779
	Other Paramedical Staff	40653
RNTCP	MOs	42454
	Lab. Techns.	7471
	Other Paramedical Staff	123887
NLEP	MOs	6227
	Other Paramedical Staff	3106
NCBP	MO	1479
	Pharma & GNM	150
	Teacher	1062
IDSP	MOs	20126
	Lab. Techns.	5302
	Other Paramedical Staff	2272
Routine Immunization	MOs	887
	Others paramedical staff	41921
Other Trainings	State and District Level	10711

Other National Health Programmes

Several National Health Programmes are now under the umbrella of NRHM. Details of other National Health Programmes are in this chapter.

11.1. NATIONAL PROGRAMME FOR CONTROL OF CANCER, DIABETES, CVD AND STROKE (NPCDCS)

11.1.1 India is experiencing a rapid health transition with a rising burden of Non Communicable Diseases (NCDs). According to a WHO report (2002), cardiovascular diseases (CVDs) will be the largest cause of death and disability in India by 2020. Overall, NCDs are emerging as the leading causes of death in India accounting for over 42% of all deaths (Registrar General of India). NCDs cause significant morbidity and mortality both in urban and rural population, with considerable loss in potentially productive years (aged 35–64 years) of life.

It is estimated that the overall prevalence of diabetes, hypertension, Ischemic Heart Diseases (IHD) and Stroke is 62.47, 159.46, 37.00 and 1.54 respectively per 1000 population of India. There are an estimated 25 Lakh cancer cases in India at any point of time. The leading sites of cancer are oral cavity, lungs, oesophagus and stomach among men and cervix, breast and oral cavity amongst women. Non-communicable diseases – especially cardiovascular diseases, cancers, chronic respiratory diseases and diabetes caused 60% of all deaths globally in 2005. Total deaths from NCDs are projected to increase by a further 17% over the next 10 years. These diseases are largely preventable by modifying the four common risk factors: tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

To address Non-communicable diseases, Ministry has formulated a National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) after integrating the National Cancer Control Programme (NCCP) with National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPDCS). Government of India has approved the programme at an estimated outlay of Rs. 1230.90 crore for the remaining period of the 11th Five Year Plan. The programme focuses on health promotion, capacity building including human resource development, early diagnosis and management of these diseases and integration with the primary health care system.

The major objectives of the NPCDCS are briefly listed below:

- Prevent and control common NCDs through behaviour and life style changes,
- Provide early diagnosis and management of common NCDs,
- Build capacity at various levels of health care for prevention, diagnosis and treatment of common NCDs.
- Train human resource within the public health setup viz doctors, paramedics and nursing staff to cope with the increasing burden of NCDs, and
- Establish and develop capacity for palliative & rehabilitative care.

11.1.2 ***Strategies:***

The programme will be implemented in 20,000 Sub-Centres and 700 Community Health Centres (CHCs) in 100 Districts across 21 States/UTs and the strategies **are** as under:

(i) **Promotion of healthy lifestyle** through massive health education and mass media efforts at country level regarding increased intake of healthy foods, increased physical activity through sports, exercise, etc., avoidance of tobacco and alcohol and stress

management through awareness generation using community education and interpersonal communication methods and social mobilization through NGOs.

(ii) **Opportunistic screening** of persons above the age of 30 years at the point of primary contact with any health care facility, be it the village, community health centre, district hospital, tertiary care hospital etc. Such screening involves simple clinical examination comprising of relevant questions and easily conducted physical measurements (such as history of tobacco consumption and measurement of blood pressure etc.) to identify those individuals who are at a high risk of developing cancer, diabetes and CVD, warranting further investigation/ action. Screening at the community level will be done by the frontline health workers - ANM and Male Health Worker in sub-centres located for every 5000 population.

(iii) **ëNCD clinicí** will be established at the Community Health Centre (CHC) located at block headquarter for every 1, 00,000 population for comprehensive examination of patients to rule out common NCDs. Screening, diagnosis and management (including diet counselling, lifestyle management) and home based care and referral will be the key services provided at this level of care.

(iv) At all selected **100 District hospitals a ëNCD clinicí** will be established for prevention and management of cancer, diabetes, hypertension and acute cardiovascular diseases including emergency care. District level health facilities will be strengthened for early diagnosis, prompt treatment, chemotherapy (including day care facilities), palliative care and rehabilitative measures including the required level of blood banking and laboratory support. District hospitals will also be strengthened for early detection of cervix cancer, breast cancer and other common cancers.

(v) **Development of trained manpower** with required skills and competencies by providing customised short term training in diabetology, cancer management, cardiovascular diseases, etc. to existing doctors, in the departments of medicine surgery and gynaecology and training in cytology to the pathologist. Non availability of these subspecialties in district level hospitals and below is a severe constraint for scaling up these services to rural areas.

(vi) **Strengthening of Tertiary level health facilities:** 65 Government Medical Colleges/ Government Hospitals will be strengthened as Tertiary Cancer Centres (TCC) to provide comprehensive cancer care services, training and research. 20 TCCs in 2010-11 and 45 TCCs in 2011-12 will be strengthened. These centres will have a high degree of specialization and comprehensive provision of all of the facets of cancer care necessary in modern cancer management. These will also be centres of Human Resource Development in the field of Cancer e.g. Capacity building for initiating/strengthening of courses in Medical/ Surgical/ Radiation/ Gynaecology Oncology etc.

(vii) **Monitoring & Evaluation:** Monitoring and supervision of the programme will be carried out at different levels through NCD cell through reports from the state, regular visits to the field and periodic review meetings. A NCD cell will be established at the National, State and District levels. This cell will be responsible for overall planning, coordination, implementation and monitoring of the programme.

During the 11th Five Year Plan, the NPCDCS will be implemented in 100 Districts. 30 districts will be taken up in 2010-11 and 70 will be added in 2011-12. List of the 21 States along with the list of 30 districts selected for the year 2010-11 is given below:-

S. No.	States	Districts	CHCs	Sub Centres
1	Andhra Pradesh	Nellore	6	481
		Vijayanagaram	7	470
2	Assam	Dibrugarh	6	240
		Jorhat	4	142
3	Bihar	Vaishali	2	336
		Rohtas	1	186
4	Chhattisgarh	Bilaspur	10	379
5	Gujarat	Gandhi Nagar	6	171
		Surendranagar	11	200
6	Haryana	Ambala	3	102

7	Himachal Pradesh	Chamba	7	170
8	Jammu & Kashmir	Leh (Ladakh)	3	24
		Udhampur	2	97
9	Jhankhand	Bokaro	8	116
10	Karnataka	Shimoga	11	307
		Kolar	6	201
11	Kerala	Pathanathitta	13	230
12	Madhya Pradesh	Ratlam	5	158
13	Maharashtra	Washim	7	153
		Wardha	6	181
14	Sikkim	East Sikkim	0	48
15	Orissa	Naupada	4	95
16	Punjab	Bhatinda	9	136
17	Rajasthan	Bhilwara	16	415
		Jaisalmer	6	136
18	Uttrakhand	Nainital	4	136
19	Tamil Nadu	Theni	6	162
20	Uttar Pradesh	Rae Bareli	11	377
		Sultanpur	14	403
21	West Bengal	Darjeeling	11	230
	TOTAL	**30 Districts**	**205**	**6482**

11.1.3. New Initiatives:

(i) Urban Health Check-up Scheme for Diabetes and High Blood Pressure:

14th November every year, is being observed as World Diabetes Day as an official United Nations Day since 2007. The day marks the birthday of Frederick Banting who discovered insulin in 1922. An **Urban Health Check-up Scheme** for Diabetes and High Blood Pressure in Urban Slums was launched on 14th November, 2010 at Baba Ramdev Park, New Delhi. In the first phase, the scheme will be initiated in seven metros, viz. Delhi, Bangaluru, Hyderabad, Kolkata, Mumbai, Chennai and Ahmedabad.

The scheme has the following objectives:

1. To screen urban slum population for diabetes and high blood pressure
2. To create database for prevalence of diabetes and high blood pressure in urban slums
3. To sensitize the urban slum population about healthy lifestyle.

The Blood sugar and Blood pressure will be checked for all ≥ 30 years and all pregnant women of all age.

11.1.4. ***Ongoing Activities:***

(i) **Membership of IARC:** International Agency for Research on Cancer is a specialized agency of WHO to coordinate International Cooperation in Cancer Research. India has become a member of IARC at the 48th Session of the governing Council of IARC held in May 2006 at Lyon, France, which shall provide a fillip to cancer research in the country. IARC has extended technical and financial support for several cancer research and preventive projects in India.

(ii) **National Cancer Awareness Day**: The birth anniversary of Nobel Laureate Madam Curie, 7th November is being observed as National Cancer Awareness Day since 2001, to create more awareness about cancer. Like the previous years, this year too awareness generation activities were carried through from 6th November to 13th November 2010 through All India Radio (AIR), Doordarshan, News Papers, Delhi Metro Rails and DTC Bus Shelters.

(iii) 'Kalyani' is a health programme telecast in 9 capital Doordarshan stations and 12 sub regional stations by Prasar Bharti targeting especially those living in the most populous States. It is an interactive programme which provides an interface to the people with experts on various health and social issues including that of cancer.

(iv) **Awareness generation** for cancer, diabetes and healthy life style was also done during the Common Wealth Games 2010 through live broadcast in AIR.

Budget Allocation: The budget allocation during 2010-11 for NPCDCS is Rs. 326.76 crore.

11.2. NATIONAL MENTAL HEALTH PROGRAMME

11.2.1 Burden of mental health disorders:

Prevalence of mental disorders as per World Health Report (2001) is around 10% and it is predicted that burden of disorders is likely to increase by 15% by 2020. According to various community based surveys, prevalence of mental disorders in India is 6-7% for common mental disorders and 1-2% for severe mental disorders. With such a magnitude of mental disorders it becomes necessary to promote mental health services for the well being of general population, in addition to provide treatment for mental illnesses. Treatment gap for severe mental disorders is approximately 50% and in case of Common Mental Disorders it is over 90%.

National Mental Health Programme(NMHP) was started in 1982 with the objectives to ensure availability and accessibility of minimum mental health care for all, to encourage mental health knowledge and skills and to promote community participation in mental health service development and to stimulate self-help in the community. Gradually the approach of mental health care services has shifted from hospital based care (institutional) to community based mental health care, as majority of mental disorders do not require hospitalization and can be managed at community level.

NMHP evaluation undertaken in 2008 identified following constraints for the effective implementation of NMHP -

- Lack of an inbuilt and dedicated monitoring and implementing mechanism for programme.
- Shortage of skilled manpower in Mental Health i.e. Psychiatrists, Clinical Psychologists, Psychiatric Social Workers & Psychiatric Nurses. This is a major constraint in meeting the mental health needs and providing optimal mental health services at the community level. Due to shortage of manpower in mental health, the implementation of DMHP suffered adversely in previous years.
- Lack of awareness /stigma about Mental Illness.
- Lack of facilities for treatment of mentally ill.
- Lack of coordination between implementing departments of DMHP i.e. Medical Education and Health in the states.
- Lack of Community involvement.

Taking into account these constraints, consultations were held with relevant stakeholders and components of NMHP were revised for XI five year plan.

11.2.2 *District Mental Health Programme-*

During IX five year plan, District Mental Health Programme was initiated (1996) based on Bellary Model developed by NIMHANS, Bangaluru. During the plan period, 27 districts were covered under DMHP. At present DMHP is covering 123 districts in 30 states and UTs. In addition to early identification and treatment of mentally

ill, District Mental Health Programme has now incorporated promotive and preventive activities for positive mental health which includes:

- *School Mental Health Services*: Life skills education in schools, counselling services
- *College Counselling services*: Through trained teachers /councillors
- *Work Place Stress Management*: Formal & Informal sectors, including farmers, women etc.
- *Suicide Prevention Services*- Counselling Center at District level, sensitization workshops, IEC, Help lines etc.

11.2.3 ***Manpower Development Schemes*** *:*

A. Establishment of Centre of Excellence in Mental Health- Centre of excellence in the field of mental health are being established by upgrading and strengthening identified existing mental health hospitals/ institutes for addressing acute manpower gap and provision of state of the art mental health care facilities in the long run. Eleven such Centre of excellence are envisaged for total budgetary support of up to Rs 338 crore (Rs 30 crore per center) for undertaking capital work, equipment, library, faculty induction and retention for the plan period. As of now 9 Mental Health institutes have been funded for developing as centers of excellence in Mental Health.

B. Establishment/up-gradation of Post Graduate Training Departments -To provide an impetus to development of Manpower in Mental Health other training centers(Government Medical Colleges/ Government General Hospitals/ State run Mental Health Institutes) would also be supported for starting PG courses or increasing the intake capacity for PG training in Mental Health. Support would be provided for setting up/strengthening 30 units of Psychiatry, 30 Departments of Clinical Psychology, 30 Departments of PSW and 30 Departments of Psychiatric Nursing. Total budget allocated for this scheme is Rs 70 crores during plan period with a limit of Rs 51 lacs to Rs 1 crore per PG Department. As of now, 23 PG departments have been taken up during the XI plan period.

11.2.4 ***Spill Over of X plan schemes-***

A. Modernization of State-run Mental Hospitals – A one time grant of up to Rs 3 crore per mental hospital is available under the scheme to old custodial pattern mental hospital for their modernization. A total of 29 mental hospitals/ institutes have been supported under this scheme.

B. Upgradation of Psychiatric wings in the government medical colleges/general hospitals. Some of the deserving areas where there is no well established government medical colleges, government general hospitals/district hospitals could be funded for establishment of psychiatry wing. A one time grant of Rs. 50 lacs per college is available for up-gradation of facilities and equipments. Preference would be given to colleges and hospitals planning to start or increase seats of PG courses in psychiatry. A total of 88 psychiatry wings have availed grant under this scheme.

11.2.5 ***Research and Training-***

There is a gap in research in the field of mental health in the country. Funds will be provided to institutes and organizations for carrying basic, applied and operational research in mental health field. In order to address shortage of skilled mental health manpower a short term skill based training will be provided to the DMHP teams at identified institutes. Standard Treatment Guidelines, Training Modules, CME, Distance Learning courses in mental Health, surveys etc will also be supported. Total allocation is Rs. 6.5 crore for the plan period.

11.2.6 ***Information, Education & Communication-***

It has been observed that there is low awareness regarding mental illness and availability of treatment. There is also lot of stigma attached to mental illness leading to poor utilization of available Mental Health resources in the country. The awareness regarding provisions under Mental Health Act, 1987 is also very low among the public and implementing authorities. These issues are addressed through IEC activities at the District level by the District Mental Health Programme. In addition to the district level activities, National Mental Health Programme Division conducts nationwide mass media campaign through audio-video and print media. Awareness activities are also conducted during World Mental Health Day, 10th October, 2010.

Print Media Campaign on World Mental Health Day 10th October,2010..

11.2.7 *Support for Central and State Mental Health Authorities*

As per Mental Health Act,1987, there is provision for constitution of Central Mental Health Authority (CMHA) at Central level and State Mental Health Authority(SMHA) at state level. These statutory bodies are entrusted with the task of development, regulation and coordination of mental health services in a state/UT and are also responsible for the implementation of Mental Heath Act,1987 in their respective states and union territories. States are required to have functional SMHAs to operationalize the mental health program activities. However in most of the states, there is no financial support for these bodies and as such they function in an ad-hoc manner and are unable to do justice to their statutory role of implementation of Mental Health Act,1987 and development of Mental Health services. Support under NMHP has been approved for SMHAs during the 11th Plan period. Total allocation is Rs. 5 crores.

11.2.8 *Monitoring & Evaluation*

In order to strengthen the monitoring and improve implementation of existing NMHP schemes in states support has been approved under the program during XI plan period. Total allocation is Rs. 8.0 crore for the plan period.

11.2.9 *Mainstreaming NMHP into NRHM*

Efforts are being made to mainstream the components of NMHP under the overall umbrella of National Rural Health Mission so that the States are able to plan requirements concerning mental health services as part of their respective PIPs.

11.2.10 *Expenditure statement under National Mental Health Programme*

Rs 1000 crore has been approved as XI plan outlay for the National Mental Health Program. Year wise financial

allocation for the NMHP and expenditure incurred is as given in the table below –

Financial Year	Allocation (Rs. In crore)	Expenditure (Rs. In crore)
2007-08	38	14 .57
2008-09	70	23.45
2009-10	55	52.27
2010-11	120 (including Rs. 53 crore GIA ad Rs. 17 crore for NE)	58.80 (Till date including Rs. 52.63 crore for GIA)

11.3. TOBACCO CONTROL LEGISLATION

11.3.1 Tobacco is the foremost preventable cause of death and disease in the world today. Globally approx. 5.4 million people die each year as result of diseases resulting from tobacco consumption. More than 80% of these deaths occur in the developing countries. Tobacco is a risk factor for 6 of the 8 leading causes of death. Nearly 8-9 lakhs people die every year in India due to diseases related to tobacco use. Nearly 30% of cancers in India are related to tobacco use. The majority of the cardio vascular diseases and lung disorders are directly attributable to tobacco consumption.

India is the second largest consumer (after China) of tobacco products in the world. As per Global Adult Tobacco Survey, India (GATS), 2009-10, 47.8% men and 20.3% women consume tobacco in some form or the other. The Global Youth Tobacco Survey (GYTS), 2009 also indicates that 14.6% children in the age group of 13-15 years are consuming tobacco in some form.

In order to protect the youth and masses from the adverse harm effects of tobacco usage, second hand smoke (SHS) and discourage the consumption of tobacco, the Govt. of India enacted the comprehensive tobacco control laws namely "Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003". The Act is applicable to all tobacco products and extends to whole of India. The specific provisions of the Anti Tobacco Law include:

1. Ban on smoking in public places. (Section -4)
2. Ban on direct/indirect advertisement of tobacco products. (Section -5)
3. Ban on sale of tobacco products to children below 18 year. (Section – 6a)
4. Ban on sale of tobacco products within 100 yards of the educational institution. (Section – 6b)
5. Mandatory depiction of Specified health warnings on tobacco products. (Section - 7).
6. Testing of tobacco products for tar and nicotine.

The rules related to prohibition of smoking in public places came into force from the 2nd October, 2008. As per the rules, it is mandatory to display smoke free signages at all public places and labeling and packaging rules mandating the depiction of specified health warnings on all tobacco product packs came into force from the 31st May, 2009.

11.3.2. *WHO-Framework Convention on Tobacco Control*

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first global health treaty negotiated under the auspices of the World Health Organization. India ratified the FCTC on 5 February 2004 and is now a party to the Convention and has to implement all provisions of this international treaty. It enlists key strategies for reduction in demand and reduction in supply of tobacco. Some of the demand reduction strategies include price and tax measures & non price measures (statutory warnings, comprehensive ban on advertisement, promotion and sponsorship, tobacco product regulation etc). The supply reduction strategies include combating illicit trade, providing alternative livelihood to tobacco farmers and workers & regulating sale to / by minors.

11.3.3. *National Tobacco Control Programme (NTCP)*

Launch of the dedicated National Tobacco Control Programme in the 11th Five Year Plan has been the major milestone to facilitate the implementation of the tobacco control laws to bring about greater awareness about the harmful effects of Tobacco and to fulfill the obligation(s) under the WHO-FCTC. NTCP was launched in 2007-08 in 18 Districts covering 9 States. In the 2008-09 it has been upscaled to 24 New Districts covering 12 States. The programme at present is under implementation in 42 districts in 21 states in the country. The main components of NTCP are:-

a. National level

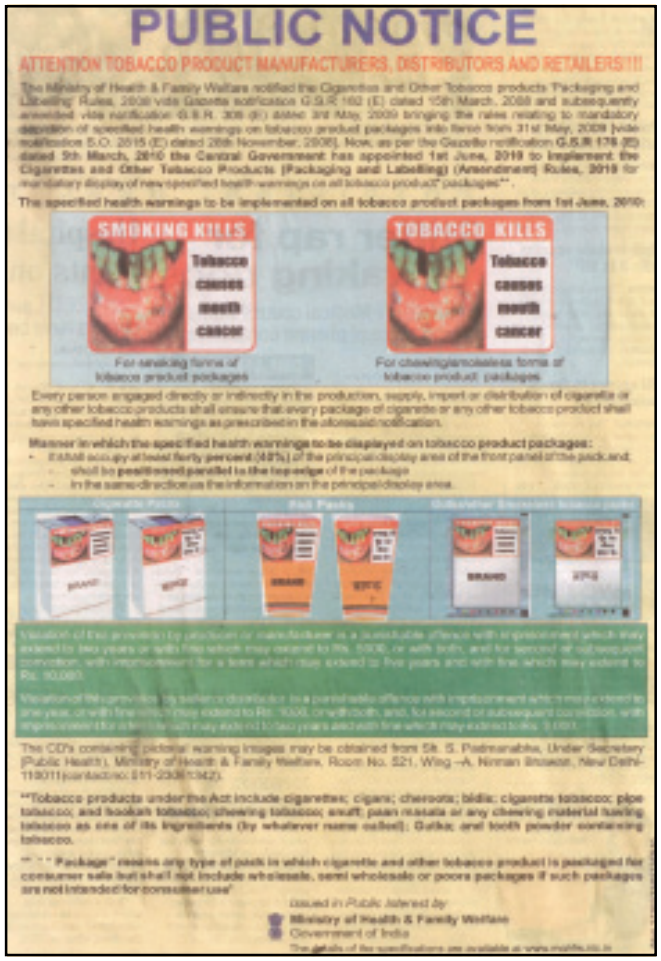
i. Public awareness/mass media campaigns for awareness building & for behavioral change. Ministry of Health has launched comprehensive mass media campaign (both print and electronic) in 2010-11. A series of public notices on tobacco control laws were issued in leading National & regional dailies all over the country. A half page coloured advertisement was also issued in the leading National & regional dailies all over the country on World No Tobacco day, 31st May, 2010.

ii. Establishment of tobacco product testing laboratories, to build regulatory capacity, as required under COTPA, 2003.

iii. Mainstreaming the program components as a part of the health delivery mechanism under the NRHM framework.

iv. Mainstream Research & Training – on alternate crops and livelihoods with other nodal Ministries.

v. Monitoring and Evaluation including surveillance e.g. Adult Tobacco Survey.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ATTENTION TOBACCO PRODUCT MANUFACTURERS, DISTRIBUTORS AND RETAILERS!!!

SMOKING KILLS

Tobacco causes mouth cancer

TOBACCO KILLS

Tobacco causes mouth cancer

b. State level

i. Dedicated State Tobacco Control Cells for effective implementation of the national programme and monitoring of anti tobacco initiatives.

c. District level

i. Training of health and social workers, NGOs, school teachers etc.

ii. Local IEC activities.

iii. School Programme

iv. Provision of tobacco cessation facilities

v. Monitoring of tobacco control laws.

11.3.4. *Other initiatives in collaboration with WHO/ BGI*

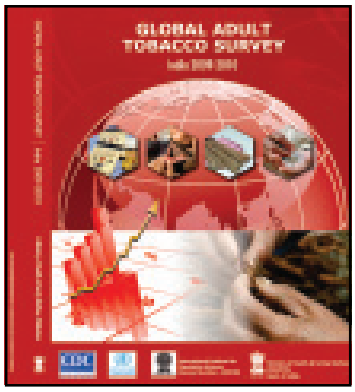
I. Advocacy Workshops

- Ministry of Health & Family Welfare had organized one National Workshop and five Regional Advocacy Workshops for Western, Central, Southern, Eastern & North-eastern and Northern region of the country to sensitize various stakeholders on tobacco control laws and related issues in India in the collaboration with WHO. The purpose of these workshops was to build awareness about tobacco control issues including the existing legislations and to improve enforcement capacity of the provisions of the India Tobacco Control Act, 2003. Through these workshops nearly 800 key personnel in the Government(s) and civil society groups were sensitized on the anti-tobacco laws and its related enforcement strategies.
- Subsequent to the successful national and regional level workshops, 11 State Advocacy Workshops were held and nearly 1200 key personnel in the Government(s) and civil society groups were sensitized on the anti-tobacco laws and its related enforcement strategies. Extensive list of recommendations were generated for preparation of national and state-wise enforcement action plans for effective implementation of tobacco control laws at district level.
- Through these workshops, the key stakeholder ministries / departments such as Police, Education, Custom & Excise, Information and Broadcasting, Tourism, Transport, Labour, Agriculture, etc were sensitized on their role in tobacco control. In addition,

various advocacy materials were developed and disseminated through these workshops.

- A workshop for developing media strategy for the north-east region was organized at Guwahati, Assam and participants were from all the seven north-east states.

II. Global Adult Tobacco Survey (GATS):



The Global Adult Tobacco Survey (GATS) is the global standard for systematically monitoring adult tobacco use (smoking and smokeless) and tracking key tobacco control indicators. Global Adult Tobacco Survey-India was carried out in all 29 states of the country and 2 Union Territories of Chandigarh and Puducherry, covering about 99 percent of the total population of India. The major objectives of the survey were to obtain estimates of prevalence of tobacco use (smoking and smokeless tobacco); exposure to second-hand smoke; cessation; the economics of tobacco; exposure to media messages on tobacco use; and knowledge, attitudes and perceptions towards tobacco use.

The Global Adult Tobacco Survey, India (GATS), Report was released on 19th October 2010. The key highlights of the survey are:

- Current tobacco use in any form: 34.6% of adults; 47.9% of males and 20.3% of females
- Current tobacco smokers: 14.0% of adults; 24.3% of males and 2.9% of females
- Current cigarette smokers : 5.7% of adults; 10.3% of males and 0.8% of females
- Current bidi smokers: 9.2% of adults; 16.0% of males and 1.9% of females
- Current users of smokeless tobacco: 25.9% of adults; 32.9% of males and 18.4% of females
- Average age at initiation of tobacco use was 17.8 with 25.8% of females starting tobacco use before the age of 15
- Among minors (age 15-17), 9.6% consumed tobacco in some form and most of them were able to purchase tobacco products
- Five in ten current smokers (46.6%) and users of smokeless tobacco (45.2%) planned to quit or at least thought of quitting
- Among smokers and users of smokeless tobacco who visited a health care provider, 46.3% of smokers and 26.7% of users of smokeless tobacco were advised to quit by a health care provider
- About five in ten adults (52.3%) were exposed to second-hand smoke at home and 29.0% at public places (mainly in public transport and restaurants)
- About two in three adults (64.5%) noticed advertisement or promotion of tobacco products.
- Three in five current tobacco users (61.1%) noticed the heath warning on tobacco packages and one in three current tobacco users (31.5%) thought of quitting tobacco because of the warning label on tobacco products package. GATS India Report is available on the website at www.mohfw.nic.in

III. Intervention related to alternative crops/ alternative vocations.

- A pilot project for alternatives to tobacco/bidi crops in collaboration with Central Tobacco Research Institute, Andhra Pradesh (Ministry of Agriculture) was launched in 6 agro-climatic zones of the country. This project costing Approx Rs. 3.28 crores will be completed in three years.
- The Ministry of labour also undertook a pilot project to provide alternative vocations to bidi rollers in the regions where bidi is produced viz Karnataka, Madhya Pradesh, Maharashtra, West Bengal and Rajasthan.
- Ministry of Rural Development has taken up the matter of rehabilitation of bidi rollers in 10 States where bidi roller are concentrated. The State Government were advised to work out special projects for developing alternative livelihood options for bidi rollers under Swarnjayanti Gram Swarozgar Yojana (SGSY) and other similar schemes of the Ministry.

11.4 NUTRITION

11.4.1 *Introduction and Initiatives*

The Nutrition Cell in the Directorate General of Health Services provides technical advice in all matters related to policy making, programme implementation, monitoring & evaluation, training content for different levels of Medical and Para Medical workers. It also provides technical inputs on standards and labels for foods, fortification of foods, nutrition related proposals, project evaluation, review of research project etc.

11.4.2. *Initiatives and Progress*

11.4.2.a. The cell has been making efforts in creating awareness regarding prevention of micro-nutrient deficiency disorders, diet related chronic disorders and promotion of healthy life style. This has been done by disseminating posters and pamphlets on the above mentioned issues. In addition to this video films and radio programme have been developed on National Iodine Deficiency Disorders Control Programme (NIDDCP), diet related Non Communicable Diseases (NCD) and promotion of healthy life style including micro-nutrient deficiency. The cell has also developed, published and disseminated a handbook on "Current Nutritional Therapy Guidelines, in Clinical Practices" for Physicians, Dieticians and Nurses.

11.4.2.b. National & Regional levels workshops and meetings were conducted on core issues related to nutrition (i.e micro-nutrient, hospital diets, fluorosis, diet related chronic disorders & promotion of healthy life style, fast/ junk food etc).

11.4.2.c. At national level the nutrition cell coordinates, monitors all administrative and technical issues related to implementation of the new health initiative namely "National Programme for Prevention & Control of Fluorosis (NPPCF)" which was launched in the year 2008-09. The programme was launched to address fluoride related health problems in the country.

11.4.2.d. In 17 States/UTs Nutrition Division have been established to provide updates on development in the field of nutrition, micro-nutrient deficiencies, diet related chronic non-communicable diseases, ill effects of junk/ fast foods etc.

11.5. STRENGTHENING OF EMERGENCY FACILITIES OF STATE HOSPITALS LOCATED ON NATIONAL HIGHWAYS

Expansion in road network, motorization and urbanization in the country has been accompanied by a rise in road accidents leading to Road Traffic Injuries (RTIs) and fatalities as major public health concern. Today road traffic injuries are one of the leading causes of deaths, disabilities and hospitalization with severe socio-economic costs across the world.

In view of the above, the Ministry of Health & FW has been implementing a project for upgradation & strengthening of Emergency Trauma Care Facility in State Government Hospitals located on National Highways under the scheme "Assistance for Capacity Building" with a view to provide immediate treatment to the victims of road traffic injury. Financial assistance was provided up to a maximum of Rs.1.5 crores per hospital or actual requirement of the hospital whichever was less, during the 9th & 10th five year plan periods. During the 9th Five year plan, 18 Hospitals/ Medical Institutions in 13 States/ UTs received grant @ Rs. 1.5 crores each for strengthening of emergency facilities of State hospitals of cities located on National Highways. During the 10th Plan Rs. 110 crores have been allocated. 85 Hospitals/ Institutions in 30 States received the grants during 10th Plan. In total about 139.00 crores has been released to 103 institutes during 9th & 10th Plan.

The scheme was subsequently evaluated by the Ministry and certain deficiencies were observed like shortage of required manpower, inadequate funding for civil work etc. In the light of the facts, a revised new scheme at a total outlay of Rs.732.75 crores has been approved for developing a network of 140 trauma care centres along the Golden Quadrilateral covering 5,846 Kms connecting Delhi-Kolkata-Chennai-Mumbai-Delhi, North-South & East-West corridors covering 7,716 Kms connecting Kashmir to Kanyakumari and Silchar to Porbandhar respectively of the National Highways during the 11th five year plan period.

The scheme provides for 3-category of trauma care centres viz. L-III, L-II and L-I. The level-III trauma centre is designed to stabilize the patients and to manage the trauma victim and to refer the trauma victim to level-II and Level-I centers as per the requirement for further management. The level-II would provide definite care to severe trauma victim while the L-I would provide the highest level of definite and comprehensive care patients with complex injuries.

So far 113 trauma care centers have been provided financial assistance in 15 states which are at various stages of progress.

The financial assistance amounting to Rs. 4.8 crores, 9.65 crores and 16 crores are provided to level-III, level-II and level-I respectively, to strengthen the manpower, building, equipments, communication network and legal services and data entry operator of existing State Govt. Hospitals.

One advances life support ambulance is augmented by Ministry of Surface Transport at each of the trauma care centers, while NHAI is providing one basic life support ambulance at every 50 kms of the highways.

The total outlay and the year wise budget allocation *viz-a-viz* the expenditure incurred on the scheme is as under:

Total outlay for the scheme during the 11th five year plan - Rs. 732.75 crores.

Year	Funds allocated (Rs. in crores)	Allocated for NE States (Rs. in crores)	Funds released (Rs. in crores)
2007-08	Rs. 42	Rs. 5	Rs. 37
2008-09	Rs. 120	Rs. 14	Rs. 110.34 (including Rs. 10 crores for NE States)
2009-10	Rs. 120 but at FE Stage reduced to Rs. 55	Rs. 14	Rs. 55
2010-11	Rs.113	Rs. 15	Rs. 75.63

Subsequently and after evaluation of the project, National Highways (other than Golden Quadrilateral, North-South and East-West corridor) with substantial number of accidents and considering the following parameter another 160 Trauma care centres could also be added to the existing network of trauma care centres during the 12th five year plan:

- ❖ Connecting two capital cities
- ❖ Connecting major cities other than capital cities
- ❖ Connecting ports to major cities
- ❖ Connecting industrial townships with capital cities.

11.6. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS

Hearing loss is the most common sensory deficit in humans today. As per WHO estimates in India, there are approximately 63 million people, who are suffering from Significant Auditory Impairment; this places the estimated prevalence at 6.3% in Indian population. As per NSSO survey, currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss (NSSO, 2002). Of these, a large percentage is children between the ages of 0 to 14 years. With such a large number of hearing impaired young Indians, it amounts to a severe loss of productivity, both physical and economic. An even larger percentage of our population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss.

11.6.1. *Objectives of the Programme*

1. To prevent the avoidable hearing loss on account of disease or injury.
2. Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness.
3. To medically rehabilitate persons of all age groups, suffering with deafness.
4. To strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, for persons with deafness.
5. To develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

11.6.2. *Components of the Programme:*

- Manpower Training & Development
- Capacity Building
- Service Provision including Rehabilitation
- Awareness Generation through IEC Activities
- Monitoring and Evaluation

11.6.3. *Programme Execution & Expansion*

The programme has been launched in 25 districts of 10 states and 1 union territory in Jan, 2007 on the pilot phase till March 2008. The programme was extended to another 35 districts in the year 2008-09, 41 districts in the year 2009-10 and 75 districts in the year 2010-11 making it a total of 176 districts of 15 States and 4 Union Territories. It is proposed to expand the programme to 203 districts by the end of eleventh five year plan. The programme

has got into fourth year of implementation in the year 2010-11.

11.6.4. ***Training activities under NPPCD***

In the current year 2010-11 the funds amounting for conducting training has been released to the states to carry out the trainings prescribed under the programme.

11.6.5. Capacity building of PHCs/CHCs/Distt. Hospitals

i) *Manpower capacity building*: Launched one year DHLS(Diploma in Hearing Language and Speech) programme to address the issue of shortage of audiometric manpower at 11 centres in the country i.e. *JIPMER Puducherry, AIIPMR Mumbai, RIMS Imphal, RML, N. Delhi, IGMC Shimla, JLNMC Ajmer, KGMC Lucknow, GMC Jabalpur, SRBMC Cuttack, RIMS Ranchi* along with the nodal centre *AIISH Mysore* with the total intake capacity of 220 students annually. The programme was officially launched on 25th August 2007.

ii) *Infrastructure capacity building of District Hospitals/CHCs/PHCs:* – Funds for 75 new districts have been released for procurement of ENT/Audiology equipments and construction of sound proof room for audiology at the district hospitals (Rs. 9.50 lakh per district) and CHC/PHC Kit (Rs. 10000 per kit).

The States/U.Ts are in the process of procurement of above stated equipments for their respective district hospitals, CHC and PHC.

11.6.6. ***IEC and awareness campaign:***

IEC material in the form of 6 different posters in English, Hindi and regional languages have been printed and distributed to various health centers, hospitals. 6 video spots and 3 audio spots were prepared and telecast/ broadcast through national TV and satellite to facilitate wider outreach of the programme.

11.6.7. ***Distribution of Hearing aids***

Funds for distribution of hearing aids were given to 25 districts in which approximately 2484 Hearing aids (BTE) have been given to the hearing impaired children who belong to families having monthly income of less than Rs 6500/- per month.

11.6.8. Under the 11th Five Year Plan, it is proposed to upscale the NPPCD to 203 districts all over the country. The EFC of Rs.94.77 crore for NPPCD has already been approved in the year 2008.

11.7. NATIONAL PROGRAMME FOR PREVENTION & CONTROL OF FLUOROSIS

Fluorosis, a public health problem is caused over a long period by excess intake of fluorosis through drinking water/ food products/industrial pollutants. Besides inducing ageing it also results in major health disorders like dental fluorosis, skeletal fluorosis and non-skeletal fluorosis.

11.7.1. ***Initiatives and Progress***

In the 11th Five Year Plan with a goal to prevent & control fluorosis in the country "National Programme for Prevention and Control of Fluorosis" have been launched. The programme was with a financial allocation of Rs. 68.00 crore for implementation in 100 districts of the country.

The objectives of the programme is to (a) collect, assess and use the baseline survey data of fluorosis from Department of Drinking Water & Supply, (b) comprehensive management of fluorosis in the selected areas and (c) capacity building for prevention, diagnosis and management of fluorosis cases.

The strategies under the porogramme are (a) imparting training to health personnel for preventive health promotion, (b) early diagnosis and prompt intervention (c) capacity building of district and medical college hospital for reconstructive surgery and rehabilitation (d) establishment of diagnostic facilities in the district hospitals, (e) health education for prevention and control of Fluorosis cases.

As per the plan, the programme will be implemented in phased manner in the 100 fluoride affected districts of the country. Presently the programme is being implemented in 20 Districts of 16 States and in the financial year 2010-11 another 40 districts of the country have been selected.

11.8. NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY (NPHCE)

According to 2001 census, there were 76.62 million Indians above the age of sixty years. The projections for

next five censuses till the year 2051 are: 96.30 million (2011), 133.32 million (2021), 178.59 (2031), 236.01 million (2041) and 300.96 million (2051). Along with rising numbers, the expectancy of life at birth is also consistently increasing indicating that a large number of people are likely to live longer than before. On the medical front an epidemiological transition is underway whereby as a result of longer survival of man, more and more chronic degenerative diseases will have to be handled. This will also be accompanied by medical, psychological, social and economic problems for the burgeoning population of older persons. At present elderly persons are sharing health care with general public which is causing severe problem to the elderly people.

Considering the growing number of elderly population accompanied by changes in society & economy and its impact on the morbidity pattern, Government of India declared National Policy on Older Persons (NPOP) in 1999 and enacted "The Maintenance & Welfare of Parents & Senior Citizen's Act, 2007".

Keeping in view the recommendations made in the "National Policy on Older Persons" as well as the State's obligation under the "Maintenance & Welfare of Parents & Senior Citizens Act 2007", the Ministry of Health & Family Welfare has formulated a "National Programme for the Health Care of Elderly" (NPHCE) during the 11th Plan period to address various health related problems of elderly people. The Planning Commission had allocated Rs.400 crore for the 11th Plan period for this Programme.

Broad guidelines on the National Programme were decided by the "Working group on communicable and non communicable diseases" for 11th Five Year Plan set up in September, 2006. Based on these guidelines, National Programme for Health Care of Elderly (NPHCE) was formulated and the EFC was approved in May 2010 for an amount of Rs. 288 crore for the remaining period of 11th five year plan, out of which Rs. 48 crore will be shared by the state Government towards 20% contribution of the total expenditure. The programme will cover 100 identified districts covering 21 states

Main objective of the programme is to provide preventive, curative and rehabilitative services to the elderly persons at various level of health care delivery system of the country. Other objectives are, to strengthen referral system, to develop specialized man power and to promote research in the field of diseases related to old age.

Major components of the NPHCE programme are, establishment of 30 bedded department of Geriatric in 8 identified Regional Medical Institutes in different regions of the country, providing dedicated health care facilities in District hospitals, CHCs, PHCs and sub centres in the 100 identified districts, covering 21 States of the country.

The 8 Regional Medical Institutions and 100 districts have been identified. 30 districts will be taken up in 2010-11 and 70 will be added in 2011-12.

List of the 21 States along with the list of 30 districts and the number of CHC/PHC/Sub Centres to be covered under these districts for the year 2010-11 is given below:-

Sl. No.	States	Districts	CHCs	PHC	Sub Centres
1	Andhra Pradesh	Nellore	6	65	481
		Vijayanagaram	7	59	470
2	Assam	Dibrugarh	6	26	240
		Jorhat	4	39	142
3	Bihar	Vaishali	2	53	336
		Rohtas	1	36	186
4	Chhattisgarh	Bilaspur	10	74	379
5	Gujarat	Gandhi Nagar	6	24	171
		Surendranagar	11	31	200
6	Haryana	Ambala	3	17	102
7	Himachal Pradesh	Chamba	7	42	170
8	Jammu & Kashmir	Leh (Ladakh)	3	13	24
		Udhampur	2	21	97
9	Jhankhand	Bokaro	8	16	116
10	Karnataka	Shimoga	11	88	307
		Kolar	6	60	201
11	Kerala	Pathanathitta	13	37	230
12	Madhya Pradesh	Ratlam	5	25	158
13	Maharashtra	Washim	7	25	153
		Wardha	6	27	181
14	Sikkim	East Sikkim	0	8	48
15	Orissa	Naupada	4	17	95
16	Punjab	Bhatinda	9	17	136
17	Rajasthan	Bhilwara	16	63	415
		Jaisalmer	6	14	136
18	Uttrakhand	Nainital	4	18	136
19	Tamil Nadu	Theni	6	23	162
20	Uttar Pradesh	Rae Bareli	11	71	377
		Sultanpur	14	77	403
21	West Bengal	Darjeeling	11	21	230

Operational guidelines have been developed for the implementation of the programme. Monitoring of the programme will be done by the common NCD Cells, being established at various levels under the National programme for Cancer, Diabetes, Cardiovascular Diseases and Stroke.

International Co-Operation For Health & Family Welfare

12.1. INTRODUCTION

Various International Organisations and United Nations Agencies continued to provide significant technical and material assistance for many Health and Family Welfare programmes in the country. The status of international assistance from various agencies is discussed in this chapter.

12.2 WORLD HEALTH ORGANIZATION (WHO)

World Health Organisation (WHO) is one of the main UN agencies collaborating in the Health Sector with the Ministry of Health & Family Welfare, Government of India. WHO provides technical support in the major areas of Health & Family Welfare programmes and health care facilities in the country.

Activities under WHO are funded through two sources: - The Country Budget which comes out of contributions made by member countries and Extra Budgetary Resources which comes from (a) donations from various sources for general or specific aspects of health; and (b) funds routed through the WHO to countries by other member countries or institute agencies. India is the largest beneficiary of the country budget within the SEA Region. The budget is operated on a biennium basis, calendar year wise.

12.2.1. Nodal Functions of WHO:

World Health Assembly*:* The World Health Assembly (WHA) is the most important annual event of the World Health Organisation. The WHA is held once every year and deliberates various draft resolutions that are put up for its approval by the Executive Board of WHO. It is the highest policy making body of World Health Organisation where all member countries are represented by high-level delegations (led by Hon'ble Health Ministers).

The 63rd WHA was held in May, 2010 at Geneva and a high level delegation comprising of technical officials of this Ministry under the leadership of Shri Ghulam Nabi Azad, Hon'ble Minister of Health & Family Welfare attended. The 63rd WHA has, inter-alia, discussed the following agenda items and the resolutions were adopted on some of the agenda items –

- Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits.
- Implementation of the International Health Regulations (2005)
- Public health, innovation and intellectual property: global strategy and plan of action
- Monitoring of the achievement of the health related Millennium Development Goals
- International recruitment of health personnel: draft global code of practice
- Infant and young child nutrition: quadrennial progress report.
- Birth defects
- Food safety
- Prevention and control of non-communicable disease: implementation of the global strategy
- Viral hepatitis
- Tuberculosis Control
- Leishmaniasis control
- Chagas disease: control and elimination
- Global eradication of measles

- Smallpox eradication: destruction of variola virus stocks
- Availability, safety and quality of blood products
- Strategic Approach to International Chemicals Management
- WHO's role & responsibilities in health research
- Counterfeit medical products
- Human organ and tissue transplantation
- Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services
- Treatment and Prevention of Pneumonia
- Progress Report on Poliomyelitis, human African trypanosomiasis, Reproductive health, Health of migrants, Climate Change and health etc.

Meeting of Ministers of Health and Regional Committee of WHO South East Asia Regional Countries*:* The Health Ministers' Meeting (HMM) and the Regional Committee (RC) Meeting of WHO SEAR countries are held annually. HMM provides a forum for Health Ministers to discuss important health issues in the region as well as for forging bilateral arrangements and the Regional Committee is a forum to review progress made on health issues and to lay down the roadmap for future action. The 28th HMM and the 63rd Session of RC held in Bangkok, Thailand during 7-10 September, 2010 and a high level delegation of this Ministry under the leadership of Hon'ble Minister of Health & Family Welfare attended. During the 28th HMM the following agenda items have come up for discussion viz.

i) Review of Kathmandu Declaration on Protecting Health Facilities from Disasters/follow up actions on the decisions and recommendations of the twenty-seventh meeting of Ministers of Health,

ii) Urbanization and Health,

iii) Decentralization of health lower case care services.

12.2.2. GOI contribution to WHO:

As a member country of WHO, India makes regular contribution to WHO for each biennium. A WHO biennium commence in January of the first year of the biennium and ends in December of the second year of the biennium. For the biennium 2010-11, the total Assessed Contribution (AC) and Voluntary Contribution (VC) to the working capital of WHO, to be paid by Government of India was US $ 45,69,900 and US $ 1,20,000 respectively. The first installment of the contribution AC & VC for the year 2010 amounting to US $ 20,89,890 and US $ 60,000 respectively, have already been paid in 2009. The second installment of US $ 24,80,010 and US $ 60,000 have also been paid on 21.12.2010.

12.2.3. GOI/WHO collaborative Activities:

WHO funding is available for taking services of the experts on contractual basis on specific terms and references; training within and outside the country; holding of workshops, seminars and meetings for raising awareness or exchange of information and medical supplies of equipment, viz: (i) Technical Services Agreement; (ii) Fellowship; (iii) Agreement for Performance of Work; (iv) DFC; and (v) Supplies and Equipment etc.

Since the biennium 2010-11, 11 Strategic Objectives have been introduced under which the GOI/WHO collaborative activities are being implemented. Monitoring the activities for timely and effective utilization of funds and their proper accounting is one of the main tasks. The areas of work financed by WHO, inter alia cover HIV/AIDS, communicable and non communicable diseases, mental health, drug abuse, environment, food safety, maternal and child health besides health policy, health financing & social protection as well as emergency preparedness & response. For the biennium 2010-11, under the Country Budget an amount of US $ 7,852,000 was allocated for carrying out various GOI/WHO collaborative activities. All the programme are being implemented efficiently with close monitoring and approx. 30% funds have been utilized till 30th November, 2010.

12.3. SPECIAL ACHIEVEMENT

During the last World Health Assembly held in May 2010, India have presented successful intervention on the agenda "Counterfeit Medical Products" which was almost accepted by WHO and a resolution was adopted accordingly. The brief of India's achievements in this regard is as under:

"On the opening day of the World Health Assembly (WHA) Hon'ble Minister of Health & FW raised the issue counterfeit medicines in his statement. He urged countries to steer clear from the commercially motivated

debates over the 'counterfeit' issue which have hampered public health by preventing access to good quality and low cost generic drugs. The resolution submitted by India on behalf of South East Asia Region (SEAR) on 'Measures to ensure access to safe, efficacious, quality and affordable medical products' contextualized the problem in the public health arena and sought World Health Organization's (WHO's) support in strengthening the national drug regulatory authorities to ensure the availability of quality, safe and efficacious medical products. It requested the Director General (DG) to replace WHO's involvement in IMPACT and the programme on 'counterfeit medical products' with an effective member driven programme to address the issues of quality, safety and efficacy. The resolution also requested the WHO not get involved with Intellectual Property (IP) enforcement and other measures that could potentially undermine availability of quality, safe, efficacious and affordable medical products and production of generic medical products. As a result WHA has adopted a resolution establishing a time limited and result oriented working group on substandard/ spurious/ falsely-labelled/falsified/counterfeit medical products comprised of and open to all Member States. The Working Group will examine, from a public health prospective, excluding trade and intellectual property considerations."

12.4. AIRPORT HEALTH ORGANISATIONS/ PORT HEALTH ORGANISATIONS

Airport and Port Health organizations (APHO/PHOs) are subordinate offices of Directorate General of Health Services. At present, there are 9 PHOs and 5 APHOs established at all major international Airports and Ports of the country. There is also one border quarantine centre at Attari border, Amritsar. In addition to these, the health offices at Bangalore and Hyderabad Airports have also been established and started functioning in full swing and action has been taken to set up the health offices at Ahmadabad, Lucknow and Trivendrum Airports. The Budget Division of the Ministry has been requested to provide sufficient budget so that contractual staff could be recruited at these 3 APHOs during the financial year 2010-2011. These are statutory organizations and are discharging their regulatory functions as delineated under Indian Aircraft (Public Health) Rules 1954 and Port Health Rules 1955 respectively.

Apart from this, India is also signatory to International Health Regulations (IHR), 2005 framed by WHO and therefore, it is obligatory on our part to implement these regulations. Accordingly, both Indian Air craft Public Health Rules as well as the Indian Port Health Rules have been framed in agreement with these International Health Regulations.

Main objective of the APHO/PHSs is to prevent spread of infectious disease of epidemic proportion from one country to another with minimum interference to the international traffic. Some of the important functions of this organization are - Health Screening of International passengers, Quarantine, Clearance of dead bodies, Supervision of airport sanitation, clearance for imported food items, vaccination to international passengers, vector control etc.

Apart from this, issuance of deratting exemption certificate is another major responsibility at international ports.

WHO has notified a list of yellow fever endemic countries under IHR and any person coming to India from these notified endemic countries is required to possess valid yellow fever vaccination certificate, failing which such passengers are quarantined for a maximum period of six days. In the light of changing global health scenario, existing IHRs have been revised by WHO and these new IHRs have come to effect from June, 2007.

12.5. CUSTOM DUTY EXEMPTION CERTIFICATE

During 2010-2011 (i.e. upto November, 2010) this Ministry has issued one time Custom Duty Exemption Certificates in favour of Additional Director Medical Store Depot, CGHS, New Delhi.

12.6. FOREIGN TRAVEL BY SENIOR OFFICERS

For the year 2010-2011, a provision of Rs.200.00 lakhs has been made against Foreign Travel Expenses under Non-Plan. Out of this, the expenditure till November, 2010 is Rs. 105,09,493 (approx.)

12.7. VISIT ON FELLOWSHIP/CONFERENCE ABROAD

During the period under report (Upto November, 2010), 116 medical personnel were permitted to participate in International conference/symposia etc. abroad. This includes 20 medical personnel from CHS cadre who have been granted financial assistance subject to a maximum of Rs.1.00 lakh- each to attend International Conference

abroad under the scheme which provides financial assistance to attend seminars/conferences abroad in order to acquaint themselves with the latest developments in the field of medicine and surgery in other countries and to exchange views with their counterparts.

12.8. AGREEMENTS/MOUS

In the year 2010-2011, this Ministry has signed the following Agreements/MoUs:-

I. An MOU on Cooperation in the field of Health between the Ministry of Health and Family Welfare of the Republic of India and the Ministry of Social Protection of the Republic of Colombia was signed on 19th January, 2010.

II. An MOU between the Government of the Republic of India and the Government of the Republic of the Croatia on Cooperation in the field of the Health and Medicine was signed on 9th June, 2010.

III. An MOU between the Government of India and the Government of Malawi in the field of Health and Medicine was signed on 3rd November, 2010.

IV. An MOU between the Government of the Republic of India and the Government of the Republic of Rwanda in the field of Health and Medicine was signed on 12th November, 2010 at New Delhi.

V. An MOU on the Establishment and Operation of Global Disease Detection- India Center between National Centre for Disease Control, Delhi (Ministry of Health and Family Welfare, Government of India) and Centres for Disease Control and Prevention, Atlanta (The Department of Health and Human Services of the United States of America) has been concluded on 6th November, 2010.

12.9. MEETINGS/CONFERENCES UNDER THE AEGIS OF INTERNATIONAL COOPERATION

(i) An Indo-Swedish Health Week was organized in New Delhi and Hyderabad to commemorate the completion of one year of the Memorandum of Understanding on Health between India and Sweden and to explore and enhance the potential for strengthened collaboration between various stake holders in the public and private health care sector in India and Sweden.

(ii) The Joint Working Group (JWG) set-up under the Memorandum of Understanding MOU on cooperation in the field of Health Care and Public Health between the Government of India and Sweden held its third joint meeting in New Delhi on 8th February, 2010, in which issues of mutual interest in health sector were discussed.

(iii) An Indian delegation led by Hon'ble HFM visited Bangladesh from 13-16th February, 2010 to attend the meeting of the Executive Committee of Partners in Population and Development (PPD)

(iv) The Joint Working Group (JWG) constituted under the Agreement on bilateral cooperation in the field of Health and Medicine between India and Fiji held its first Joint meeting in New Delhi.

Ministerial/Official bilateral meeting between India and Turkey, Nigeria, Australia, Pakistan, China, U.K., Iraq, Sweden, Armenia were held with a view to improving the bilateral relations in the Health Sector during the year 2010-2011 (upto November, 2010.)

12.10. PERMISSION FOR INTERNATIONAL CONFERENCES

In the year 2010-2011 (upto November, 2010), permissions were granted to 70 Organizations/ Instsitutions for holding health related international Conferences in India.

Medical Relief And Supplies

13.1 CENTRAL GOVERNMENT HEALTH SCHEME (CGHS)

Central Government Health Scheme has been in existence since 1954, when it started functioning in Delhi. Central Government Health Scheme has since come a long way and presently Central Government Health Scheme covers 25 cities. In order to make the CGHS user friendly, its functioning has been streamlined and revamped. Important actions in this direction have been the computerisation of the functioning of the CGHS and its dispensaries, delegation of enhanced financial powers to CGHS functionaries and to Ministries / Departments, issue of plastic cards to beneficiaries enabling them to take treatment in any dispensary, introduction of direct indenting of commonly prescribed medicines by CMOs in charge of dispensaries, empanelment of private hospitals and diagnostic centres to provide options, in addition to the facilities available in Government hospitals, polyclinics and laboratories, outsourcing of sanitary work in dispensaries, outsourcing of dental services, opening of stand-alone dialysis unit in Delhi, appointment of the Bill Clearing Agency (BCA) of settlement of bills of hospitals of pensioner beneficiaries treated in hospitals, etc. These measures have resulted in increased satisfaction level of CGHS beneficiaries.

The Central Government Health Scheme (CGHS) is a scheme for providing health care to serving Central Government employees and their dependant family members. Over the years, the scheme has been extended to cover central government pensioners, their dependant family members and certain other categories like Members of Parliament and ex Members of Parliament, freedom fighters etc. Employees of some select autonomous bodies as also PIB accredited journalists have also been extended CGHS facilities on cost-to-cost basis in Delhi.

13.1.1. Membership Profile

As on 31st March 2009, CGHS had 9.34 lakh members with coverage of over 31.81 lakh beneficiaries. The break-up of the current membership profile is given in the table below:

Membership profile (31.3.2009)

Category	Card Holders	Beneficiaries
Serving	627004	2518805
Pensioners	290880	634167
Freedom Fighters	13068	18293
MPs	609	2437
Ex-MPs	1010	2593
Journalists	128	220
Others	1452	3235
General Public	674	1969
Total	**9,34,825**	**31,81,719**

COVERAGE

CGHS was started initially in Delhi. Today it covers 25 cities as indicated below:

Ahmedabad	Allahabad	Bangaluru	Bhubaneshwar	Bhopal	Chennai	Chandigarh
Delhi	Dehradun	Guwahati	Hyderabad	Jaipur	Jabalpur	Kanpur
Kolkata	Lucknow	Meerut	Mumbai	Nagpur	Patna	Pune
Ranchi	Shillong	Jammu	Thiruvananthapuram			

There is no CGHS coverage in the States of Himacjhal Pradesh, Chattisgarh, Punjab, Haryana, Tripura, Manipur, Mizoram, Nagaland, Sikkim, Goa and Union Territory of Puducherry.

13.1.2. CGHS Infrastructure

The beneficiaries are being provided health service through a huge network of:

A) Dispensaries (247 Allopathic, 82 AYUSH),

B) Yoga Centres (4),

C) Polyclinics (19),

D) Laboratories (65)+ 1(Hind lab)

E) Dental Units (21)

F) Gynae– maternity Hospital (1)

G) Dialysis Centre (Sadiq Nagar, New Delhi).

In addition, beneficiaries are offered medical facilities in private hospitals and diagnostic centres empanelled by the CGHS by following an open tender system.

CGHS was finding it difficult to fill up the vacancies of medical officers as the majority of the doctors recommended by the Union Public Service Commission did not assume charge in the CGHS for various reasons. To overcome the problem of unfilled vacancies, it has been decided to appoint, on contract basis, doctors who had retired from Government service. As a result of this decision, 79 retired doctors have been appointed on a contract basis in the CGHS.

13.1.3. Facilities provided under CGHS

Facilities of outpatient care in all systems and emergency services in allopathic system, supply of necessary drugs, laboratory and radiological investigations, domiciliary visits to the seriously ill patients, specialists consultation both at the dispensary and hospital level, family welfare services, treatment in specialised hospitals, both Government and CGHS empanelled private hospitals etc. are being provided to the beneficiaries through dispensaries, polyclinics and Government / CGHS empanelled private hospitals / diagnostic centers. There are special facilities for the convenience of pensioners and senior citizens. CGHS Pensioner beneficiaries can obtain a CGHS pensioner card with life-time validity, by paying an amount equivalent to ten years' subscription. The pensioners living in areas not covered by the CGHS have the option to get their CGHS pensioner cards from the nearest CGHS covered city. Credit facilities are also available to the pensioners for treatment taken in private hospitals /diagnostic centers empanelled under CGHS by obtaining a permission / referral letter from CGHS. In such cases, the hospitals are directed to send the bill for the treatment to the CGHS and not to charge from the pensioners. Pensioner beneficiaries are being allowed to get medicines for chronic ailments up to three months at a stretch.

Two Geriatric Clinics have been established and are functioning at CGHS Timarpur and Janakpuri in Delhi.

13.1.4. Computerisation of CGHS

The computerisation of CGHS and its' dispensaries which was initiated in 2005 has been completed in all cities. Computerisation of CGHS Wing in Dr. Ram Manohar Lohia Hospital in Delhi has also been completed.

13.1.5. Issue of Plastic Cards

All the new cards in Delhi and other cities are made only in the form of Plastic Cards to each beneficiary with a distinct beneficiary identification number. Each card will have a bar code. In Delhi so far 8.5 lakh cards have been printed and distributed to CGHS beneficiaries.The benefit of having a plastic card is that the beneficiaries, while on tour to any CGHS city, can go to the wellness centre in that city and obtain treatment in case of need.

13.1.6. Subscription to CGHS

Serving Government servants residing in areas covered by the CGHS are compulsorily covered by the CGHS. In order to avail the CGHS facility, they have to contribute on a monthly basis at the rates brought into force from 1st June, 2009, which are as below:

S. No.	Grade pay drawn by the officer	Contribution(Rupees per month)
1	Upto Rs. 1,650/- per month	50/-
2	Rs. 1,800/-; Rs. 1,900/-; Rs.2,000/-; Rs.2,400/-; and Rs.2,800/- per month	125/-
3	Rs. 4,200/- per month	225/-
4	Rs. 4,600/-; Rs.4,800/-; Rs.5,400/-; and Rs. 6,600/- per month	325/-
5	Rs. 7,600/- and above per month	500/-

Central Government pensioners can avail CGHS facilities by depositing the applicable subscription rates. Pensioners have the option of either subscribing on an annual basis or pay a lump sum equivalent to 10 years' contribution and avail CGHS facilities for life time alongwith dependent family members.

13.1.7. Definition of Family

A. Family for purposes of availing CGHS facilities has been defined as under:

(i) Husband / wife

(ii) Parents and stepmother

(iii) Female employee has a choice to include her parents or her parents-in-law and option exercised can be changed once during the service period

(iv) Children (including legally adopted children) subject to the conditions that:

(a) Son – till he starts earning or attains the age of 25 years, whichever is earlier. A son, if married, even if he is dependent on his parents and is below 25 years' of age will not be part of the family for CGHS purposes

Son, even if he is more than 25 years of age, but is suffering from permanent disability [as defined in (i) Disabilities defined in Section 2(i) of *"The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (No: 1 of 1996)", and in Clause (j) of Section 2 of National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 (No: 44 of 1999)] and* is fully dependent on his parents will be entitled to CGHS facility.

The matter regarding ineligibility of sons above the age of 25 years has been challenged in Delhi High Court and final orders of the Court are awaited.

(b) Daughter – Till she starts earning or gets married, whichever is earlier, irrespective of age-limit. Widowed dependent daughters, divorced / separated daughters if dependent on her parents will be entitled to CGHS facility irrespective of age-limit.

(v) Sisters including unmarried / divorced / abandoned or separated from husband / widowed sisters, if dependent on the Government servant will be entitled to CGHS facilities irrespective of age-limit.

(vi) Minor brothers

13.1.8. Dependency Criteria

Members of the family (other than one spouse) whose income from all sources is less than Rs.3,500/- ***plus*** an amount equivalent to the DA announced by the Government from time to time will be treated as dependent on the Government servant and hence are entitled to avail CGHS facilities.

13.1.9. Empanelment of private hospitals and diagnostic centres

As CGHS does not have adequate facilities to offer medical treatment to its beneficiaries in Government hospitals, it empanels private hospitals and diagnostic centers in all CGHS covered cities. For this purpose tenders were floated in 2009 calling for private hospitals and diagnostic centers interested in being empanelled under CGHS to offer their rates for various procedures / tests, etc. Based on the rates quoted by the private hospitals and diagnostic centers, the lowest rates in respect of each procedure / test were offered to the private hospitals and diagnostic centers and those private hospitals and diagnostic centers which accepted the rates have been empanelled under CGHS in Delhi and most of other cities. It is expected that with the completion of the tender process and introduction of continuous empanelment scheme, almost all the cities will have private hospitals/ diagnostic centres in the CGHS panel.

Private hospitals and diagnostic centers which were empanelled under CGHS have signed MOAs with the CGHS. Any violation of the provisions of the MOA meant that fines would be levied on these private hospitals and diagnostic centers and bank guarantee could also be utilised.

13.1.10. Procedure for referral to empanelled hospitals & diagnostic centres

The CGHS beneficiary first visits the dispensary (now renamed as Wellness Centre) for treatment of an ailment. The CMO in the wellness centre will refer to the patient to a specialist in a Government hospital for suggesting the procedure / tests, etc., to be undergone by the patient. If the CGHS beneficiary is a pensioner, then the wellness centre will issue a referral letter to the private hospital and diagnostic centre where the beneficiary wants to be treated. The private hospitals and diagnostic centres will provide credit facility to the beneficiary and raise their bill on the CGHS.

If, however, the CGHS card holder is a serving Central Government servant, then he / she will have to obtain permission from his / her Ministry / Department.

13.1.11.Change in procedure for payment of hospitals / diagnostic centres' bills:

Private hospitals and diagnostic centres have to provide credit facility to pensioner CGHS beneficiaries referred to them by the CGHS. Due to paucity of funds and procedural bottlenecks, settlement of the bills of private hospitals and diagnostic centers got delayed with the result that many private hospitals and diagnostic centers refused to extend credit facility without receiving payment towards the bills already submitted. To overcome the problem, a Third Party Administrator (TPA) (the Bill Clearing Agency – UTI – TSL) has been engaged for processing of bills and release of payments electronically. CGHS will then carry out medical audit of the bills passed for payment by the TPA.

13.1.12. Supply of medicines to beneficiaries

Medicines for CGHS are procured by HSCC / Medical Stores Depot and Medical Stores Organisation, on the basis of the indents made by different wellness centres, and supplied to the wellness centres. The medicines prescribed by the treating doctor, if available in the store of the wellness centre, are supplied to the beneficiary. If, however, the prescribed medicine is not available by the brand name but in another brand name or there is another medicine with the same active ingredients, then the same is supplied to the beneficiary.

13.1.13. Local indenting of medicines

Each wellness centre holds certain quantity of branded and generic drugs, which are distributed to the beneficiaries on the basis of prescriptions of specialists. If any drug is not available in stock, then the wellness centre places an indent on the locally authorised chemist for the wellness centre for the supply of the drugs.

As it is not possible for the wellness centers to keep in stock all the drugs that are prescribed by the specialists and if drugs with the same active ingredients are also not available, then the wellness centre is authorised to place an indent on the local authorised chemist for the supply of the drug prescribed by the specialist.

Authorized local chemists for wellness centres are appointed on the basis of tenders floated by the CGHS for such appointment. The selection of the chemist is done on the basis of the highest rebate offered by the chemist on the printed MRP. Before the chemist is appointed, his premises are inspected to ensure that he has the capacity to handle the volume of indents that will be placed by the wellness centre on the chemist.

13.1.14. Treatment for Cancer

As there is no private hospital empanelled (both old and new) under CGHS for treatment of cancer patients, ad-hoc arrangements for treatment of cancer patients have been made in view of the hardships faced by CGHS beneficiaries undergoing treatment for cancer. Patients can be referred to any hospital offering treatment to CGHS beneficiaries suffering from cancer.

In addition, orders have been issued for treating the following Regional Cancer Centres as empanelled under CGHS / CS (MA) Rules.

13.1.15.Regional Cancer Centres deemed to be empanelled under CGHS:-

1. Kamla Nehru Memorial Hospital, Allahabad, Uttar Pradesh;
2. Chittaranjan National Cancer Institute, Kolkata, West Bengal;
3. Kidwai Memorial Institute of Oncology, Bangaluru, Karnataka;
4. Regional Cancer Institute (WIA), Adyar, Chennai, Tamil Nadu;
5. Regional Cancer Centre, Thiruvananthapuram;
6. Gujarat Cancer Research Institute, Ahmedabad, Gujarat;
7. MNJ Institute of Oncology, Hyderabad, Andhra Pradesh;
8. Dr. B.B. Cancer Institute, Guwahati, Assam;
9. Indian Rotary Cancer Institute (AIIMS) , New Delhi;
10. RST Hospital & Research Centre, Nagpur, Maharashtra;
11. Tata Memorial Hospital, Mumbai, Maharashtra; and
12. Indira Gandhi Institute of Medical Sciences, Patna, Bihar.

13.1.16. Regional Cancer Centres deemed to be empanelled under CS(MA) Rules, 1944

1. Acharya Harihar Regional Cancer Centre for Cancer Research & Treatment, Cuttack, Orissa;
2. Puducherry Regional Cancer Society, JIPMER, Puducherry;
3. Regional Cancer Control Society, Shimla, Himachal Pradesh;
4. Cancer Hospital and Research Centre, Gwalior, Madhya Pradesh;
5. Pt. JNM Medical College, Raipur, Chhatisgarh;
6. Acharya Tulsi Regional Centre Trust and Research Institute (RCC), Bikaner, Rajasthan; and
7. Regional Cancer Centre, Pt. B. D. Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana.

13.1.17. Other facilities

CGHS beneficiaries in Kolkata can avail treatment / facilities in the Afternoon Pay Clinics run by the Government of West Bengal, with a provision for reimbursement of the consultation fee. The OPD consultation fee charged by the Pay Clinics will be reimbursed at the rate of Rs. 100/- (Rupees one hundred only) for the first visit and Rs. 60/- (Rupees Sixty only) for subsequent visits. The reimbursement of the expenditure will be made by the concerned Department / Ministry in case of serving employees and by CGHS in case of pensioner beneficiaries.

Beneficiaries under CGHS possessing a valid CGHS card can avail treatment / investigation facilities at Nizam's Institute of Medical Sciences, Hyderabad, for which prior referral / permission / approval will not be necessary from the concerned Department / CGHS Dispensary. Similarly, beneficiaries under Central Services (Medical Attendance) Rules, 1944 can also avail treatment / investigation facilities at Nizam's Institute of Medical Sciences, Hyderabad without prior referral / permission / approval.

13.1.18. Grievance Redressal Mechanism

13.1.18.a. Local Advisory Committees

Instructions have already been issued to all CGHS cities that meetings of Local Advisory Committees should be held on Second Saturday of every month in each dispensary. The meetings are held under the chairmanship of CMOs in charge of the dispensaries, in which Area Welfare Officers and representatives of pensioners' associations are members to discuss local problems faced by the beneficiaries and dispensaries and to resolve such issues.

All wellness centers have been directed to keep a complaints / suggestions Box and also to maintain a complaints / suggestions register. The complaints Box will be opened at the time of the meeting of the Local Advisory Committee.

CGHS Help Lines (No. 011-66667777 & 155224), are in operation between 9.30 A.M. to 5.30 P.M. There is also a e-mail help line – cghs @ nic.in where readily available information is provided E-mails are addressed. Otherwise, beneficiaries are directed to contact the concerned nodal officers to get the desired information.

13.1.18.b. Holding of Caims Adalats under CGHS

Complaints were received in the CGHS and in the Ministry that old cases of reimbursement of medical expenses incurred by pensioners had been pending for settlement for a long time. It was decided that Claims Adalats be held in each CGHS city under the chairmanship the Additional / Joint Directors of the respective city. For holding of the Adalats, advertisements were released in local leading newspapers requesting aggrieved pensioners to apply to the respective Additional Directors by furnishing the details of their long pending claims. A good number of long pending cases could be settled in Delhi and in outside CGHS cities through this mechanism. Instructions have been issued for holding such Adalats in 2011 also.

13.1.18.c. Expenditure:

Over the years, expenditure under CGHS has been showing an increasing trend. The details of actual expenditure since 2005 – 06 are as under:-

(Rs. In crores)

S. No.	Year	PORB Head	Other heads	Total Expenditure
1.	2006-07	349.47	397.86	747.39
2.	2007-08	438.45	470.69	909.14
3.	2008-09	498.00	547.91	1045.91
4.	2009-10	617.00	532.00	1149.00
5.	2010-11	600.00 Proposed (RE)	568.65	811.07 (Till 22-12-10)
6	2011-12 Proposed (BE)	604.00	680.81	1,284.81

13.1.19.Status in respect of North East:

The CGHS is in operation in two cities in the North Eastern States viz. Guwahati and Shillong since 1996 and June 2002 respectively. One Ayurvedic and one Homeopathy dispensary in Guwahati have since started functioning. There were 12,008 card holders with 45,427 beneficiaries in Guwahati and 1,857 card holders with 6,544 beneficiaries in Shillong as on 31-3-09.

13.1.19.a. Recent initiatives taken

1) **Strengthening of administrative set up of CGHS:** To further improve the functioning of CGHS, a senior position at the level of Additional Secretary & Director General (CGHS), to be filled up under the Central Staffing Scheme has been newly created. The full administrative control of the entire CGHS staff has been vested with Additional Secretary & Director General (CGHS).

2) **Simplification of procedures under referral System and Reimbursement :**

a. Submission of Medical claims has been simplified by doing away with the requirement of verification of bills by the treating doctor and Essentiality Certificate.

b. Specific guidelines have been issued for examining requests for full reimbursement of claims. The power for relaxation of rules is vested with the Ministry of Health & Family Welfare, except in case of Hon'ble Members of Parliament and Sitting Judges and Former Judges of Hon'ble Supreme Court of India.

3) **Reimbursement from two-sources:** Instructions were issued in February 2009 regarding reimbursement under CGHS and Health Insurance Scheme. As per the revised guidelines beneficiaries have the option to submit the original bills under the Health Insurance Scheme and claim the balance amount from CGHS / Department subject to the condition that the reimbursement (balance amount) from CGHS/ Department shall be as per CGHS rates and regulations.

4) **Bulk Procurement of Commonly Indented Medicines from Manufacturers/ Suppliers:** Based on the Data generated by Computers a list of 272 medicines commonly indented through Authorised Local Chemists (ALCs) was prepared. Based on the success of a pilot project which was started in 10 WCs in Delhi to procure these commonly indented medicines directly from manufacturers / suppliers on a monthly basis, the same has been replicated in 16 cities namely Ahmedabad,, Allahabad, Bengaluru, Bhubaneswar, Chennai, Guwahati, Hyderabad, Jabalpur, Jaipur, Kolkata, Lucknow, Mumbai, Nagpur, Patna, Pune, and Ranchi..The advantage being that medicines are readily available for issue to beneficiaries instead of indenting through ALC. Manufacturers / suppliers offer a better discount on rates as compared to ALCs.

5) **Health Check-Up of Beneficiaries above 40 years in Delhi**

A pilot project is being implemented in 2 Wellness Centres, namely Sector 8 and Sector 12 in Ramakrishna Puram, for the Health Check-up of all beneficiaries above the age of 40 years in Delhi.

30 beneficiaries per day would be registered in advance – online and would undergo a list of identified investigations. Beneficiaries would have a clinical check up on the date of appointment along with investigation report. The health check-up is proposed to identify risk factors including Life –style related diseases for prevention / early identification for further follow-up and treatment, if required. So far, 1200 beneficiaries have availed of this facility.

6) **Outsourcing of Dental Services:** Dental services in eight dispensaries in Delhi have so far been outsourced though Public Private Partnership (PPP). These are at Moti Bagh, Ramakrishna Puram Sector 12, Kidwai Nagar, Sadiq Nagar, Srinivas Puri, Kalkaji I, Pushp Vihar Sector IV and Faridabad.

7) **Delegation of Financial Powers to settle reimbursement claims in CGHS:** Powers for settlement of reimbursement claims by pensioner beneficiaries by CGHS were last delegated in 1999. This resulted in delay in settlement of claims by CGHS. Instructions have been issued on 24th January, 2011, delegating enhanced financial powers to AS & DG (CGHS), Director CGHS and all Additional Directors / Joint Directors of CGHS. This is expected to ensure speedy settlement of reimbursement claims of all hospitals and individual beneficiaries.

8) **Increasing the level of Imprest Money at dispensary level:** Imprest money available with the Chief Medical Officer in charge of dispensaries were very low resulting in CMOs not being able to attend to minor items of work. In order that minor items of work do not get delayed, the quantum of Imprest Money available with CMO in charge of each dispensary has been increased to Rs. 20,000/- (Rupees Twenty thousand only) per annum. Instructions have been issued to declare Chief Medical Officers in charge of dispensaries as Heads of Office under provisions of the Delegation of Financial Power Rules.

9) **Engagement of Bill Clearing Agency (BCA):** The major grouse of private hospitals and diagnostic centres empanelled under CGHS was that settlement of bills sent to CGHS in respect of treatment given to pensioner CGHS beneficiaries took unduly long time, which was one of the reasons why hospitals and diagnostic centres were showing their unwillingness to provide credit facility to CGHS beneficiaries. In order to overcome this difficulty, CGHS has appointed UTI – TSL as the Bill Clearing Agency, by signing a MOA with it. Under the procedure, hospitals and diagnostic centres are required to submit their bills electronically to UTI – TSL after discharge of the patient, followed by forwarding of bill physically. UTI – TSL is required to pay to the hospitals the applicable amount as per package rates for the treatment within ten days of receipt of the bill physically. To enable UTI – TSL to make payments to hospital, an advance of Rs. 70.00 crores has been forwarded to it by the CGHS. After UTI-TSL makes payments to the hospitals, it will submit the bills to CGHS periodically for recouping the money paid to hospitals.

13.2 SAFDARJANG HOSPITAL &VMMC

13.2.1. Introduction of the Hospital

Safdarjang Hospital was founded during the Second World War in 1942 as a base hospital for the allied forces. It was taken over by the Government of India, Ministry of Health in 1954. Until the inception of All India Institute of Medical Science in 1956, Safdarjang Hospital was the only tertiary care hospital in South Delhi. Based on the needs and developments in medical care the hospital has been regularly upgrading its facilities from diagnostic and therapeutic angles in all the specialties. The hospital when

NEW OPD BUILDING AT SAFDARJANG HOSPITAL

started in 1942 had only 204 beds, which has now increased to 1531 beds. The hospital provides medical care to millions of citizens not only of Delhi but also the neighboring states free of cost. Safdarjung Hospital is a Central Government Hospital under the Ministry of Health & Family Welfare and is receives its budget from the Ministry. Safadarjung Hospital has a Medical College associated with it named Vardhman Mahavir Medical College.

13.2.2. Vardhman Mahavir Medical College was established at Safdarjung Hospital in November 2001 and on 20th November 2007, the Vardhman Mahavir Medical College building was dedicated to the nation. The first batch of MBBS students joined the college in February 2002.

Vardhman Mahavir Medical College

The college has recognition from the Medical Council of India. The college is affiliated to Guru Govind Singh I P University, Delhi. From 2008 onwards the post graduate courses are also affiliated to GGSIP University which were with Delhi University.

13.2.3. The Services Available:

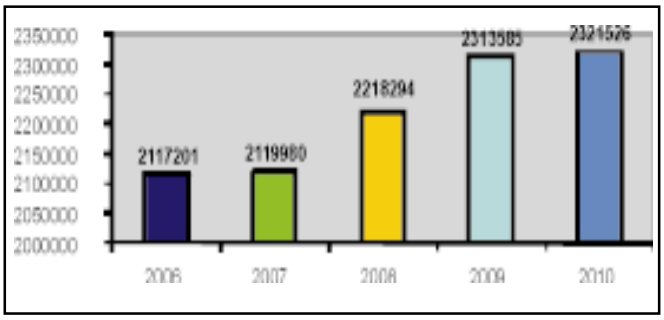
The hospital provides services in various Specialties and Super Specialties covering almost all the major disciplines like Neurology, Urology, CTVS, Nephrology, Respiratory Medicine, Burns & Plastics, Pediatric Surgery, Gastroenterology, Cardiology, Arthroscopy and Sports Injury clinic, Diabetic Clinic, Thyroid Clinic. Further, it has two Whole Body CT Scanner, MRI, Colour Doppler, Digital X-ray, Cardiac Cath. Lab. A Homoeopathic OPD and Ayurvedic OPD are also running within this hospital premises.

13.2.4. OPD Services

OPD Services are running in New OPD Building of V.M.M.C & Safdarjang Hospital. Patients coming to OPD of Safdarjang Hospital find a congenial and helpful atmosphere. Various Public Friendly Facilities exist in the OPD registration area of the New OPD Building like the 'May I help You' Counter, Computerized Registration Counters, which are separately marked for Ladies, Gents , Senior Citizens and Physically Challenged.

The hospital has an ever increasing attendance of 23,21,526 in the year 2010 i.e. @ 7790 per working day of patients in the OPD. To cater to this load and for convenience of the patients a new OPD Block was commissioned in August, 1992. All Departments run their OPD in the new OPD block. There are several disciplines for which the OPD services are provided daily. The OPD complex has a spacious registration hall with 18 registration windows. The OPD registration services have been computerized and the new system is functional since mid February 2005. The first floor of the OPD complex caters to the Department of General Medicine and allied Super-specialties; the second floor caters to the Department of General Surgery and allied super-specialties; the third floor is occupied by Pediatrics and Homeopathy; the fourth floor houses the ENT & Eye OPD's and the fifth floor is occupied by the Department of Skin & STD. The out – patient attendance for the last 5 years are as under :-

YEAR	OPD ATTENDANCE
2006	21,17,201
2007	21,19,980
2008	22,18,294
2009	23,13,585
2010	23,21,526



13.2.5. Sports Injury Centre (SIC) : The Government of India has established the Sports Injury Centre (SIC) at Safdarjang Hospital, New Delhi at an approved cost

of Rs. 70.72 crores with an objective of providing Comprehensive Surgical, Rehabilitative and Diagnostic services under one roof for specialized treatment of Sports and related Joint disorders. The benefits would not be limited only to the sports persons but will also be extended to other patients sustaining similar and related joint injuries. The Centre has become functional from 26.9.2010 after its inauguration by the Hon'ble Prime Minister. The Centre also aims to develop the specialty of sports medicine in due course.

Besides the OPD and emergency services, the Centre has an in-patient capacity of 35 beds in single bed, two bed, 4 bed wards and is expected to take care of about 2500 cases pertaining to Arthroscopic & specialized joint surgical procedures every year. The SIC building comprising of seven floors apart from the basement has been equipped with state of the art Operation Theatres and Physiotherapy Centre with all latest facilities adhering to the global standards. The Centre, as part of providing diagnostic services under one roof is housing all modern diagnostic facilities such as MRI and CT scan, Ultrasound, Bone Densitometer, Colour Doppler, etc. and laboratory services which have been wet-leased under PPP mode on revenue sharing basis. The centre will have its own facilities of CSSD and laundry which are being outsourced.

13.2.6. In-Patient Services

The hospital has total bed strength of 1531 including bassinets. There are in addition observation beds for Medical (Ward A) and Surgical (Ward B) patients in the first and second floor of the main causality building. There are 10 beds in the causality for observation. As a policy the hospital does not refuse admission if indicated to any patient in the causality. As a major shift in policy decision, the casualty is now run by post graduate doctors. Senior Residents from the disciplines of Medicine, Surgery, Paediatrics, Orthopaedics and Neuro-Surgery are available round the clock in the causality to provide emergency care.

The administrative requirements of the causality are taken care of by a chief medical officer and a specialist (nodal officer) who are also posted in the causality from various Departments by rotation. There is a 24 hour laboratory facility besides round the clock ECG, Ultrasound, X-ray & CT Scan services. The Departments of Obst. & Gynaecology and the burns have separate, independent causalities.

13.2.7. Casualty Services

CMO I/c Casualty- Dr. Veer Bhushan, was nominated as the Nodal Officer for CWG 2010 for SJH. He successfully coordinated & managed two venues at Sirifort Stadium & also provided medical facility at JLN Stadium, SJH was supplementary response hospital for many stadium. One Defibrillator for casualty procured for Patient care. Surveillance Cameras were installed to strengthen the Security System. Safdarjang Hosptial successfully managed the Epidemics of Swine Flu and Dengue. Waste management training has been made compulsory for casualty. The guidelines for referral of poor patient to other hospital have been strengthened. Large display board in Hindi regarding Poor Patient referral to Pvt. Hospital were put at several prominent places.

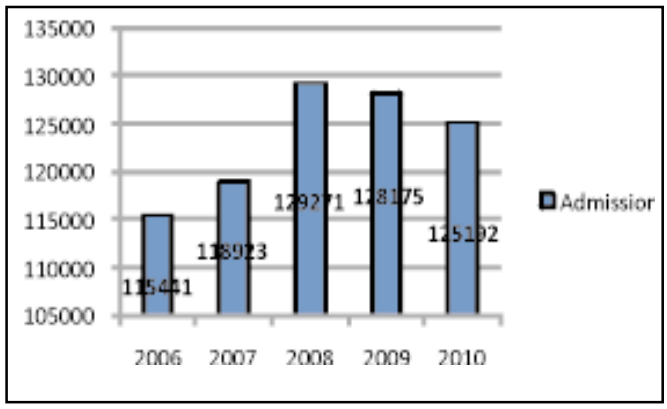
Several New Super Speciality Departments (Endocrinology, Medical Oncology, Nephrology, Nuclear Medicine and Haematology) are also being run in this hospital.

The hospital also provides the services for cardiac catheterisation, lithotripsy, sleep studies, endoscopies, arthroscopies, video EEG, spiral CT, MRI, colour Doppler, mammography and BAC T ALERT microbiology rapid diagnostic system.

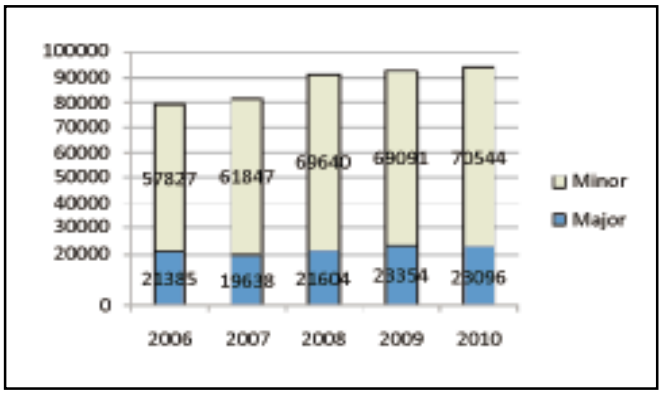
Total No. of In-Patients admitted and operations conducted in this hospital for the last 5 years are as under :-

OPERATIONS				
Years	Admissions	Major	Minor	Total
2006	1,15,441	21,385	57,827	79,212
2007	1,18,923	19,638	61,847	81,485
2008	1,29,271	21,604	69,640	91,244
2009	1,28,175	23,354	69,091	92,445
2010	1,25,192	23,096	70,544	93,650

ADMISSION:-



OPERATIONS:-



The total number of deliveries conducted in the Department of Obst. & Gynae during the **year 2010 was 25439**.

The details of Lab Examination and X-ray examinations since 2006 are given below:

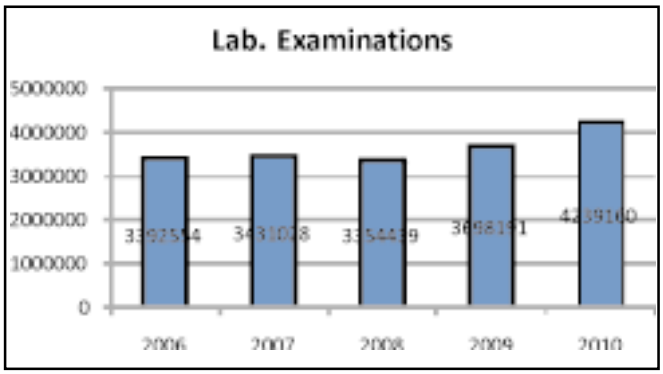
The Significant Achievements during the year 2010

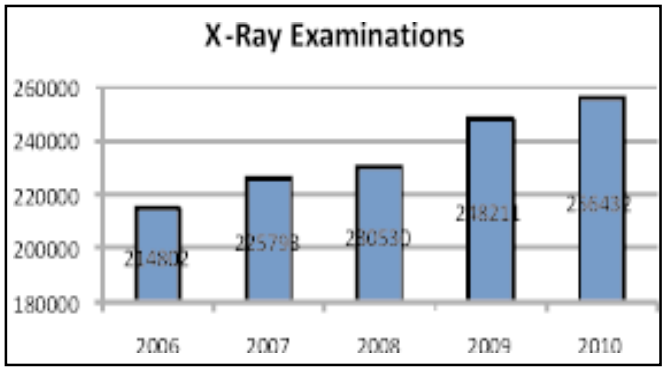
1. The transport Deptt. VMMC & Safdarjang Hospital intent to purchase 16 new vehicles. out of which presently 9 (Nine) Ambulances including (2 Advance Life Support & 4 Basic Life Support) and 3 normal ambulances have been procured and put on service.

2. Two Ultrasound machines, Multi load CR system, Digital OPG X-ray Machine, Bone Mineral Density Measurement Equipment & HD 11 XE High Definition U/S system (Color Doppler Machine) have been installed in the Deptt. of Radiology.

3. The construction of residential hostel for MBBS Student, VMMC was started in 18.01.2008 and the same has completed on May 2010, 254 MBBS students have been accommodated since August 2010.

	2006	2007	2008	2009	2010	Daily Average 2010
Lab. examination	3392554	3431028	3354439	3698191	4239160	**11614**
X-Ray examination	214802	225793	230530	248211	256432	**703**





4. The hospital has successfully completed Community Based Rehabilitation, Pilot Project sponsored by WHO at District Gurgoan in selected rural area. A rural rehabilitation programme is being run in the selected areas of Gurgaon district by the Deptt. of Physical Medicine and Rehabilitation. Regular rehabilitation services are being given at the door steps at selected rural communities.

5. Hematology OPD in the H Block extension has been started.

6. Blood Bank and Transfusion Medicine has 25005 donations and 14,241 components (from Jan'09 to Nov.09) and it has issued 31,988 units of blood and components to hospital.

7. A Museum has been built up in VMMC Pathology. Fluid cytology on cytospin has been introduced and

DNB course has been started in the Pathology Department.

8. Three new tests 1) VMA 2) Anti HBs 3) Parathyroid Hormone have been introduced in the Lab. Medicine Deptt. of Clinical Pathology.

9. A total no. of 156 CCTV cameras have been installed on approved locations and are functional.

10. A special counter for senior citizens, physically handicapped patients and hospital staff was opened in Central Dispensary to avoid inconvenience to these patients. Additional counter for Clinic patients was opened with in the existing strength of Pharmacists in order to minimize waiting time of the patients.

11. M.Sc. Perfusion Training Course has been started w.e.f. 01.08.2009.

12. A total of 6399 poor patients were given free sanction for various tests.

13. A "Dual Head Gamma Camera with integrated Multislice CT", Turnkey works has already been installed and is functional in the Deptt. of Nuclear Medicine .

14. Blood Gas & Electrolyte Analyzer Model ABL800 Basic Radiometer-Copenhagen: was installed in the Deptt. of Respiratory Medicine in January 2009. A Tyco-sleep lab was established in the Deptt in February 2009.

15. A new pharmacokinetic lab has been established in the Deptt. of Pharmacology. Animal house facility too has been created in the Department.

16. The Casualty Deptt. has been equipped with Tracked overhead IV system.

17. The Deptt. of Burns, Plastic and Maxillofacial Surgery has been equipped with Scrub station in Plastic & Burn O.T., Transport ventilator in Burn I.C.U. & Deep Freezer in Burn O.T. to store skin graft for longer period and Six Vital monitor have also been procured in the Deptt. for managing seriously ill patients.

18. Mother & Child care 100 bedded satellite hospital in Gurgaon Sec. 10 has been taken over by Safdarjang Hospital.

19. A 360 bedded new Super specialty building proposal has been sent to Min. of Health & Family Welfare Site earmarked.

13.2.8. Transport Services

Safdarjang Hospital has **21 Ambulances** which are available for emergency services round the clock. Out of 21 ambulances six ambulances were purchased during C.W.G. 2010, of which 4 are Basic Life support ambulance and 2 Advance Life Support ambulance. Three other newly acquired ambulances will be used as patient transport ambulances for needy patients.

Besides this 8 other vehicles are available which include 2 Buses, 1 STD Van, 1 Truck and 4 Staff cars.

13.2.9. Right To Information Cell (RTI)

An R.T.I. Cell is also functioning on the guidelines of Ministry of Law & Justice, as per the RTI Act 2005, in the Gazette of India on 15th June 2005.

13.2.10. Hindi Section:

It is constant endeavor of Hospital to regularly monitor and see the progressive use and implementation of the Official Language in the functioning of hospital. Due to the constant efforts, the use of official language has reached to approximately 60%.

13.2.11. Web Site

VMMC & Safdarjang Hospital had launched its web site (www.vmmc-sjh.nic.in) which was inaugurated on 17.09.2002 by the then Union Health Minister. The website is a user friendly and reveals all the necessary information about hospital and its activities.

13.2.12. Training And Teaching

Teaching of Post-graduate Degree & Diploma to the students enrolled through GGSIP University are conducted in the Departments of Medicine, Surgery, Orthopaedics, Obst. & Gynae, Paediatrics, Anaesthesia, Radio-Diagnosis, Radiotherapy, Opthalmology, ENT, Dermatology, PMR, Physiology, Anatomy, Community Medicine, Microbiology, Biochemistry, Pathology, Pharmacology. In the year 2010, 10 students have been enrolled for M.Ch. Plastic surgery course & 1 student for M.Ch. CTVS course. Out of 173 seats sanctioned for PG Degree courses, 130 students have joined for the session 2010-11 & PG Diploma courses are abolished from the 2010-11 session.

The regular courses are also being run for Nurses Training, Medical Lab. Technology (MLT) apprenticeship; Diploma in Lab Technology; Pre-hospital trauma technician course and courses in pharmacy. Medical Record Technician (MRT) and Medical Record Officer training, Physiotherapy training, O.T. Assistants training and Short term laboratory training programs for all MLT are being conducted regularly.

The proposal for starting MDS course in prosthodontis was approved by Ministry of H.& F.W and extra space for that purpose has been allotted to Dental Department. The branch of Prosthodontics deals with replacement of teeth and associated structures. With starting of this course this hospital will be able to provide facilities of crowns, bridges and dentures to common OPD patients in large scale. The post graduate course will start in near future.

13.2.13. Research Activities

Besides the regular clinical work various research activities are undertaken on a regular basis in the different Departments of the hospital. A number of those have been published in national and international medical journals. A few journals have been also published from Safdarjang Hospital. The research activities are often in coordination with ICMR, DST& WHO.

- ICMR Research Project "Multi Centric National Task Force Project on Epidemiology of Musculoskeletal conditions in India" is being followed in Rehabilitation Section.
- WHO Project "Community Based Rehabilitation-Pilot Project- Gurgaon" has been completed by Rehabilitation Deptt.
- Comparative efficacy of Novamin vs Potassium Nitrate in treatment of Dentinal Hyper-sensitivity.
- Comparative efficacy of Tacrolimus vs Triamcinalone in treatment of Lichen Planus.
- Effect of gum disease in pregnant patients on incidence of preterm low birth weight babies.

13.2.14. Construction Activities

Two additional theatres for general surgery have been started on 1st floor OT.

One theatre has been added for Cancer surgery and Urology services. The microsurgery operational theatre is under up-gradation .

Safdarjang Hospital & VMMC

13.2.15. Budget Allocation

Funds	Budget Allocated				
	(2006-2007)	(2007-2008)	(2008-2009)	(2009-2010)	(2010-2011)
Plan	48.00	70.00	70.00	**84.00**	**132.53**
Non – Plan	74.40	79.90	95.70	**157.00**	**160.00**
Total	122.40	149.90	165.70	**241.00**	**292.53**

VMMC (Revenue) (Rs. in crores)

	Budget allocated	Expenditure incurred
2004-05	5.00	4.66
2005-06	BE 28.76 FE 32.25	32.24
2006-07 (plan)	4.00 FE 4.20	4.03
2007-08 (Plan)	1.00 FE 2.50	2.49
2007-08 (Non-Plan)	0.01	-
2008-09	Nil	Nil
2009-2010	**Nil**	**Nil**
2010-2011	**2.00**	**2.00 (till mid Dec-2010)**

Plan Revenue (SJH)

(Rs. in crores)

Year	Allocation (Year wise)	Expenditure
2006-07	48.00	47.66
2007-08	30.00 FE 37.22	37.08
2008-09	30.00	63.12
2009-2010	44.00	101.68
2010-2011	77.00	63.03

Non – Plan Revenue (SJH)

(Rs. in crores)

Year	Allocation (Year wise)	Expenditure
2006-2007 (non plan)	74.40 FE 81.41	81.33
2007-2008	79.89 F.E 95.79	95.65
2008-2009	95.70	141.81
2009-2010	157.00	189.89
2010-2011	160.00	146.18 (till mid Dec-2010)

VMMC(4210) Construction (Rs. in crores)		
	BE	Expenditure incurred
2006-07	26.00	25.32
2007-08	20.00 FE 15.00	15.00
2008-09	20.00	19.99
2009-10	15.00	04.73
2010-11	05.00	04.30 (till mid Dec 2010)

4210 (SJH)		
	BE	Expenditure incurred
2007-08	19.00	16.06
2008-09	20.00	37.08
2009-10	20.00	29.62
2010-11	43.53	22.20 (till mid Dec-2010)

4216(SJH)		
	BE	Expenditure incurred
2009-10	5.00	0.78
2010-11	5.00	0.10 (till mid Dec 2010)

13.2.16. Library

The library in SJH has all the basic essential tools including Photostat, computers (in computer lab) and Internet facilities. Book bank facilities are given to poor students. It has electronic security system of books and journals for safety purpose. The library has latest and international books and journals. A total number of 360 books were purchased during the last year.

13.2.17. Telephone Exchange

The Telephone Department is located in a double storey building near Gate No.1 next to Dental Surgery Department. Ground floor of the building has an Operator room with console of Exchange and Administrative office. On the first floor is the EPABX Electronic Exchange with other Machinery and Equipments. It interconnects the various Deptts. of SJ Hospitals and also to the medical college through telephonic services. One hundred lines for V.M.M.C are operational for the benefit of many Departments of VMMC. One Mini Intercom Exchange with capacity of 100 lines also has been made operational in casualty recently so as to avoid any interruption in Emergency Services due to power failure or any other circumstance.

13.3.18. Staff Strength as at the end of November 2010

S. No.	Name of the Group	No. of Post Sanctioned	In Position
1.	Group A Gazetted	382	314
2.	Group A Non Gazetted	95	94
3.	Group B Gazetted	56	28
4.	Group B Non Gazetted	1362	1199
5.	Group C	961	807
6.	Group D	1234	1076
7.	Resident Doctors/ PG/DNB/Intern	1279	1096
	Total	**5369**	**4614**

13.3 DR. RAM MANOHAR LOHIA HOSPITAL

13.3.1. Background

The Hospital, originally known as Willingdon Hospital and Nursing Home, renamed as Dr. Ram Manohar Lohia Hospital, was established by the British Government in the year 1933. The hospital has thus surpassed over 75 years of its existence and also emerged as a Centre of Excellence in the Health Care under the Government Sector Hospitals. Its Nursing Home was established during the year 1933-35 out of donations from His Excellency Marchioner of Willingdon. Later, its administrative control was transferred to the New Delhi Municipal Committee, now Council (NDMC). In the year 1954, this hospital was taken over by the Central Government. In the recent past, the Old Building portion of the hospital has been declared as a Heritage Building.

Starting with 54 beds in 1954, the hospital has been expanded to meet the ever-increasing demand on its services and now is a 1055 bedded hospital, spread over an area of 37 acres of land. The hospital caters to the needs of C.G.H.S. beneficiaries and Hon'ble MPs, Ex-MPs, Ministers, Judges and other V.V.I.P. dignitaries besides other general patients. The mandate of the hospital is to provide utmost patient care and the hospital authorities are making all out efforts to fulfill the mandate for which it has been set-up. The hospital is providing comprehensive patient care including specialized treatment to C.G.H.S. beneficiaries and General Public. Nursing Home facilities are available for entitled CGHS beneficiaries. The Nursing Home, including Maternity Nursing Home , is having 75 beds for the CGHS and other beneficiaries

The hospital is one of the most prestigious Government Hospitals not only because of its central location, near the Parliament House and in close proximity to North and South Block where most of the V.V.I.Ps stay but also because of availability of expertise and super specialties. The Government of India has chosen this Hospital for NABH accreditation, an international hallmark for health care service provider, through the Quality Council of India (QCI). The accreditation application has already been made to QCI for undertaking inspection to get the accreditation and to become the first NABH accredited Central Government Hospital.

The hospital annually provides health care services to approximately 16 lacs outdoor patients and admits around 50000 indoor patients. About 1.99 lacs patients are attended in the Emergency and Casualty Department annually. The hospital has round-the-clock emergency services and does not refuse any patient requiring emergency treatment irrespective of the fact that beds are available or not. All the services in the hospital are free of cost except Nursing Home treatment and some nominal charges for specialized tests.

13.3.2. The Services Available

The hospital provides services in the following Specialties and Super Specialties covering almost all the major disciplines:

Clinical Services

- Accident & Emergency Services
- Anaesthesia Services
- Dermatology
- Eye
- ENT
- Family Welfare
- General Medicine
- General Surgery
- Gynaecology & Obstetrics
- Orthopedics
- Paediatrics
- Psychiatry
- Physiotherapy
- Dental

Super Speciality Departments / Units

- Neuro-Surgery
- Burns & Plastic Surgery
- Cardiology
- Cardio Thoracic & Vascular Surgery
- Gastroenterology
- Neurology
- Paediatrics Surgery

- Urology
- Nephrology
- Endocrinology

Departmental Special Clinics

- Diabetic Clinic
- Asthma Clinic
- Pre Anaesthetic Clinic
- ART Clinic
- ARC Clinic

Paediatrics & Neonatology Specialty Clinics

- Neonatology & Well Baby Clinic
- Follow – up clinic
- Neurology Clinic
- Nephrology Clinic
- Rheumatology Clinic
- Asthma Clinic
- Thalassemia clinic
- Nutrition Clinic

Gynaecology & Obstetrics

- Antenatal Clinic
- Infertility Clinic

Skin

- Leprosy Clinic
- Leukoderma

Eye

- I.O.L
- Glaucoma
- Retina

Psychiatry

- Child Guidance Clinic
- Drug De-addiction Clinic
- Marriage counselling
- Psycho-Sexual Clinic
- Geriatric Psychiatry Clinic

Yoga Centre for cardiac and other patients Unani OPD (Daily)

Ayurveda clinic has been started and

Homeopathy clinic has been planned

Blood Bank Services

Dental

- Dental Fracture

DIAGNOSTIC SERVICES

- Hematology
- Pathology
- Microbiology
- Histopathology & Cytology
- Biochemistry
- Radiology including CT Scan, digital X-ray, Color Doppler, Ultrasound & MR

SUPPORT SERVICES

- State of the art Library
- C.S.S.D
- Laundry
- Pharmacy
- Bank
- Post Office
- ISD, STD, PCO Booth
- Mortuary including Hearse Van
- Hospital Waste Management Facilities
- Departmental Canteen
- Ambulance Services

13.3.3. Emergency & Trauma Care Services

This hospital has well- established Emergency services including round- the-clock services in Medicine, Surgery, Orthopedic and Paediatrics while other specialties are also available on call basis. All services like laboratory,