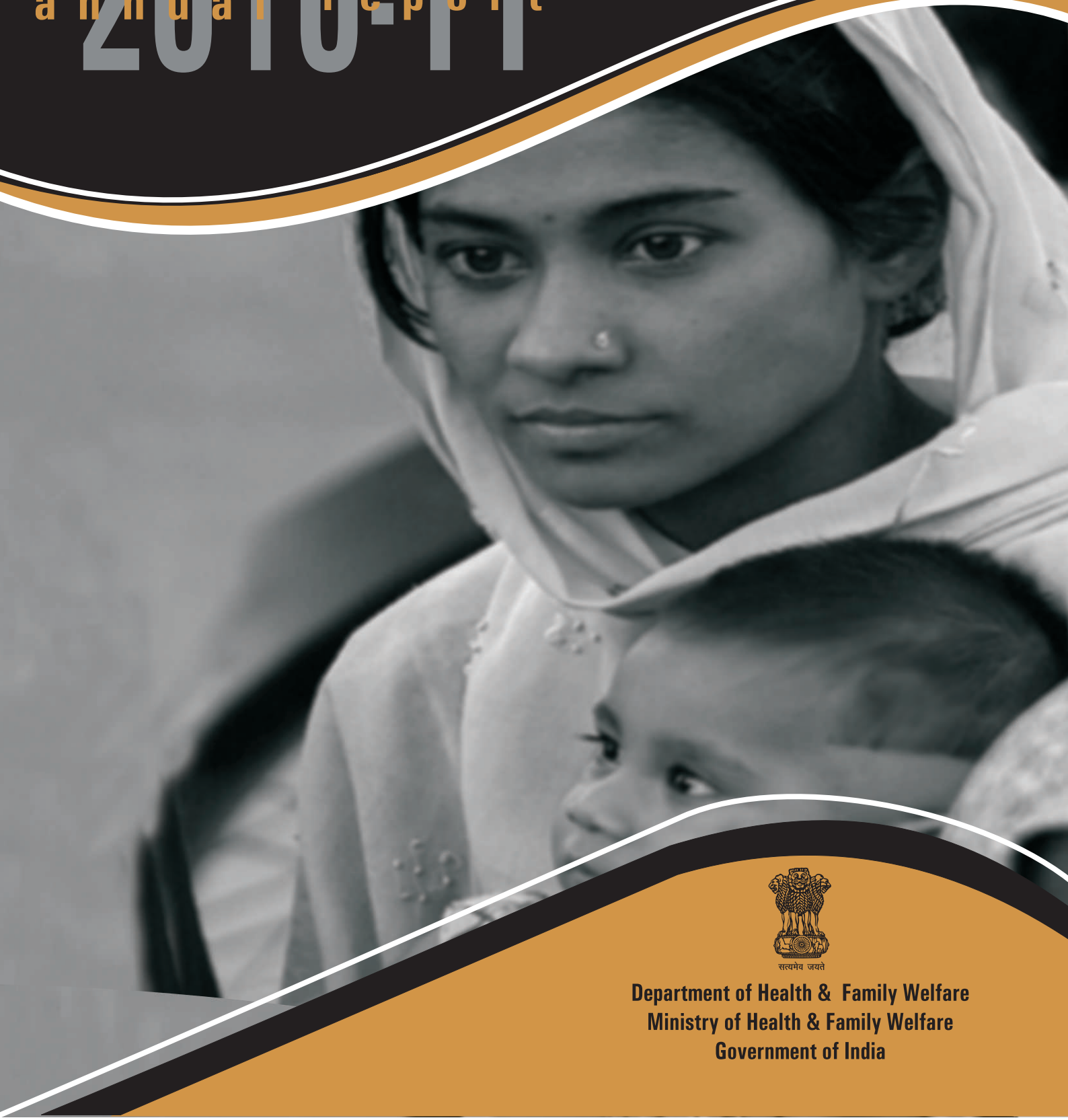



annual report 2010-11



सत्यमेव जयते

Department of Health & Family Welfare
Ministry of Health & Family Welfare
Government of India

ANNUAL REPORT
2010-11

Department of Health & Family Welfare
Ministry of Health & Family Welfare
Government of India
Website : www.mohfw.nic.in

Content

Introduction

The Ministry of Health and Family Welfare oversees the implementation of policies and programmes for health care around the country, within the framework set by the National Health Policy of 2002 and the priorities set in successive Five Year Plans. While the responsibility for the delivery of health care rests largely with the State Governments, the Government of India plays a role in setting policy and providing resources for the implementation of National Programmes.

Despite substantial progress made on many fronts there are still areas of concern. Maternal and Infant Mortality are still unacceptably high in several areas, infectious disease continues to remain a threat to public health. Non-Communicable Diseases including cancers, cardio-vascular disease, diabetes and mental illnesses affect sizeable numbers of our population. India does not as yet have an adequate number of all categories of health professionals, whether of doctors, specialist doctors, nurses, nurse practitioners, para-medics and health workers.

The National Health Policy (NHP) was formulated in 2002 to provide prophylactic and curative health care services towards building a healthy nation. The NHP-2002 aims to achieve an acceptable standard of good health amongst the general population of the country. This is sought to be done by increasing access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing areas and institutions. The challenge has been to provide the country more equitable access to health services across the social and geographical expanse of the country. Thus, keeping in line with this broad objective, several health programmes/ schemes have been launched from time to time. There has been a steady increase in the aggregate public health investment, in the country. The contribution of Central Government towards public investment for provision of health care services has also been enhanced over the years. Expenditure in Health Sector on Public Health is about 1% of the GDP.

National Rural Health Mission (NRHM)

The country has a well structured multi-tiered public health infrastructure, comprising District Hospitals, Community Health Centres, Primary Health Centres and Sub-Centres spread across rural and semi-urban areas and tertiary medical care providing multi-Speciality hospitals and medical colleges. Improvements in health indicators can be attributed, in part to this network of health infrastructure. However, the progress has been quite uneven across the regions with large scale inter-State variations. Despite the consistent effort in scaling up infrastructure and manpower, the rural and remote areas continue to be deficit in health facility and manpower.

Conscious and vigorous efforts continue to be made during the current year to step up funding in the health sector and to increase spending in the public domain, at least to raise it to the level of 3 per cent of the GDP by 2012. The major thrust in the National Rural Health Mission (NRHM) has been towards achieving qualitative improvements in standards of public health and health care in the rural areas through strengthening of institutions, community participation, decentralization and creating a workforce of health workers viz. ASHAs. While the Mission was formally launched in 2005 and has taken a while to effectively find a firm footing, early indications reflect its positive impact. Reliable estimate based on surveys show an appreciable decline in infant mortality (50 per 1000 live births in 2009 as against 60 in 2003), decline in total Fertility Rate (from 3.0 children per women in 2003 to 2.6 in 2008) and improvement in the percentage of safe deliveries etc. (from 48.0 in 2004 to 52.7 in 2007-08).

A new initiative under NRHM has been taken to identify backward districts for ensuring differential financing. Based on health indicators 264 backward districts across

the country have been identified for providing focused attention. Similarly, after many years the agenda of family planning is back in mainstream health discourse and has been repositioned for better maternal and child health apart from population stabilization.

The Reproductive and Child Health (RCH) Programme is a key element of National Rural Health Mission(NRHM). The system strengthening being undertaken under the Mission has lent support to the Programme towards reducing MMR, IMR and TFR. Janani Suraksha Yojana(JSY) has resulted in a steep rise in demand for services in public health institutions with the institutional deliveries registering a substantial increase. The number of JSY beneficiaries has risen from 7.3 lakhs in 2005-06 to about 1 crore in 2009-10. Facility upgradation on a large scale has been undertaken to strengthen health care services for mothers and the neonates. Establishment of new born corners, new born stabilization units and special care units for new born has received a special thrust. In addition, capacity building initiatives such as IMNCI, FIMNCI SBA, NSSK, EMOC and LSAS have been upscaled. SBA trainings have started showing positive results with percentage of skilled attendants at birth registering an increase. Multi skilling of doctors in EMOC and LSAS has led to operationalization of First Referral Units providing C-Section services. Referral Transport for pregnant women has seen considerable progress across States and has emerged as a key intervention to improve timely access of pregnant women to public health facilities. Family Planning has again come back to centre stage after several decades. Wide political support for voluntary family planning has given a new impetus to the Ministry‘s initiatives.

A name-based tracking of mother and children has been launched whereby pregnant women and children can be tracked for their Ante-natal Care and immunisation along with a feedback system for the ANM, ASHA etc to ensure that all pregnant women receive their Ante-Natal Care Check-ups (ANCs) and post-natal care (PNCs); and further children receive their full immunisation. All new pregnancies detected are being registered from 1st April, 2010. The states are putting in place systems to capture such information on a regular basis.

In pursuance of the commitment made by the Government in the address of Hon’ble President of India to the Joint Session of Parliament on 4th June 2009 an Annual Report to the People on Health was published in September 2010 to generate a debate on the issues presented in the Report.

National Council of Human Resources in Health (NCHRH)

The President in her address to the Joint Session of Parliament on 26th June 2009, announced the Government’s intention to set up a National Council of Human Resources in Health (NCHRH) as an overarching regulatory body for health sector to reform the current regulatory framework and enhance supply of skilled personnel. Consequently, a Task Force under the Chairmanship of former Union Secretary (Health & Family Welfare) was constituted to deliberate upon the issue of setting up of the proposed National Council.

The National Commission, which will coordinate all aspects of medical, dental, nursing, pharmacy & paramedical education, will in itself consist of senior professionals and experts of known integrity and social commitment, selected/ nominated by the most stringent standard.

Accordingly, the following three bodies have been proposed to be formed under the ambit of NCHRH – National Board for Health Education, National Evaluation, Assessment & Accreditation Committee and National Councils.

Non Communicable Disease:

The Ministry of MoHFW has launched two new programmes namely (i) The National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke(NPCDCS) and (ii) The National Programme for Health Care of Elderly(NPHCE) to address the menace of Non-Communicable Diseases(NCDs) such as cancer, diabetes, cardiovascular diseases and stroke that are major factors reducing potentially productive years of human life and resulting in huge economic loss. Initially, these two new programmes will be implemented in 100 districts of 21 selected states of the country.

The country is experiencing a rapid health transition with a rising burden of Non-Communicable Diseases which are emerging as the leading cause of death in India accounting for over 42% of all deaths with considerable loss in potentially productive years of life. The Government of India initiated National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke. During the

remaining part of the 11th Plan, 100 districts across 21 States will be supported under this programme. Main activities would include health promotion, opportunistic screening of 30+ population and management of common NCDs. District Hospitals will be upgraded by setting up NCD Clinic, District Cancer Facility and Cardiac care Units. Besides, 65 Tertiary Cancer Centres will be set up to provide comprehensive treatment to common cancers across the country. A provision of Rs. 1230 crores has been made for this programme during 2011-12.

In addition, with increasing life expectancy, there is a growing geriatric population who require special health care. National Programme for Health Care of the Elderly has also been initiated this year in the same districts. The programme will provide services to the elderly population at various levels. Geriatric Clinic and 10 bedded Geriatric wards will be set up in District Hospitals. In addition, 8 Regional Geriatric Centres will be set up in selected medical colleges for tertiary care, training and research activities. A provision of Rs 288 crores has been made during 2010-12.

The Ministry of Health Family Welfare, Government of India has launched National Programme for Prevention and Control of Deafness (NPPCD) on the pilot phase basis in the year 2006-07(January 2007) covering 25 districts which was extended to another 35 districts, 41 districts and 75 districts in the year 2008-09, 2009-10 and 2010-11 respectively, covering total of 176 districts of 16 States and 3 UTs.

The launch of the dedicated National Tobacco Control Programme (NTCP) 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 fulfil the obligation(s) under the WHO-FCTC. The programme at present is under implementation in 42 districts in 21 states in the country. The Global Adult Tobacco Survey (GATS) Report was released by Hon'ble HFM on 19th October, 2010. An out lay of Rupees 30.00 Crore has been earmarked for the NTCP in the current financial year 2010-11, out of which an amount of Rs. 17.17 Crores has been spent till date.

Central Government Health Scheme

The Central Government Health Scheme has been in existence since 1954, when it started functioning in Delhi. The 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.

Control of Infectious Disease

The upgradation of National Centre for Disease Control (NCDC) is being taken up to enhance the capabilities of the Central and State Governments in disease surveillance outbreak investigation and rapid response to disease outbreaks. The proposal has been approved by the Cabinet. During the year 2010, about 1000 disease outbreaks were reported and responded to under Integrated Disease Surveillance Programme (IDSP).

Under Externally Aided Projects, scaling up of Long Lasting Insecticidal Nets (LLINs), Rapid Diagnostic Tests (RDTs) and Artemisnin Based Combination Therapies (ACTs) in high malaria endemic states has been taken up. Similarly, for Kala-Azar elimination, RDTs and oral drugs are also being scaled up. In view of growing threats of other vector-borne diseases like dengue and chikungunya, institutional surveillance has been strengthened and source reduction measures have been taken. In spite of the widespread prevalence of dengue infection in Delhi before and during Common-wealth Games (CWG), members of foreign delegations and other participants in the CWG were not affected by dengue due to sustained source reduction measures at CWG sites.

The Revised National Tuberculosis Control Programme (RNTCP) has moved beyond the case detection rate of 70% and cure rate of 85% in India and efforts are being

made to further improve the rates. With a view to meeting the challenge of Multi-Drug Resistant Tuberculosis (MDR-TB), 43 Culture and Drug Sensitivity Laboratories are being set up and MDR-TB care and management services scaled up.

The Ministry of Health & Family Welfare is giving financial assistance to the poor patients for treatment at different hospitals in all over the country under the following two schemes namely: (i) Rashtriya Arogya Nidhi and (ii) Health Minister's Discretionary Grants. "Rashtriya Arogya Nidhi is providing financial assistance to patients, living below poverty line, who are suffering from major life threatening diseases to receive medical treatment in Government Hospitals. "Financial Assistance up to a maximum of Rs.50,000/- is available to the poor indigent patients from the Health Minster's Discretionary Grant to defray a part of the expenditure on Hospitalization/treatment in Government Hospitals in cases where free medical facilities are not available.

K. Chandramouli
Secretary (H&FW)
Ministry of Health & Family Welfare

March 14, 2011
New Delhi

Organization & Infrastructure

1.1 INTRODUCTION

In view of the federal nature of the Constitution, areas of operation have been divided between Union Government and State Governments. Seventh Schedule of Constitution describes three exhaustive lists of items, namely, Union list, State list and Concurrent list. Though some items like Public Health, Hospitals, Sanitation, etc. fall in the State list, the items having wider ramification at the national level like family welfare and population control, medical education, prevention of food adulteration, quality control in manufacture of drugs etc. have been included in the Concurrent list.

The Union Ministry of Health & Family Welfare is instrumental and responsible for implementation of various programmes on a national scale in the areas of Health and Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. In addition, the Ministry also assists States in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance.

Expenditure is incurred by Ministry of Health & Family Welfare either directly under Central Schemes or by way of grants–in–aids to the autonomous/statutory bodies etc. and NGOs. In addition to the 100% centrally sponsored family welfare programme, the Ministry is implementing several World Bank assisted programmes for control of AIDS, Malaria, Leprosy, Tuberculosis and Blindness in designated areas. Besides, State Health Systems Development Projects with World Bank assistance are under implementation in various states. The projects are implemented by the respective State Governments and the Department of Health & Family Welfare only facilitates the States in availing of external assistance. All these schemes aim at fulfilling the national commitment to improve access to Primary Health Care facilities keeping in view the needs of rural areas and where the incidence of disease is high.

The Ministry of Health & Family Welfare comprises the following four departments, each of which is headed by a Secretary to the Government of India:-

- Department of Health & Family Welfare
- Department of AYUSH
- Department of Health Research
- Department of AIDS Control

Organograms of the Department of Health & Family Welfare are at Annexure at the end of the Annual Report.

Directorate General of Health Services (DGHS) is an attached office of the Department of Health & Family Welfare and has subordinate offices spread all over the country. The DGHS renders technical advice on all medical and public health matters and is involved in the implementation of various health schemes.

1.2 MINISTER IN CHARGE

The Ministry of Health and Family Welfare is headed by Union Minister of Health and Family Welfare, Shri Ghulam Nabi Azad since 29th May 2009. He is assisted by the Ministers of State for Health and Family Welfare – Shri Dinesh Trivedi and Shri S Gandhiselvan.

Shri Ghulam Nabi Azad
Union Minister of Health and Family Welfare

Shri Dinesh Trivedi
Minister of State for Health and Family Welfare

Shri S. Gandhiselvan
Minister of State for Health and Family Welfare

1.3 ADMINISTRATION

The Department has taken new initiatives and steps to ensure that the Government policies and programmes are implemented in a time-bound and efficient manner, as part of Government's commitment to provide better healthcare facilities. It has enforced discipline and accountability amongst its officers and staff.

Director (Administration) attends to service related grievances of the staff in the Department of Health and Family Welfare. Secretary (Health and Family Welfare) also gives personal hearing to staff grievances.

Director (Welfare & PG) in the Department is functioning as nodal officer for redressal of public grievances. Under Secretary (Welfare and PG) assists him in the matter.

1.4 HEALTHY LIFESTYLE CENTRE (YOGA & GYM)

A Healthy Lifestyle Centre (Yoga & Gym) duly funded by WHO has been functioning in the Ministry since 28th November, 2005. Two well-trained (one male and one female) Yoga instructors from Morarji Desai National Institute of Yoga have been deployed to take yoga classes for male and female employees of the Ministry.

1.5 CENTRAL HEALTH SERVICE

The Central Health Service was restructured in 1982 to provide medical manpower to various participating units like Directorate General of Health Services (DGHS), Central Government Health Service (CGHS), Government of National Capital Territory (GNCT) of Delhi, Ministry of Labour, Department of Posts, Assam Rifles, etc. Since inception a number of participating units like ESIC, NDMC, MCD, Himachal Pradesh, Manipur, Tripura, Goa, etc. have formed their own cadres. JIPMER, Puducherry which has become an autonomous body w.e.f. 14th July, 2008 has gone out of CHS cadre. The latest in the list of institutions which has gone out of CHS cadre is Govt. of NCT of Delhi. Consequent upon the formation of Delhi Health Service 906 posts (14 SAG, 150-Non-Teaching, 742-GDMO) belonging to Govt. of NCT of Delhi have been decadred from CHS. At the same time units like CGHS have also expanded. The Central Health Service now consists of the following four Sub-cadres and the present strength of each Sub-cadre is as under:

(i)	General Duty Medical Officer sub-cadre	-	2155
(ii)	Teaching Specialists sub-cadre	-	850
(iii)	Non-Teaching Specialists sub-cadre	-	772
(iv)	Public Health Specialists sub-cadre	-	078

In addition to the above there are 19 posts in the Higher Administrative Grade, which are common to all the four sub cadres.

1.5.1. Recruitment:

(a) **Recruitment of GDMOs**: -Dossier of 450 candidates has been received from UPSC on the basis of Combined Medical Service Examination-2009 including 16 physically handicapped candidates and they were allocated to different Ministries/Departments as below:

i)	Ministry of Railoways	- 248 (including 8 PH)
ii)	Ministry of Defence	- 005 (including 1 PH)
iii)	MCD	- 026 (including 1 PH)
iv)	NDMC	- 019
v)	Central Health Service	- 152 (including 6 PH)

Government's policy on reservation for SC, ST, OBC & Physically Handicapped is being followed strictly in the recruitment of Medical Officers of CHS.

"In order to avoid inordinate delays in issuing offers, provisional offer of appointment are being issued to the CMSE candidates pending verification of their character and antecedents from the authorities concerned as per decision of Committee of Secretaries."

1.5.2. Promotions:

During the year, the following numbers of promotions were effected/under process in various sub-cadres of the Central Health Service:

Sub-cadre	Sr. No.	Designation of posts	No.
GDMO	1.	Senior Medical Officers to (Grade Pay Rs. 6600/- in PB-3) to Chief Medical Officers. (Grade Pay Rs. 7600/- in PB-3)	01
	2.	Chief Medical Officer (Grade Pay Rs. 7600/- in PB-3) to Chief Medical Officer (NFSG)(Regular) (Grade Pay Rs. 8700/- in PB-4)	89
	3.	Chief Medical Officer (NFSG) (Grade Pay Rs. 8700/- in PB-4) to Senior Administrative Grade (Grade Pay of Rs. 10000/- in PB-4)	586
TEACHING	1.	Assistant Professor (Grade Pay Rs. 6600/- in PB-3) to Associate Professor (Grade Pay Rs. 7600/- in PB-3)	55
	2.	Associate Professors (Grade Pay Rs. 7600/- in PB-3) to the post of Professor (Grade pay 8700 in PB-4).	34
	3.	Professor (Grade Pay Rs. 8700/- in PB-4) Director-Professor(SAG) (Grade Pay Rs. 10000/- in PB-4)	160
NONTEACHING	1.	Specialist Grade-II (Junior scale) (Grade Pay Rs. 6600/- in PB-3) to Specialist Grade –I (Grade Pay Rs. 7600/- in PB-3)	57
	2	Specialist Grade-II (Senior scale) (Grade Pay Rs. 7600/- in PB-3) to Specialist Grade –I (Grade Pay Rs. 8700/- in PB-4)	17
	3.	Specialist Grade-I officers (Grade Pay Rs. 8700/- in PB-4) promoted to the post of SAG (Grade Pay Rs. 10000/- in PB-4) under DACP Scheme	219
	4.	A proposal for holding DPC for one post of HAG for 2008- 09 and 5 posts for 2009-10 and 2 posts for 2010-11 is being sent to UPSC.	
	5.	Proposal for holding DPC for 1 post of Special DGHS sent to UPSC	
PUBLICHELTH	1	Specialists Gr. I officers (Grade Pay Rs. 8700/- in PB-4) to SAG (Grade Pay Rs. 10000/- in PB-4)	14

I. Review of CHS-Rules, 1996:

Recruitment Rules, 1996 for Central Health Service has been revised in consultation with DOP&T and sent to UPSC for approval.

II. Posting of doctors to Andaman & Nicobar Islands:

Despite best efforts on the part of this Ministry, the vacancies of Specialists (Non-Teaching) Sub-Cadre in A & N Islands could not be filled. Accordingly, from August 2008 onwards, General Duty Medical Officers with requisite PG qualification as well as Specialists are being deputed to the A & N Islands for a period of 90 days in Specialities of Paediatrics, Medicine, Radiology, ENT, and Obstetrics & Gynaecology, Anaesthesia and Ophthalmology. Requisition for all vacant Non-teaching Specialist CHS posts in A&N Islands have been sent to UPSC with a request to fill up these posts urgently.

1.5.3. Other Service related matters

(i) **RTI:** The number of RTI cases received in this Division is 548.

(ii) **Court Cases:** There were 79 Court cases pending in various CAT/Courts in the beginning of financial year 2010-11. But due to vigorous efforts by the CHS Division, 14 cases have been disposed off by the courts and only 65 cases are pending in courts.

1.5.4. Constitution of a Committee for considering the representations of CHS Officers for Upgradation of below bench Mark Grading in the ACRs:

Consequent to the instructions contained in Department of Personnel and Training's O.M. No. 21011/1/2010-Estt.A dated 13.4.2010 , a Committee under the Chairmanship of Shri Keshav Desiraju , Additional Secretary has been constituted for considering the representations of hundreds of CHS officers for upgradation of the below bench mark grading in their ACRs.

1.5.5. Non Medical Scientists 2010-11.

A proposal has been mooted to amend the ISP Rules, 1990 to incorporate provisions for inclusion of more posts within its ambit. Participating Units/Institutes have been asked to submit proposals in this regard.

A proposal for amendment of UPSC (Exemption from Consultation) Regulations, 1958 under Ministry of Health and Family Welfare with the view to do away with the requirement of consultation with the UPSC in the matter of in-situ promotions upto S.IV level has been sent to Department of Personnel and Training.

Action has been taken to fill up Seven posts as S-V level with UPSC. Pending ACRs and Bio-data are being collected.

1.5.6. Dental Side - 2010-11

During the year six posts of Dental Surgeons under Ministry of Health and Family Welfare have been filled up on regular basis. For one post, administrative formalities are being completed before offer of appointment to be issued to recommended candidate by UPSC.

13 officers had been considered for promotion to SAG level. 7 were promoted and 6 were not found fit, as having below bench mark of ACRs, formalities for upgradation of ACRs as per DOP&T's guidelines are being completed.

The process has also been initiated to amend the Dental Posts Recruitments Rules, 1997 to bring them in conformity with the changes that have since taken place.

1.6 E-Governance Initiatives of the Ministry of Health & FW

Health Informatics Division of National Informatics Centre provides MIS and Computerization support to Ministry of Health & Family Welfare. More than 1300 PCs of the Ministry are connected to the Local Area Network (LAN), which in turn, connected to NICNET through RF Link and leased line circuits. Salient features of the some of the projects handled by NIC are as follows:

1.6.1. Web Page

The updation of Website of the Ministry of Health & Family Welfare http://mohfw.nic.in and various other websites under the Ministry are done on a regular basis, as and when the information is provided by the users. Critical information such as notifications of the CGHS, Tenders and Advertisements under the Ministry, sanction details of the Principal Accounts Office & Public Expenditure Management, etc are such areas where regular updation takes place. In addition a no. of websites under the MoHFW are being maintained by the respective users on their own.

1.6.2. Network Maintenance and email, internet usage

NIC provides new LAN connections; network based Anti-virus solution in addition to maintaining existing network users. At present over 1300 LAN nodes have been provided in the Department of Health & Family Welfare, Directorate General of Health Services and about 100 LAN nodes at IRCS Building at Dept of AYUSH. The email and internet usage has grown significantly and officials prefer email communication over other means. The network maintenance and desktops require constant updation from the operating system service providers and hence the un-authorized access is controlled effectively.

1.6.3. Computerization of Mother and Child Tracking System (MCTS)

It has been decided to have a name-based tracking whereby pregnant women and children can be tracked for their ANCs and immunisation along with a feedback system for the ANM, ASHA etc to ensure that all pregnant

women receive their Ante-Natal Care Check-ups (ANCs) and post-natal care (PNCs); and further children receive their full immunisation. All new pregnancies detected/ being registered from 1st December 2009 at the first point of contact of the pregnant mother with the health facility/ health provider would be captured as also all Births occurring from 1st December, 2009. The states are putting in place systems to capture such information on a regular basis. The National Informatics Centre is rolling out their software application to other States based on the Gujarat model of e-Mamta.

The master data entry of health facilities is almost complete and now states will start entering the names of the mothers and children in the online system. The system will help in developing work plan for the ANMs and ASHAs so as to deliver the health services to all the mothers and children. An offline version of the MCTS system has also been developed for facilities where the internet connectivity is not there and this can be linked to the online system on a periodic basis. The first cycle of the system is expected to be completed by March 2011. The URL is http://nrhm-mcts.nic.in .

1.6.4. Computerization of Central Govt. Health Scheme (CGHS)

CGHS is high on the agenda of the Government with the ultimate objective to provide effective, timely and hassle free healthcare to the CGHS beneficiaries. The computerized system is aimed at computerizing all functions of the dispensary such as Registration, Doctors' prescription, Pharmacy Counter, Stores, Laboratory & Indent etc. The system has been successfully implemented in all the 24 cities of CGHS including Delhi/ NCR covering 248 allopathic wellness Centres (WCs).

The introduction of plastic cards for every individual CGHS beneficiary with the barcoded number has been implemented successfully in Delhi/NCR. Now all the new CGHS beneficiary has to have a plastic card in all CGHS cities.

Bulk procurement of commonly indented medicines from manufacturers / suppliers has been successfully operational in Delhi/NCR and in 6 cities outside Delhi/ NCR.

The implementation of online MRC Claims module is under implementation in Delhi/NCR. The AYUSH WCs are being computerized in Delhi/NCR and are expected to be completed by March 2011. The URL of the site is http://cghs.nic.in.

The implementation of the CompDDO package for the DDOs of CGHS in Delhi/NCR and 6 cities outside Delhi/ NCR is underway.

The telephone number for the CGHS HELPLINE 011-66667777 is operational during office hours on all working days and it provides information to the CGHS beneficiaries.

1.6.5. Intra-Health Portal for the Ministry:

Intrahealth portal is a G2G and G2E application and caters to the needs of employees and Divisions of MoHFW / DteGHS. It has the following facilities:

1. Notice Board consisting of circulars/orders issued by various Divisions of MoHFW and DteGHS.
2. Payslips for the employees under Department of Health & FW, AYUSH, DGHS are available online
3. Office Procedure Automation (OPA) for tracking of file movements
4. Bulletin Board for exchange of views and comments.
5. Links to various Govt. web-sites.
6. Photo gallery relating to important events in Health and FW sector.

The portal URL is http://intrahealth.nic.in.

1.6.6. Computerisation of Medical Stores Organization (MSO) and General Medical Stores Depots (GMSDs)

The MSO is a premier organization of the MoHFW, which is involved in procurement and supply of medicines to the Central Govt. hospitals across India, CGHS, Para-military forces. MSO does it through its 7 GMSDs located across India. Inventory management is therefore, very vital for the MSO so that the medicines are supplied to the indenters in time after proper quality check.

The web based Inventory management system for the MSO & GMSD has been implemented on a full scale now. All the stakeholders such as MSO, GMSDs, indenters, suppliers; Labs etc are using the online system. The suppliers have been providing the medicine supplies with the barcodes (1D) at the tertiary level packaging and secondary level packaging. http://msotransparent.nic.in

1.6.7. Usage of NIC CompDDO package by various DDOs under the MoHFW

Composite DDO Package (CompDDO) has been in regular usage by Cash(Health) Section, Cash(FW) Section, MoHFW, and Cash Section, DteGHS, Nirman Bhawan, New Delhi, with the technical support from NIC. The same package has been in use by PPAO, PAO(Sectt.), PAO(DteGHS), attached with MoHFW/ DteGHS, Airport Health Office,New Delhi, Rural Health Training Centre(RHTC),Najafgarh,New Delhi, and National Centre for Disease Control(NCDC). Recently,the package has also been installed and made operational at FSSAI,National Institute of Biologicals,Central Pharmacopia Commission and National Institute of Health and FW. The package automates functions of Cash Sections as regards preparation of pay bills, payments of employees' salaries through their bank accounts/ECS, GPF, income tax, etc. The staff at all these organizations/sites has been trained to operate the package, and issues that arise from time to time are taken care of by NIC..

1.6.8. CPGRAMS and E-Service Book

Centralised Public Grievance and Redressal & Monitoring System (CPGRAMS) is under implementation in the Ministry and DteGHS. It provides for on-line monitoring, processing and disposal of Public Grievances.

E-service Book project has provision for updation and maintenance of service books of employees electronically. The project is under implementation in the Ministry and DteGHS.

1.6.9. Usage of PAO Package of NIC under MoHFW

PAO-2000 is a software package developed by NIC, and it monitors details of expenditure by MoHFW, DteGHS and sub-ordinate organizations through on-line transfer of data from various PAOs to PPAO, MoHFW, Nirman Bhawan, New Delhi. The PPAO then transmits the compiled data to CGA through the NETWORK for on-line updation of database at their end. Provision is also there for various reports and queries at different levels. The package is in continued usage by PAOs and PPAO attached with MoHFW / DteGHS and sub-ordinate organizations.

All the 11 PAOs attached with MoHFW / DteGHS and sub-ordinate Organizations have been using the package: 1.PAO(Secretariat) 2.PAO(DteGHS) 3. PAO(Safdarjung Hospital). 4. PAO(Dr RML Hospital) 5. PAO(LHMC) 6. PAO(NCDC) 7. PAO(CGHS) 8. PAO(Mumbai) 9. PAO (Kolkata) 10. PAO(Puducherry) 11. PAO(Chennai).

1.6.10. OncoNET India Project:

This project envisages connecting of 27 Regional Cancer Centres with associated Peripheral Cancer Centres to provide early cancer diagnosis/detection, treatment and follow up for cancer patients. The project has been implemented successfully in 4 RCCs and 4 PCCs at present and 3 more sites are under implementation.

1.6.11. Implementation of e-Hospital Solution at the Sports Injury Centre, Safdarjang Hospital, New Delhi:

The e-Hospital[@NIC] - consists of more than 14 core modules that cover major functional areas of the Hospital viz. Out Patient Department, In Patient Department, Casualty, Ward Management, Operation Theatre Management, Clinic Information, Path Laboratories, Radiology, Blood Bank, MRD, Stores & Inventory control Management, Accounts, Personnel Management have been planned for implementation during this year. Implementation support is being provided by NICSI from Sep, 2010.

1.6.12. Online allotment and Display System of Central Quota of UG/PG Medical/Dental seats:

DGHS, Ministry of Health & Family Welfare allots 15% of M.B.B.S/B.D.S and 50% M.D/M.S/M.D.S and Post-graduate Diploma seats of recognised Medical Colleges to the merit holders as provided by CBSE/AIIMS who conduct competitive examinations on All India basis. The Computerized Allotment and Display System software of NIC fully complies with guidelines and orders given by Hon'ble Supreme Court of India and various other High Courts on various occasions over the period of last 15 years or so. Salient features of the Scheme are as follows:

1.6.13. Under-Graduate Counselling

- More than 2250 MBBS and around 200 BDS seats are available in 127 colleges across India.
- Allotment is done in two or more rounds as per court orders.

- SC, ST, OBC and PH reservations done through roster system approved for this purpose.
- This system does VC based on-line allotment at Delhi, Kolkata, Chennai and Mumbai, through NICNET.

1.6.14. Post-Graduate Counselling

- More than 4250 MD/MS/Diploma in 106 disciplines and 154 PG Dental seats in 28 Dental Colleges across India.
- Allotment is done in two or more rounds as per court orders.
- SC, ST, OBC and PH reservations done thro' roster system devised for this purpose.
- This system does VC based on-line allotment at Delhi, Kolkata, Chennai and Mumbai through NICNET.

1.6.15. Technical Support to AYUSH

- NIC AYUSH wing provides necessary IT support including LAN, WAN, web security, anti-virus etc to all the users of AYUSH at IRCS Building, New Delhi.

1.6.16. Integrated Disease Surveillance Project (IDSP)

NIC has completed establishment of IT centers at all 796 IDSP sites across the country and handed over the same to the IDSP wing of NCDC. The URL of the site is http://idsp.nic.in.

1.7 ACCOUNTING ORGANIZATION

As provided in Article 150 of the Constitution, the Accounts of the Union Government, shall be kept in such form as the President of India, may on the advice of Comptroller & Auditor General of India prescribe. The Controller General of Accounts (CGA) in the M/o Finance shall be responsible to prepare and compile the Annual Accounts of the Union Government to be laid in Parliament. The CGA performs this function through the Accounts Wing in each Civil Ministry. The Officials of Indian Civil Accounts Organization are responsible for maintenance of Accounts in Ministry of Health & Family Welfare. They have dual responsibility of reporting to the Chief Accounting Authority of the Ministry/Department through the Financial Adviser for administrative and accounting matters within the Ministry, as well as to the Controller General of Accounts, on whose behalf they function in this Ministry to carry out its designated functions under the Allocation of Business Rules. The administration of Accounts Officials in Ministry of Health & Family Welfare is under the control of the office of the CGA.

The Secretary of each Ministry/Department is the Chief Accounting Authority in Ministry of Health & Family Welfare. This responsibility is to be discharged by him through and with the help of the Chief Controller of Accounts (CCA) and on the advice of the Financial Advisor of the Ministry. The Secretary is responsible for certification of Appropriation Accounts and is answerable to Public Accounts Committee and Standing Parliamentary Committee on any observations of the accounts.

Accounting Set Up In the Ministry:

The Ministry of H&FW has four Departments viz. Department of Health & Family Welfare, Department of Ayush (Ayurveda, Yoga, Unani, Sidha & Homeopathy), Department of Health Research & Department of AIDS Control (NACO). There is a common Accounting Wing for all the Departments. The Accounting Wing is functioning under the supervision of a Chief Controller of Accounts supported by a Controller of Accounts (CA), Dy. CA and eleven Pay & Accounts Officers (PAOs) and Drawing & Disbursing Officers (DDOs) in the field. The CCA is submitting internal audit observations and matter related to financial discipline directly to the Secretary in respect of each Department and its subordinate organizations. The Annual Review Report of the Internal Audit is also subject to scrutiny by the CGA and Ministry of Finance. The CCA is also entrusted with the responsibility of Budget Division & Official Language Division of the Ministry.

In addition, there are fourteen encadred posts of the Accounts Officers located at various places. There is a common Internal Audit Wing for all the Departments, which carry out the inspection of all the Cheque Drawing and Non-Cheque Drawing Offices, Pr. Accounts Office and all the PAOs. There are 5 Field Inspection Parties located at Delhi, Chandigarh, Mumbai, Kolkata and Bangaluru.

Accounting Functions in the Ministry:

The Accounting function of the Ministry comprises of various kinds of daily payments and receipts, compiling

of daily challans, vouchers, preparation of daily Expenditures Control Register etc. Monthly expenditure accounts, monthly receipts and monthly net cash flow statements are being prepared for submission to Ministry of Finance through the CGA's office. The entire work of payment and accounts has been computerized.

The Pr. Accounts Office prepares Annual Finance Accounts, Annual Appropriation Accounts, Statement of Central Transactions, Annual Receipts Budget, Actual Receipts and Recovery Statement for each grant of the Ministry. The head wise Appropriation Accounts are submitted to the Parliament by the CGA along with the C&AG's report.

In addition, the Pr. Accounts Office issues orders of placement of funds to other civil Ministries, issues advices to Reserve Bank of India (RBI) for release of loans/ grants to State Governments and LOC to the accredited Bank of the Ministry for placing funds with DDOs. Apart from general accounting functions, the Accounts Wing gives technical advices on various Budgetary, Financial and Accounting matters.

The Accounting Wing also functions as a coordinating agency on all accounts matters between Ministry and the Office of the Controller General Accounts & the Comptroller and Auditor General. Similarly it coordinates on all budget matters between Ministry and the Budget Division of the Ministry of Finance.

Internal Audit Wing

The Internal Audit Wing of the Department of Health and Family is handling the internal audit work of all the four Departments. There are more than 600 audit units of the Department of Health and Family Welfare, 24 units of Department of AYUSH and 25 units of Department of Health Research. The Internal Audit plays a significant role in assisting the Departments to achieve their aims and objectives.

The role of Internal Audit is growing and shifting from Compliance audit confined to examining the transaction with reference to Government Rules and Regulations to complex auditing techniques of examining the performance and risk factors of an entity. In 2009-10, 97 audit paras have been raised which include observations to the tune of Rs. 1368.47 crores. A total No. of 851 paras have been settled during 2009-10.

1.8 IMPLEMENTATION OF RTI ACT, 2005

The Right to Information Act, 2005, enacted with a view to promote transparency and accountability in the functioning of the Government by securing to the citizens the right to access the information under the control of public authorities, have already come into effect w.e.f. 12.10.2005.

Under the Right to information Act, 2005, 32 Central Public Information Officers(CPIOs) and 17 Appellate Authorities(A/As) have been appointed in the Ministry of Health & Family Welfare (Department of Health & Family Welfare).

All CPIOs including autonomous organizations/PSUs have placed all obligatory information pertaining to their Division/programme, under Section 4(i) of the RTI Act, 2005 in the Website of Ministry. Now RTI Request/ Appeal Management System (RRAMS) is under implementing stage. Under this system CPIOs and Appellate Authorities (including autonomous organizations) would create computer Based management of RTI requests and appeal.

Applications under the Act for seeking information are accepted at Facilitation Centre, near Gate No.5, Nirman Bhavan & at Coordination-II (CDN-II) Section, Room No. 215A, 'D' Wing, Nirman Bhawan, New Delhi. Applications are also accepted by post through Receipt & Issue (R&I) Section. During 2009-2010, 1541 applications and 250 RTI Appeals were received under RTI Act, 2005. Annual return for the year 2009-2010 has already been sent to CIC. During 2010-11, 2419 applications and 389 appeals till 31.12.10 have been received.

1.9 VIGILANCE

Vigilance Wing of the Department of Health and Family Welfare functions under the overall control of an officer of the rank of Joint Secretary to the Government of India who also works as part time Chief Vigilance Officer (CVO) of the Ministry . The CVO is assisted by a part –time Director(Vig.), an Under Secretary(Vig.) and the supporting staff of Vigilance Section.

The Vigilance Division of the Ministry deals with vigilance and disciplinary cases of the Department of Health and Family Welfare and vigilance cases involving officers of Dte.GHS and CGHS. The Vigilance wing monitors vigilance enquiries, disciplinary proceedings in respect of Doctors and non-medical/technical personnel borne on the Central Health Service (CHS), P&T Dt.GHS

dispensaries and other institutions like Medical Stores Organizations, Port Health Organizations, Labour Welfare Organization etc.

During 2010-11(till ending December,2010), one charge sheet each for major penalty and minor penalty for alleged irregularities were issued. Penalties were imposed in 7 cases and charges were dropped in 6 cases. Sanction for prosecution was granted in one case and 2 appeal cases were received/processed. One official was placed under suspension. Suspension was revoked in 2 cases and ongoing cases of suspension were reviewed by the Committee. More than 115 complaints were received from CVC, 45 miscellaneous complaints were forwarded by CBI and 75 complaints were received from other sources. 29 references were sent to CVC, 6 to UPSC, 3 references to DOP&T and 6 references were sent to Ministry of Law & Justice for advice. Presently there are 2 court cases being dealt with in the Division.

Central Vigilance Commission guidelines of use Information Technology for vigilance administration are being implemented vigorously and major initiatives have been taken regarding use of technology in e-governance for minimising the need of interfacing officials with beneficiaries. The entire process of registration of patients, maintenance of personal records, prescription, investigation advices, distribution of medicines etc. have been computerised in the CGHS to make the entire process transparent. In Central Drugs Standard and Control Organization, standard operating procedures and e-submission has been introduced. The official web-site has also been launched giving all details.

Vigilance Division, MOHFW – Organization and Functions

The Vigilance Division of the Ministry functions under the overall control of the Chief Vigilance Officer (CVO), an officer of the rank of Joint Secretary to Government of India, assisted by a Director, an Under Secretary and a Vigilance Section with supporting staff. The CVO is appointed by the Department with the concurrence of Chief Vigilance Commission. The CVO is responsible for keeping an eye on the integrity and conduct of public servants of the Ministry and also for implementation of anti corruption measures. He deals with all vigilance cases and act as a link between the Ministry and agencies like CBI, CVC, UPSC, DOP&T, etc. The CVOs of the autonomous organizations and VO's in attached/ sub-ordinate offices under the Ministry are appointed in consultation with CVO.

The main function of the Division is to implement the preventive and punitive measures to combat the corruption. Preventive measures adopted are – Examination of Rules and procedure of the organization to eliminate or minimize scope for corruption, identification of sensitive issues, surprise inspections, surveillance on officers and doubtful integrity, scrutiny of property returns etc.

The Division follows rules, regulations and guidelines issued from time to time in respect of vigilance cases of different types and appropriate action is taken in consultation with CVC, UPSC, and DOP&T etc. wherever necessary.

1.10 ACTIVITIES OF THE COMPLAINT COMMITTEE ON SEXUAL HARASSMENT OF WOMEN EMPLOYEES

In pursuance of the directions of Hon'ble supreme Court in their judgement in the case of Vishakha and other vs. State of Rajasthan and others, a Complaint Committee has been constituted in the Department of Health & Family Welfare to look into the complaints of sexual harassment of women employees in the Department. The SHC is chaired by Smt. Shalini Prasad, Joint Secretary and has three members Smt. Aparna Sachin Sharma, Smt. Rekha Chauhan and Sh. J. P. Pandey. No new case is received for hearing during the period 2010-11.

1.11 PUBLIC GRIEVANCE CELL

Public Grievance Redressal Mechanism is functioning in the Ministry of Health & Family Welfare as well as in the attached offices of the Directorate of Health Services and the other Subordinate offices of CGHS (both in Delhi and other Regions), Central Government Hospitals and PSUs falling under the Ministry for implementation of the various guidelines issued from time to time by the Government of India through the Department of Administrative Reforms & Public Grievances.

Shri B. Nayak, Joint Secretary in the Department of Health & Family Welfare has been designated as Nodal Officer for Public Grievances relating to the Department. Shri R. D. Indora,Under Secretary in the Department of Health & Family Welfare is functioning as Public Grievance Officer. Similarly other organizations under the Ministry have also senior level officials functioning as Public Grievances Officers.

Pursuant to the instructions of the Govt. for creation of Sevottam Compliant system to redress and monitor public grievances under Results Framework Documents for 2010-11 and implementation of Centralised Public Grievance Redress and Monitoring System (CPGRAMS) in the Ministries/Departments, CPGRAMS has been implemented in the Department, Attached Office, i.e., Directorate General of Health Services,(DteGHS), Central Govt. Health Scheme, and extended to Autonomous Bodies/PSUs. It is being extended to other Subordinate Offices of Dte.GHS It is a web based portal and a citizen can lodge grievance through this system directly with the concerned Departments. A link of CPGRAMS has also been provided on the website of the Ministry, i.e., www.mohfw.nic.in.

The number of written Grievance petitions received/ disposed of and pending during 2009 & 2010 are as follows:

Year	Opening Balance	Grievance petitions received during the year	Grievance petitions disposed of during the year	Pending
2009	102	165	117	150
2010	150	249	225	174

The position in regard to grievance received through CPGRAMS is as under (as on 24.01.2011):

No. of Grievances received	Disposal	Pendency
2259	1006	1253

1.12 INFORMATION & FACILITATION CENTRE

To strengthen the Public Redressal Mechanism in the Ministry of Health & Family Welfare, an Information & Facilitation Centre is functioning adjacent to Gate No.5, Nirman Bhawan. The Facilitation Center provides the following information to public:

1. Circulars/ Booklets/ Pamphlets/ Posters/ NGO Guidelines and forms for public use.
2. Information and Guidelines to avail of financial assistance from Rashtriya Arogya Nidhi and Health Minister's Discretionary Grant.
3. Guidelines and instructions regarding issue of NOC to Indian Doctors to pursue higher medical studies abroad.
4. Information and guidelines relating to CGHS and Queries relating to the work of the Ministry.
5. Receiving Petitions/Suggestions on Public Grievances.
6. General queries regarding the work of the Ministry received at the Information and Facilitation Centre on telephone and personally were disposed of to the satisfaction of all concerned.

1.13. NATIONAL URBAN HEALTH MISSION (NUHM)

The launch of National Rural Health Mission (NRHM) for providing accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions has changed the health services' delivery scenario remarkably in the rural areas of the country, particularly in the high focus/backward States. However, while there is somewhat a uniform public health infrastructure in the rural areas, it is largely non-existent in urban areas except in some large urban centres and metropolitan cities that too mostly focused on reproductive and child health services. Approximately three-quarters of urban healthcare is accounted for by private health facilities and therefore, result in substantial out of pocket expenses.

The health indicators for the urban poor are as bad as their rural counterparts and much worse than the urban average. Poor environmental condition in the slums along with high population density makes them vulnerable to various communicable and vector borne diseases. Although, the government has been active in initiating improvements in the living conditions in slums, unsatisfactory living conditions continue to prevail in most of the slums. The poor health outcomes can partially be traced to the inadequate services, like water supply and sanitation, and housing facilities.

The unenviable health indicators of the urban poor along with not so effective health care service delivery mechanism clearly articulate the need to address the

growing challenges of urban health in a concerted way. Ministry of Health & Family Welfare proposes to launch National Urban Health Mission (NUHM) to address these issues with a focus on the slum dwellers and other disadvantaged sections. The proposed NUHM, presently at consultation stage, aims to improve the health status of the urban population by facilitating equitable access to quality healthcare with active involvement of the Urban Local Bodies (ULBs) in cities with population of one lakh and above and State Capitals.

The NUHM would encourage the participation of the community in planning and management of health care services. It would promote community leadership in urban settlements; ensure the participation by creation of community based institutions under the local bodies. It would proactively reach out to urban poor settlements by way of regular outreach sessions and monthly health and nutrition day. It would mandate special attention for reaching out to other vulnerable sections like construction workers, rag pickers, sex workers, brick kiln workers, rickshaw pullers, etc. This could be done through the public healthcare systems or through PPP or other innovative models deemed suitable by the states.

Discussions with various stakeholders including the States and Union Territories, Ministry of Urban Development, Ministry of Housing and Urban Poverty Alleviation have been undertaken, to finalise the contours of the Mission and formulation of the framework of its implementation. NHUM would also leverage the reform component of JnNURM for promoting public health component among Urban Local Bodies. With a view to improving convergence and synergy among various stakeholders, NUHM would envisage the active participation of these stakeholders in Mission Steering Group, Coordination Committees at the national, state and municipal levels. NUHM would also utilize the infrastructure and skill-sets of other programmes like JnNURM, SJSRY and ICDS etc. to improve the urban health care service delivery system.

1.14 RURAL HEALTH SERVICES

The health and family welfare programme in the country is being implemented through primary health care system. In rural areas, primary health care services are provided through a network of 145894 Sub-centres, 23391 Primary Health Centres and 4510 Community Health Centres as on March 2009 based on the following norms of population case load/work load and distance.

The population norms for SC/PHC/CHC is as follows :

Centre	Plain Area	Population NormsHilly/ Tribal area
Sub-Centre	5000	3000
Primary Health Centre (PHC)	30,000	20,000
Community Health Centre (CHC)	1,20,000	80,000

Sub-Centre

Sub-centre is the first peripheral contact point between Primary Health Care system and the community. It is manned by one Female (ANM) and one Male Health Worker and one LHV for six such Sub-Centres. Sub-centres are assigned task relating to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes and provided with basic drugs for minor ailments needed for taking care for essential health need for women and children. The number of sub-centres functioning in the country present as on March, 2009 is annexed.

Govt. of India bears the salary of ANM and LHV besides rent liability and contingency whereas, the salary of the Male Health Worker is borne by the State Governments.

Expenditure per annum for the existing Sub-centres

Item	Amount
Salary of ANM and LHV	As per State Govt. pay scale
Rent	Rs. 3000
Medicine	To be supplied under RCH Programme
Contingency	Rs. 3200
Voluntary Worker	Rs.1200/- as honorarium

Under NRHM, Sub-centres are being strengthened by provision of untied funds of Rs.10,000/- per year which is operated by the ANM and the Sarpanch, supply of allopathic and indigenous medicines and provision of an additional worker (male multipurpose worker or additional ANM), Annual maintenance grant of Rs.10,000/- is also made available to every Sub-centre to undertake and supervise improvement and maintenance of the facility.

Upgradation of existing Sub-centres, including building for Sub-centres functioning in rented premises and setting them up as per 2001 census has also been envisaged under NRHM.

Primary Health Centre (PHC)

PHC is the first contact point between village community and the Medical Officer. It is manned by a Medical Officer and 14 other staff. It acts as a referral Unit for 6 Sub-Centres and has 4-6 beds for patients. It performs curative, preventive, promotive and Family Welfare services. There are 23391 PHCs functioning in the country.

The PHCs are being strengthened under NRHM to provide a package of essential public health programmes and support for outreach services to ensure regular supplies of essential drugs and equipment, round the clock services in all PHCs across the country, upgrading single doctor PHC to 2 doctors PHC by posting AYUSH practitioners at PHC level, provision of 3 Staff Nurses in a phased manner. The States/UTs have to incorporate their proposals and requirement of funds in their Annual Programme Implementation Plans under NRHM. Untied Grant of Rs.25,000/- per PHC for local health action and Annual Maintenance Grant of Rs.50,000/- per PHC through PHC level Panchayat Committee/Rogi Kalyan Samiti to undertake and supervise improvement and maintenance of physical infrastructure have been provided.

Community Health Centre (CHC)

CHC is established and maintained by the State Governments and as per standards it is supposed to be manned by four Medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, and Labour Room and Laboratory facilities and serves as a referral centre for 4 PHCs. It provides facilities for emergency obstaetrics care and specialist consultations. Indian Public Health standards lays down that this CHC is to be manned by 6 Medical Specialists including Anaesthetics and an eye surgeon (for 5 CHCs) supported by 24 paramedical and other staff with inclusion of two nurse midwives in the present system of seven nurse midwives. At present 4510 CHCs are functioning in the country.

For Upgradation of CHCs as per the Indian Pubic Health Standards (IPHS). State/UTs have been requested to carry out the facility survey of all CHCs so as to gauge the exact requirement of funds in terms of upgrdation of the facility as far as manpower, building, equipments etc. Funds are being provided every year as requested by the States in their annual Programme Implementation Plan under NRHM.

Strengthening of the Sub-Divisional /Sub-District and District Hospitals

Strengthening of sub-divisional /sub-district and district hospitals is an approved activity under NRHM. The funds are released to States/UTs Governments as per their requirement reflected in their annual PIP. The same is examined in this Ministry and funds are released the recommendations of NPCC.

Indian Public Health Standards (IPHS)

Indian Public Health Standards (IPHS), which detail the specifications of standards to which institutions of primary health care would have to be raised to so that the citizen is confident of getting public health services in the hospital that can be measured to be of acceptable standards. Indian Public Health Standards (IPHS for Sub-centres, PHCs, CHCs, Sub-divisional/Sub-district Hospitals and District Hospitals lay down Standards not only for personnel and physical infrastructure, but also for delivery of services, and management. A system of performance bench marks will be introduced to concurrently assess the adherence of public hospitals to IPHS, in a transparent manner.

Each Hospital would, as part of IPHS, be required to set up a Rogi Kalyan Samitti (RKS)/Hospital Management Committee), which will bring in community control into the management of public hospitals. Guidelines for setting up of Rogi Kalyan Samiti have been circulated to all States/UTs. Based on the registration details of RKSs set up by various States/UTs, funds @ Rs. one lakh per PHC, CHC, Sub-divisional/Sub-district Hospitals and @ Rs.5.00 lakhs per District Hospital have been released for RKSs to these States/UTs. The objective is to provide sustainable quality care with accountability and peoples participation alongwith total transparency.

Mobile Medical Units/Health Camps

With the objective to take health care to the door step of the public in the rural areas, especially in under-served areas, Mobile Medical Units (MMUs), have been provided, one per district under NRHM. The States are however, expected to address the diversity and ensure the adoption of more suitable and sustainable model for

the MMU to suit their local requirements. They are also required to plan for long-term sustainability of the intervention.

Two kinds of MMUs are envisaged, one with diagnostic facility for the States other than North-East States, Himachal Pradesh and J&K. In addition, for the North-Eastern States, Himachal Pradesh and J&K, specialized facilities and services such as X-ray, ECG and ultrasound are proposed to be provided in MMUs due to their difficult hilly terrain, non-approachability by public transport, long distances to be covered etc.

The States are needed to involve District Health Society/ Rogi Kalyan Samiti/NGOs in deciding the appropriate modality for operationalization of the MMUs. The provision of staff will be considered only for the States who will run the vehicles with support of NGOs/RKSs and in case of States out-sourcing the vehicles. States are needed to work out numbers of mobile dispensaries/ health camps as a means of mobilizing local communities of health action and for creating demand

Tackling the problem of lack of manpower in Rural Areas:

The Government is seized of the problem of lack of skilled manpower in rural health infrastructure. A number of new and innovative steps have been taken by various State/UT Governments to bridge the gap between the available and required manpower especially for ensuring the availability of Doctors in rural areas. A Task Group constituted under the National Rural Health Mission under the chairmanship of Director General of Health Services has recommended the following measures to ensure the services of doctors in rural areas :

- Increase in the age of retirement of doctors to 65 years preferably with posting near hometown;
- Decentralization of recruitment at district level;
- Walk-in-interview and contractual appointment of doctors;
- Enhancing the salary for posting in rural areas by one-third;
- Increasing the admission capacity in medical colleges for Anaesthesia;
- Reviving the Diploma Course in Anaesthesia;
- To start one year Certificate Course in Anaesthesia for Medical Officers working in the system at present to be given by National Board of Examination.
- Recognition of five hundred bedded Hospitals to provide the facility for conducting the above course;
- Hiring of private practitioners on case-to-case basis.

The above recommendation were circulated to All the State /UT Governments. State/UT Governments have taken a number of initiatives to ensure presence of doctors in rural areas such as :

- Compulsory rural/difficult area posting for admission to post-graduate courses and as a pre-requisite for promotion, foreign assignment or training abroad ;
- Compulsory rotation of doctors on completion of prescribed tenure as per classification of locations;
- Contractual appointment of doctors;
- Option to forgo non practicing allowance and undertake practice without compromising on assigned duties, as per the service rules; offering incentive in form of allowance etc.
- Manning of PHCs by NGOs/ Non Government Stakeholders;
- Involvement of Medical colleges.

Apart from doctors, steps have been taken to deploy contractual manpower in all other cadres ie. ANM, MPWs, Pharmacists etc. The funds are being released to all States/UTs under NRHM as per their demand reflected in their NRHM PIPs. There has been significant improvement in manpower after engaging contractual staff under NRHM.

NRHM, Health & Population Policies

2.1 NATIONAL RURAL HEALTH MISSION (NRHM)

The National Rural Health Mission was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The detailed Framework for Implementation that facilitated a large range of interventions under NRHM was approved by the Union Cabinet in July 2006. Under the NRHM, the difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. The thrust of the Mission is on establishing a fully functional, community owned, decentralized health delivery system with inter sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities. From narrowly defined schemes, the NRHM is shifting the focus to a functional health system at all levels, from the village to the district.

The NRHM is about increasing public expenditure on health care from the current 0.9% of the GDP to 2 to 3% of the GDP. The corollaries of such a policy directive are not only has increased Central Government budgetary outlay for health, but States are also make a matching increase – at least 10% of the budget annually including a 15% contribution into the NRHM plan, and that the center – state financing ratio shifts from the current 80:20 to at least a 60:40 ratio in this plan period. Another important corollary is that the state health sector develops the capacities to absorb such fund flows. There are currently many constraints, especially in the High Focus states to absorb these funds and the poorest performing states which require the largest infusion of resources have some of the greatest problems to spend the funds already with them. This is one of the main reasons why a process of reforming and strengthening the state health systems needs to go hand in hand with the increase of fund flows.

The NRHM is thus also about health sector reform. The architectural correction envisaged under NRHM is organized around five pillars, each of which is made up of a number of overlapping core strategies.

a) **Increasing Participation and Ownership by the Community**: This is sought to be achieved through an increased role for PRIs, the ASHA programme, the village health and sanitation committee, increased public participation in hospital development committees, district health societies in the district and village health planning efforts and by a special community monitoring initiative and also through a greater space for NGO participation.

b) **Improved Management Capacity**: The core of this is professionalising management by building up management and public health skills in the existing workforce, supplemented by inculcation of skilled management personnel into the system.

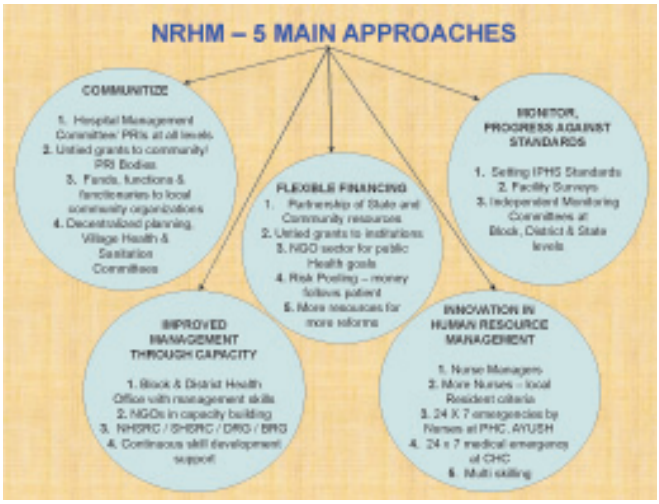
c) **Flexible Financing**: The central strategy of this pillar is the provision of untied funds to every village health and sanitation committee, to the sub-center, to the PHC, to the CHC including district hospital.

d) **Innovations in human resources development for the health sector**: The central challenge of the NRHM is to find definitive answers to the old questions about ensuring adequate recruitment for the public health system and adequate functionality of those recruited. Contractual appointment route to immediately fill gaps as well as ensure local residency, incentives and innovation to find staff to work in hitherto underserved areas and the use of

multi-skilling and multi-tasking options are examples of other innovations that seek to find new solutions to old problems.

e) **Setting of standards and norms with monitoring**: The prescription of the IPHS norms marks one of the most important core strategies of the mission. This has been followed up by a facility survey to identify gaps and funding is directed to close the gaps so identified.

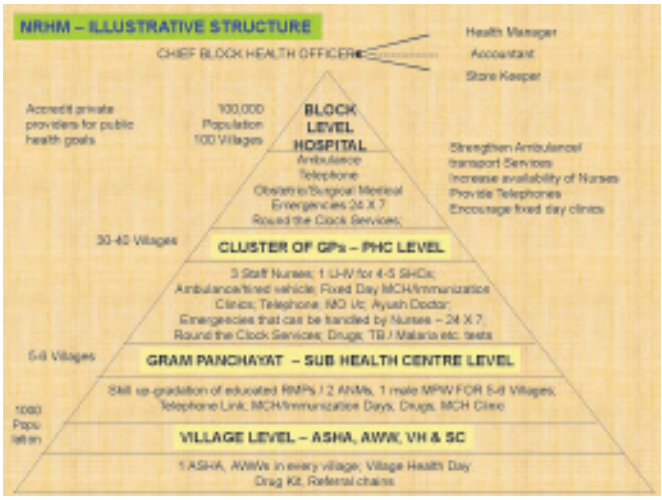
The NRHM approach is summed up in the figures below:



Many path breaking initiatives operationalised under the NRHM

2.1.1. More than 8.3 lakh Accredited Social Health Activists (ASHAs) are connecting households to health facilities. The presence of community volunteers on this unprecedented scale has resulted in people's growing pressure on utilization of services from the public sector health system. States across the country are reporting significantly higher utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care. Large scale demand side financing under the Janani Suraksha Yojana (JSY) has brought poor households to public sector health facilities on a scale never witnessed before. Over 348.94 lakh women have been covered under JSY so far since its introduction in 2005.

2.1.2. A second ANM in Sub Centres, 3 Nurses in PHCs for 24X7 services along with diagnostic services, co-location of AYUSH doctor at PHC and availability of Specialist Doctors and Nurses on a much larger scale has been attempted under the NRHM to take accountability to the people. States are recruiting Nurses and other Para Medic Staff on contract based on local criteria. Even Doctors and Specialists are recruited at the district level on contract and based on local criteria. Various form of performance based incentives have been attempted to make money follow the patient and to keep the motivation of public health workers in remote areas high. A lot more needs to be done in the sphere for performance based incentives in remote and difficult areas in order to ensure availability of skilled human resources where needed.



2.1.3. Through formation of registered Societies (Rogi Kalyan Samitis) at PHCs, CHCs and District Hospitals, legal entities are created that have far greater flexibility in discharge of their functions. NRHM has provided an opportunity to provide cashless hospitalised services to the poor through the Rogi Kalyan Samiti resources. It has also provided an opportunity to charge a modest fee from those who can afford to pay. The Rogi Kalyan Samitis have adequate resources for local health action and for ensuring a well maintained hospital. Wherever Medical Officers, in-charge of PHCs and CHCs and their RKSs, have taken interest, the face of government hospital has been transformed with the untied funds available to every institution under NRHM. NRHM is an opportunity for States to display to the people that fully functional quality health care is possible within the existing public system.

2.1.4. The untied grants to sub-centres has given a new confidence to our ANMs in the field who are far better equipped now with Blood Pressure measuring equipment, stethoscope, the weighing machine etc. They can actually undertake a proper ante-natal care and other health care services. Sub Centres are now functioning as sub-centres

providing services of which, many of them were absent on account of lack of regular resources. The constitution of the Village Health and Sanitation Committees is taking a little time in many States as the effort is to set up these Committees within the umbrella of Panchayati Raj Institutions. The intention of NRHM is inter-sector convergence and the effort in all the States is to bring Health, Sanitation, Nutrition, Water and Education together on a common platform within the framework of PRIs, at the village level. The untied funds to Village Committees are a great boon for public health action as was demonstrated in Kerala in Alleppey District where large scale vector control measures could be taken up with untied funds.

2.1.5. Human Resources is a key issue in the health sector and, specially, resident health workers in remote areas. Some excellent innovations have been attempted in the States to train local women as ANM. West Bengal's efforts in this direction has been path breaking where educated women from the 100 most difficult blocks of West Bengal are being trained to become ANMs on condition that they go back to the village for performing duties. The efforts to provide opportunities for ASHAs and Aanganwadi Workers to become ANMs has also been emphasised as ultimately the quest for better health care must realize that a locally resident person is the best bet to secure a resident health worker. The problems of absenteeism can be tackled through emphasis on the local criteria in such recruitments.

2.1.6. Many un-served areas have been covered through Mobile Medical Units. The efforts in Gujarat in this direction have been commendable. Andhra Pradesh's EMRI system enables people to access well equipped ambulances within no time anywhere in the State. Such successful models are worthy of replication and NRHM's efforts have been to encourage emulation. Sincere efforts to promote good practices have been made by providing opportunities of all State level teams to visit such regions that have done good work. There is a lot to learn from each other and NRHM promotes the bonding of States through regular inter-State visits to see good practices.

2.1.7. While in some regions government health facilities have geared up by utilizing flexible finances under NRHM to cope with the increased workload, in many other regions there is a long way to go before health facilities fully gear themselves to meet the growing need of people's health care. Poor households have voted with their feet by coming to the public system as never before. The challenge of NRHM now is to provide quality health care to the growing number of households whose faith in the government system has been restored. NRHM cannot afford to let down poor households who have come to the public system with so much hope and aspiration. There is a sense of urgency in improving the facilities for quality health care.

2.1.8. The journey of NRHM has been crafted by the responses of the States. It is for the States to decide on what their priorities are. District and State Programme Implementation Plans form the basis of approvals. Never before has there been so much flexibility in a programme to suit the diverse needs of States and regions. NRHM has set a new standard of partnership with States where it is the States that determine what is needed to resolve the crisis of the public sector health system. Human Resources, physical infrastructure, equipment, capacity building, resources, skill up-gradation resources etc. are available on an unprecedented scale. The philosophy of NRHM is to move from distrust to trust. Within the umbrella of Panchayati Raj Institutions, NRHM has tried to formulate an accountability framework that makes every health facility responsible to the people whose needs it caters to. Starting from the Village Health and Sanitation Committees, NRHM has crafted facility specific public institutions within the framework of PRI to ensure that Health Institutions have the flexibility to deliver in partnership with the community.

2.1.9. From the village to the district level all requirements of the health system can be met through the NRHM and States have come up with innovative plans to suit their needs. Realizing the need for improved management of the Public Sector Health System, NRHM has extended management support to States at all levels and for all institutions. The thrust on Nursing Institutions, Nurses and ANMs has been its foremost message to the States considering the need for public sector facilities to provide round the clock services.

2.1.10. Improved Financial Management:

In order to ensure that enhanced fund allocations to States/UTs and other institutions under the NRHM are fully coordinated, managed, and utilized, the Financial Management Group for NRHM (FMG-NRHM) has been set up to operationalize the following financial management arrangements and funds flow processes for release, monitoring and utilization of funds under NRHM as per

recommendations of the Empowered Programme Committee (EPC).

Organizational Set up

1. Joint Secretary (Policy) heads the NRHM Division, under him Director, NRHM (Policy) looks after the policy, infrastructure Development, Coordination & Human Resource Development functions.

2. NRHM Finance Division under the Director (NRHM-Finance) is functioning under the direct control of Special Secretary & Mission Director (NRHM) and coordinates the financial management activities of all NRHM Programmes such as RCH-II, NRHM Additionalities, Routine Immunization and the National Disease Control Programmes.

3. NRHM Finance Division is functional since 21.12. 2006 with ministerial staff i.e Director, Under Secretary, Accounts Officer, Section Officer and other financial management staff. The reorganized FMG-NRHM isstaffed also by financial management personnel on contract basis such as Finance Controllers, Finance Analysts, Financial Assistants. All sanction orders for release of funds under all programmes and pools under NRHM are processed through the FMG.

Objectives of FMG-NRHM

- Bring about integration in the financial management of the National Health Programs subsumed under the NRHM.
- Improve Financial Management Systems at the Centre, State and District levels under the NRHM.
- Systematize the funds flow, monitoring utilization, accounting and audit of all programmes under NRHM.

Functions of FMG-NRHM

- Release of funds under RCH Flexible Pool and Mission Flexible Pool and clearance of release proposals of all other programmes under NRHM.
- Centrally transfer funds electronically to State Health Societies for all programmes under NRHM and maintain a centralized data base for all releases and utilization under all components of NRHM viz. (a) RCH, (b) Additionalities under NRHM, (c) Routine Immunization and (d) National Disease Control Programs.
- Monitoring and compilation of Financial Monitoring Reports (FMRs) on quarterly basis.
- Claim refund of eligible expenditure from Development Partners like World Bank, UNFPA, DFID etc.
- Statutory Audit arrangements and submission of Audit Reports to Development Partners.
- Provide Financial Management Formats, monitor financial performance indicators and update state-wise profiles.
- Capacity building of finance and accounts personnel of States/UTs.
- Obtaining UCs for various programs under NRHM.
- Generating MIS reports on the basis of FMRs received.

System for Funds Release

- Obtaining approval of National Programme Coordination Committee (NPCC) and communicating approved amounts to States/UTs.
- Release of funds is made on the basis of BEs/REs approved by the Ministry of Finance, communicated separately to States.
- As per GFRs, up to 75% of the approved BEs are released to States on receipt of provisional UCs/ FMRs for the previous year.
- Balance 25% is released after receipt of satisfactory audited accounts with final UCs. Concurrence of IF is obtained in all cases.

Training/capacity building of Finance & Accounts Personnel

- FMG-NRHM periodically conducts the training of Finance and Accounts personnel of State/District Health Societies.
- State-wise workshops with State Finance and Accounts Managers were organized in August, 2010 to discuss various issues to prepare and update the state-wise profiles on financial management.
- NRHM Finance Division is actively engaged in preparing E-training Modules, Hand Books for

State, District and Block level finance personnel under NRHM.

- While e-transfers through the accredited bank of the Ministry are taking place to all States, e-banking has been introduced on a pilot basis in Karnataka Stae which uses the Core Banking System (CBS) for generation of MIS report to provide information on funds movement, utilization and unspent balances to the management. The Ministry is awaiting the results of the pilot initiated in Karnataka to further implement e-banking in other States/UTs.
- Detailed Operational Guidelines on Financial Management are also being prepared for adoption and implementation at State, District and Block and Village levels under the NRHM to being about efficiency, accuracy and accountability in financial processes.

2.1.11. Under NRHM, electronic Transfer of Funds (ETF) has been started from GoI to States and also States to Districts. This has reduced the time lag in transfer of funds from 1-2 months to a few hours. E-banking is being operationalized for real time financial reporting and monitoring. Financial Monitoring Reports are now being received from all States. Detailed guidelines for Delegation of Administrative & Financial Powers under NRHM have been given to States. State Finance and Accounts Managers and accounts personnel have been recruited at State, district and block levels under NRHM. A system for Concurrent Audit has been set up in the SHSs and DHSs.

The National Rural Health Mission represents a major departure from the past, in that central government health financing is now directed to the development of state health systems rather than being confined to a select number of national health programmes. NRHM is therefore, an effort at building a partnership with States to ensure meaningful reforms with more resources. Ultimately, success of NRHM will depend on ability of the Mission interventions to galvanize State Governments into action, pursuing innovations and flexibility in all spheres of public health action. The progress on several key indicators on NRHM has been noticed.

2.1.12. Progress under National Rural Health Mission (NRHM)

ASHAs

- Selection of 8,33243 ASHAs have been done in the entire country, out of which 7,82807 up to 1st Module and 6,75693 up to 2nd Module 6,59037up to 3rd Module, 641421 up to 4th Module and 3,19429 up to 5th Module.
- 5.70 lakhs ASHAs have been provided with drug kit as well.

Infrastructure

- 1.46 lakhs Sub-centres in the country are provided with untied funds of Rs. 10,000 each. 4,82219 Sub-centres & VHSC have operational joint accounts of ANMs and Pradhans for utilization of annual untied funds. 50,728 Sub-centres are functional with second ANM.
- Out of 4510 Community Health Centres(CHCs), 2921 CHCs have been selected for upgradation to IPHS and facility survey has been completed in 2864 CHCs (includes other also).
- 29904 Rogi Kalyan Samitis have been registered at different level of facilities.

Manpower

- 9856 Doctors and Specialist, 53552 ANMs, 26734 Staff Nurses,18272 Paramedics have been appointed on contract by States to fill in critical gaps.

Management Support

- 1784 professionals (CA/MBA/MCA) have been appointed in the State and 635 District level Program Management Units (PMU) and 3529 Block level Program Management Units (BPMU) have been established to support NRHM.

Mobile Medical Units

- In 381 districts, the Mobile Medical Units has been operationalised till September,2010.

Immunization

- Intense monitoring of Polio Progress – Services of ASHA useful.
- JE vaccination completed in 11 districts in 4 states – 93 lakh children immunized during 2006-07. JE vaccination has been implemented in 26 districts of 10 states in 2007. The 11 districts of 4 states where JE vaccination was carried out in 2006 have introduced JE vaccine in Routine Immunization to vaccinate new cohort between 1-2 years of age with booster dose of DPT.

- House tracking of polio cases and intense monitoring.
- Neonatal Tetanus declared eliminated from 7 states in the country.
- Full immunization coverage evaluated at 43.5% at the national level.(NFHS-III)
- Accelerated Immunization Programme taken up for EAG and NE State.

Institutional Delivery

- Janani Suraksha Yojana (JSY) is operationalised in all the States, 7.38 lakh women are benefited in the year 2005-06, 31.58 lakh in 2006-07, 73.28 lakh in 2007-08, 90.36 lakh in 2008-2009, 100.78 in the year 2009-2010.

Neo Natal Care

- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started in 323 districts and 3,13,783 health personnel trained in IMNCI.

Convergence

- Over 35 lakhs in 2006-07, 49 lakhs in 2007-08, 58 lakhs in 2008-2009, 58 lakhs in year 2009-2010, and 34 lakhs in 2010-11 so far. Monthly Health and Nutrition Days being organized at the village in various States.
- The States have constituted 4,98378 Village Health and Sanitation Committees. They are being involved in dealing with disease outbreak.
- Convergence with ICDS/Drinking Water/ Sanitation/NACO/PRIs ground work completed.
- School health programmes have been initiated in over 26 States.

Health Action Plans

- State PIPs have been received from 35 States/UTs during the Plans have been apprised and funds are being released for the year 2010-11.
- The first cut of Integrated District Health Action Plans (IDHAP) has been finalized for 642 districts.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH has been taken up in the State.14766 AYUSH facilities are available at District and below district level health institutions. AYUSH person are part of State Health Mission / Society / RKS / ASHA training as members.

Trainings

- Trainings in critical areas including Anesthesia, Skilled Birth Attendance (SBA) taken up for MOs/ ANMs. Integrated Skill Development Training for ANMs/ LMV/MOs, Training on Emergency Obstetrics care and No Scalpel Vasectomy (NSV) for MOs, Professional Development Programme for CMOs is on full swing.
- ANM Schools being upgraded in all States.
- New nursing schools taken up.

Health Resource Centres

- National Health Systems Resource Centre (NHSRC) set up at the National level.
- Regional Resource Centre set up for NE.
- State Resource Centre being set up by States.

Monitoring and Evaluation

- Independent evaluation of ASHAs / JSY by UNFPA / UNICEF / GTZ in 8 States.
- Immunization coverage evaluated by UNICEF.
- Independent monitoring by identified institutions like Institute of Public Auditors of India.
- Phase I of community monitoring in 9 states namely Rajasthan, Orissa, Maharashtra, Madhya Pradesh, Tamil Nadu, Chhattisgarh, Jharkhand, Karnataka and Assam has been completed.
- Concurrent evaluation by several independent agencies is in progress.
- District wise Annual Health Survey for high focus states are in pipeline. Cabinet approved.

Surveys

- NFHS III and DLHS III completed.

Financial Management:-

- Financial Management Group set up under NRHM in the Ministry.
- During the FY 2005-06, out of total allocation of

Rs. 6,731.16 crore for the ministry, an amount of Rs. 5,862.57 crore was released as part of NRHM.

- Against Rs. 9065 crore for NRHM activities during 2006-07, Rs. 7,361.08 crore released.
- During the FY 2007-08, out of total allocation of Rs. 11,010 crore for the ministry, an amount of Rs. 10,189.03 crore was released as part of NRHM.
- During the FY 2008-09, out of total allocation of Rs. 12,050 crore for the ministry, an amount of Rs. 11,229.47 crore was released as part of NRHM.
- During the FY 2009-10, out of total allocation of Rs. 14,050 crore for the ministry, an amount of Rs. 11631.39 crore was released as part of NRHM.
- For the FY 2010-11, the total allocation for NRHM is Rs. 15,440 crore for the ministry, an amount of Rs. 4300.13 crore is released so far.

2.1.13. Interventions under NRHM to Address the Issues Relating to Left Wing Extremism

From the directions of the Union Home Minister, 33 High Focus District have been identified by the Planning Commission in order to address the critical gaps in these districts in respect of the certain key parameters of the concerned Ministries through Integrated Action Plan (IAP) with the support of the respective State Governments, District Administration, Elected Representative and the respective State Holders. An Interministrial Committee has been set up for providing necessary recommendations and suggests possible interventions for the purpose of addressing the focused need of the affected blocks.

The necessary steps have been initiated in the Ministry of Health and Family Welfare to fill up the corresponding critical gaps in health infrastructure, human resources, training, immunization, supply of drugs and equipments etc. The necessary preventive steps have been formulated to incentivize the difficult areas.

The following are some of the Measure taken under NRHM:

- A Cadre of supportive and caring ASHA's created to stem alienation.
- Bridging infrastructure and human resource gaps.
- Appointment of Resident Health workers through local criteria.
- Organizing of outreach camps.
- Incentivizing health workers and pooling of resources.
- Cluster based development through Community Health Workers.
- Creation of separate cadre of Rural Medical Assistance to serve in the conflict prone areas, like Chhattisgarh.
- Providing reservation of seats in Post Graduation for Medical Studies as an incentive for serving in rural areas.
- Performance based incentives for difficult areas, hard areas, allowances etc. for encouraging doctors and specialists to serve in these areas.
- Short term courses for Medical Officers posted in CHCs for comprehensive obstretrics care, anesthesis for emergency obstetrics and neo-natal care.
- Providing health care service to inaccessible areas through Mobile Medical Units.
- To increase awareness among women and local communities about their health rights and their public service entitlements.

2.1.14. Supportive Supervision of High Focus Districts

In order to provide emphasis on evidence based planning, using data triangulation methods in order to include some non-negotiable elements and targeted health outcomes, an attempt has been made to undertake Supportive Supervision in 264 pre-identified backward districts for high focus planning, based on the following criteria:-

- 140 backward districts based on ranking of 13 indicators from the DLHS III data prepared by the Statistics Division of the Ministry. The indicators inter alia include female literacy, households with low standard of living, percentage of girls married below 18 years, use of contraceptives, institutional births, full Immunization, proximity to health facilities, road connectivity etc, among others.
- Those districts with SC/ST population above 35%. It is desirable that a certain percentage of allocation is earmarked in the District Plans for these pockets in the non SC/ST majority districts to minimize

disparities. Some of the North Eastern States have been excluded in this criterion, as they already have a high percentage of tribal population and this earmarking may not be essential.

- 33 highly left wing affected districts as prepared by the Ministry of Home Affairs.

The Supportive Supervision intervention consistently engages in refinement of the tools and techniques used for reporting. It also serves as a channel for horizontal communication of ideas and innovations to the state through sharing of experiences between consultants.

For the purpose, the Ministry of Health & Family Welfare has developed an action oriented monitoring plan in which joint teams have been formed to visit the high focus districts, in which the Consultants are visiting the states in the identified districts and providing assistance to them for improving the measurable health indicators with the objective to bring desired improvements in health indicators. The visits of consultants to the health facilities, viz. Sub-centers, PHCs/CHCs and DH are relating to monitoring of the progress, status and functioning of health facilities in terms of infrastructure, human resources, training etc. together with the quality of health care service delivery by interaction with ASHAs, PRIs, Civil Society Group etc.

Consultants interact at various levels such as village, block, district, state and the center. Real time feedback is given to the facility in charge. A detailed report so prepared is shared with district and state authorities and submitted at respective Programme Directors level for necessary action.

2.1.15. Meeting of International Advisory panel on NRHM

A meeting of the International Advisory Panel on NRHM under the chairmanship of the Hon'ble Minister for Health & Family Welfare held was on 7th August, 2009. In this meeting several important issues relating to rural health were discussed in detail.

The last meeting of the Forum held on 4th February, 2010 had recommended certain issues for implementation. Among the various recommendations of IAP meeting held on 7.9.2009 one recommendation was regarding possibilities to explore the partnership with IAP in developing model districts across the country, and adopt the same practices in respect of districts of other States.

2.1.16. Meeting of Inter-Sectoral convergence under NRHM with the other departments of the Government of India.

A meeting of the Inter-Sectoral convergence under NRHM was held on 7th September, 2010 with the departments of HRD, Rural Development, Human and Child Development, Panchayati Raj and the Department of AYUSH. Among the various recommendations of the meetings, one of the recommendations was for better implementations of School Health Programme and Joint Review of the Programme by the two Ministers. The other important recommendations include, preparation of Health Education Module for National Literacy Mission; preparation of Integrated Training Module with inputs from the Ministers of Health (including NACO & AYUSH), Education, Women and Child Development (WCD), Water and Sanitation; preparation of common IEC booklets with inputs from (including NACO & AYUSH) and preparation of training module for Emergency Medicine for AYUSH doctors at public health facilities; Joint Review of the programmes of Health and the Ministry of Education.

2.2. HEALTH POLICY

The National Health Policy-2002 (NHP-2002) gives prime importance to ensure a more equitable access to health services across the social and geographical expanse of the country. The policy outlines the need for improvement in the health status of the people as one of the major thrust areas in the social sector. It focuses on the need for enhanced funding and organizational restructuring of the public health initiatives at national level in order to facilitate more equitable access to the health facilities. An acceptable standard of good health amongst the general population of the country is sought to be achieved by increasing access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions. Emphasis has been given to increase the aggregate public health investment through a substantially increased contribution by the Central Government. Priority would be given to preventive and curative initiatives at the primary health level through increased sectoral share of allocation.

2.3. NATIONAL COMMISSION ON POPULATION

In pursuance of the objectives of the National Population Policy 2000, the National Commission on Population was

constituted in May 2000 to review, monitor and give directions for the implementation of the National Population Policy (NPP), 2000 with a view to meeting the goals set out in the Policy, to promote inter-sectoral co-ordination, involve the civil society in planning and implementation, facilitate initiatives to improve performance in the demographically weaker States in the country and to explore the possibilities of international cooperation in support of the goals set out in the National Population Policy.

The first meeting of the Commission was held on 22.07.2000 and the then Prime Minister had announced the formation of an Empowered Action Group within the Ministry of Health and Family Welfare for paying focused attention to States with deficient national socio-demographic indices and establishment of National Population Stabilization Fund [Jansankhya Sthirata Kosh] to provide a window for canalizing monies from national voluntary sources to specifically aid projects designed to contribute to population stabilization.

The National Commission of Population has since been reconstituted in April 2005 with 40 members under the Chairmanship of the Prime Minster. Minister of Health & FW and the Deputy Chairman of the Planning Commission are Vice Chairmen of the Commission. The present membership also includes the Chief Ministers of the States of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Jharkhand, Kerala and Tamil Nadu.

The reconstituted National Commission on Population had decided on the following.

- There should be Annual Health Survey of all districts which could be published annually so that health indicators at district level are periodically published, monitored and compared against benchmarks.
- Setting up of five groups of experts for studying the population profile of the States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Orissa to identify weaknesses in the health delivery systems and to suggest measures that would be taken to improve the health and demographic status of the States.

Annual Health Survey: The Ministry is in the process of conducting an Annual Health Survey (AHS) to prepare the District Health Profile of all Districts in pursuance to the decisions of the National Commission on Population. The Registrar General of India (RGI) has been designated as the Nodal agency. The Mission Steering Group (MSG) of NRHM, in its third meeting had approved the proposal for AHS in 284 EAG districts including Assam. The Survey is being conducted by RGI at an estimated annual cost of Rs.110 crores. The current status of the Survey is that the field units have been identified, the sample units selected and the survey schedules/questionnaire finalized in consultation with various stake holders. The survey would be spread over 20252 sampling units in the 9 States and shall cover about 36 lakh households. It is expected that the first set of results would be available in early 2011.

Expert Groups: Five groups of experts were constituted for studying the population profile of the States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Orissa. The draft reports of the expert groups was examined in the Commission for correctness of the demographic data and then sent to the concerned five States for the following: -

- Commenting on the report of the expert group.
- Provide an update on what they are doing for stabilization of population under NRHM.
- Prepare a presentation on their work on Population Stabilization for the next meeting of the NCP.

The Commission has been providing policy support to the population stabilization efforts under overall framework of implementation of NRHM by the states. The Commission has come out with a number of publications in collaboration with Registrar General of India and Institute of Economic Growth, which provides valuable inputs on future demographic trends, challenges and suggestive measures for achieving population stabilization as envisaged in NPP 2000 and NRHM goals.

The second meeting of the Commission was held on 21st October 2010 under the Chairmanship of Prime Minister. The Commission deliberated upon population stabilization issue amongst other issues and after deliberation, the Commission adopted the following resolution with broad consensus recommending the key points for the stakeholders as follows:

- **According Priority**
  - Population Stabilization should be accorded high priority.

- Chief Ministers should provide leadership to the promotion of small family norm.
- Social experts, social scientists and communication experts should be involved.
- A safe motherhood campaign should be carried out on the lines of pulse polio programme, with focus on population issues.

- **Programmatic Interventions**

- IEC Campaign should be revitalized vigorously.
- Undertake strategy to meet the unmet need for family planning services.
- Strengthen Public Health services and facilities like clean toilets, water, electricity, etc.
- Strengthen Post Partum family planning services at all centres where deliveries takes place.
- Focus to be on Delay of age at marriage, delay in birth of first child and promotion of birth spacing between children.
- Availability of medicines at all Public Health Facilities.
- Involve AYUSH Doctors in family planning programmes.

- **Inter-Sectoral Co-ordination**

- Ministries of HRD, WCD and Panchayati Raj should be actively involved in population stabilization programme.
- Utmost attention to be given for education, particularly of girls.
- Education regarding family life including reproductive and sexual health issues at a younger age be given to adolescents to further empowerment of women.
- Interventions to improve nutritional status, particularly pregnant mothers to be strengthened.
- Institutions and Hospitals run by institutions like ESI, Railways and Defence Services should be involved in family planning services.

- **Other Interventions**

- Raising of legal age at marriage of girls to be considered.
- Gender to be included in medical education.
- NGOs working among members of Muslim Community may be actively involved in enhancing awareness regarding small family norms.
- Emphasis on research to develop more innovative contraceptives to expand available contraceptive choices.
- Availability of funds for heath sector, as well as for family planning should be increased.

2.4. JANSANKHYA STHIRATA KOSH

The National Population Stabilisation Fund was constituted under the National Commission on Population in July 2000. Subsequently it was transferred to the Department of Health and Family Welfare in April 2002. It was renamed and reconstituted as Jansankhya Sthirata Kosh (JSK) under the Societies Registration Act (1860) in June 2003. The General Body of JSK is chaired by the Minister for Health and Family Welfare, while the Governing Board is chaired by Secretary (H & FW). The Executive Director is the Chief Executive Officer of the Kosh.

JSK has undertaken a number of initiatives for population stabilization which in brief are as follows:

GIS Mapping: JSK has taken up the mapping of 485 districts and its sub divisions in the country through a unique amalgamation of GIS maps and Census data. The maps identify the basic health infrastructure available and accessibility in terms of availability of roads. The density of population in each district has now been added as another layer, to provide an in - depth view of the health services availability in relation to the density of population in the area.

Call Centre: JSK runs a Call Centre (1800-11-6555) to provide reliable and authentic information on issues related to reproductive and child health. It specifically cater to adolescents, newly married and about to be married persons from the High Focus states of UP, Bihar, MP, Rajasthan, Jharkhand and Chhattisgarh. Till 31st October 2010, the Call Centres have received approximately 2,00,000 calls and more than 3,00,000 enquiries. The maximum numbers of queries being received are on issues related to contraception, pregnancy, sexual health and infertility. Strict quality checks are in place to ensure high quality service. Extensive publicity has been taken up to promote the Call Centre number.

Prerna Strategy: This strategy identifies and recognizes young married couples from backward districts who have adopted Responsible Parenthood Criteria as role models for other young couples in the district. JSK has instituted Prerna Awards for couples who fulfil basic criteria, which are girls marrying at the age of 19; having first child two years after marriage; and keeping a gap of 3 years between first and second child followed by sterilisation of either parent. The couples are awarded with a certificate and Kisan Vikas Patras at a widely publicized and well attended function in the district. JSK has worked in tandem with Union Ministries/ Departments, district administration, civil society, the community, and corporate houses and has identified 378 couples till 31st October 2010 to award them with the Prerna Award.

Santushti: The *Santushti* strategy provides private sector gynaecologists and vasectomy surgeons an opportunity to conduct sterilisation operations in Public Private Partnership (PPP) mode under the scheme already announced by Ministry of Health and Family Welfare in September 2007. It offers accredited health facilities a start up advance for 100 sterilization surgeries and an additional Rs 500 per case to accredited nursing homes for conducting 30 sterilization cases in camp mode in a single day. Under this Scheme, 3331 sterilizations have been performed during the period April 2010 to October 2010.

IUCD 380A: JSK has taken up the promotion of the IUCD 380 A as a contraceptive device offering long term highly effective, reversible protection against pregnancy. Till dated about 400 senior Obstetricians and Gynaecologists have been trained on NTT for IUCD 380A insertion in different training sessions organized by JSK. Presently JSK is pursuing training of more doctors, ANMs in target States to increase utilization rates of this device.

Celebration of World Population Day 2010:

MoHFW, JSK and Govt. of NCT, Delhi jointly organized a run for population stabilization on Raj Path, New Delhi on the Population Day in which 3000 adolescents from schools of Delhi participated.

The event was flagged up by the Union Minister for Health & Family Welfare, Shri Ghulam Nabi Azad and Chief Minister of Delhi, Smt. Shiela Dikshit in presence of Union Minister of State for Health & Family Welfare and important dignitaries of Govt. of NCT, Delhi. The event was marked with participation of Kumari Saina Nehwal, the World acclaimed Badminton star in the run.

Emphasizing the need of population stabilization Shri Azad reiterated Government's commitment to promote population stabilization by making people aware about the benefit of small families and on the need to educate girls. He ruled out coercion completely in the efforts for population stabilization. Speaking on the occasion, Smt Sheila Dikshit stressed the need for empowerment of girls and women to control population growth. The event was widely covered in both print and electronic media. JSK collaborated with NDTV to highlight Population Stabilisation efforts of Union Government before a large audience through some of its popular shows preceded with week long promos and factoids on the issues.

Activities in states having high population growth:

In partnership with Kendriya Vidyalaya Sangathan and DPS society, JSK organized debate, painting and photography competition on Population Stabilisation themes in schools managed by KVS and DPS Societies in states of UP, Bihar, MP, Rajasthan, Jharkhand, Orissa, Delhi and Chhattisgarh in which approximately 3.5 lakh children participated.

A national level quiz and debate competition was organized in Delhi on Population Stabilization for schools from the 6 states. Shri Dinesh Trivedi, the Minister of State for Health and Family Welfare gave away the prizes to the winning teams and participants.

In Bihar, competitions were organized in all higher secondary schools in partnership with the State Education Department thereby reaching out to almost 25 lakh students.

At university/ higher level institutions, JSK organized various competitive events on Population Stabilisation in medical colleges of Bihar and Kalinga Institute of Medical Sciences (KIMS) Orissa.

Mid-Media Campaign

JSK in participation with the Song & Drama Division of GOI organized 2000 shows in selected high fertility districts on issues of Population Stabilisation. Advertisement panels highlighting population issues were printed and distributed in high fertility states for its display in schools to make the adolescent aware about the impending need of population stabilization.

2.5. FAMILY PLANNING INSURANCE SCHEME

2.5.1. India is the first country that launched a National Family Planning Programme in 1952, emphasizing fertility regulation for reducing birth rates to the extent necessary to stabilize the population at a level consistent with the socio-economic development and environment protection. Since then the demographic and health profiles of India have steadily improved.

2.5.2. Government of India Scheme to Compensate Acceptors of Sterilization for Loss of Wages:

With a view to encourage people to adopt permanent method of Family Planning, Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization.

Apart from providing for cash compensation to the acceptor of sterilization for loss of wages, transportation, diet, drugs, dressing etc. out of the funds released to States/UTs under this scheme, some States/UTs were apportioning some amount for creating a miscellaneous purpose fund. This fund was utilized for payment of ex-gratia to the acceptor of sterilization or his/her nominee in the unlikely event of his/her death or incapacitation or for treatment of post operative complications attributable to the procedure of sterilization, as under:-

i) Rs. 50,000/- per case of death.

ii) Rs. 30,000/- per case of incapacitation.

iii) Rs.20,000/- per case of cost of treatment of serious post operation complication.

Any liability in excess of the above limit was to be borne by the State/UT/NGO/ Voluntary Organization concerned from their own resources.

The Hon'ble Supreme Court of India in its Order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai V/s Union of India) has, *inter alia*, directed the Union of India and States/UTs for ensuring enforcement of Union Government's Guidelines for conducting sterilization procedures and norms for bringing out uniformity with regard of sterilization procedures by -

I. Creation of panel of Doctors/health facilities for conducting sterilization procedures and laying down of criteria for empanelment of doctors for conducting sterilization procedures.

II. Laying down of checklist to be followed by every doctor before carrying out sterilization procedure.

III. Laying down of uniform proforma for obtaining of consent of person undergoing sterilization.

IV. Setting up of Quality Assurance Committee for ensuring enforcement of pre and postoperative guidelines regarding sterilization procedures.

V. Bringing into effect an Insurance Policy uniformly in all States for acceptors of sterilizations etc.

The above directions have all been taken into consideration and consolidated in the updated manuals on Standards and Quality Assurance in Sterilization Services available on the Ministry's website (www.mohfw.nic.in). The Family Planning Insurance Scheme is one of the initiatives launched under direction from the Hon'ble Supreme Court w.e.f 29th November, 2005.

Under the existing Government Scheme no compensation was payable for failure of sterilization, and no indemnity cover was provided to Doctors/Health Facilities providing professional services for conducting sterilization procedures etc. There was a great demand in the States for indemnity insurance cover to Doctors/Health Facilities, since many Govt Doctors are currently facing litigation due to claims of clients for compensation due to failure of sterilization. This has led to reluctance among the Doctors/Health Facilities to conduct sterilization operations.

2.5.3. First Year of Scheme : With a view to do away with the complicated process of payment of ex-gratia to the acceptors of Sterilisation for treatment of post operative Complications, or Death attributable to the procedure of sterilization, the **Family Planning Insurance Scheme (FPIS)** was **introduced w.e.f 29th**

November, 2005 with Oriental Insurance Company, to take care of the cases of Failure of Sterilization, Medical Complications or Death resulting from Sterilization, and also provide Indemnity Cover to the Doctor / Health Facility performing Sterilization procedure, as follows:-

Section I:		
a)	Death due to Sterilization in hospital:	Rs.1,00,000/-
b)	Death due to Sterilization within 30 days of discharge from hospital	Rs.30,000/-
c)	Failure of sterilization (including first instance of conception after sterilization).	Rs.20,000/-
d)	Expenses for treatment of medical complications due to sterilization operation (within 60 days of operations	Rs.20, 000/-*
Total liability of the Insurance Company shall not exceed Rs. 9 crore in a year under each Section.		

(*To be reimbursed on the basis of actual expenditure incurred, not exceeding Rs.20, 000.)

Section II: All the doctors/health facilities including doctors/health facilities of Central, State, Local-Self Governments, other public sectors and all the accredited doctors/health facilities of non-government and private sectors rendering Family Planning Services conducting such operations shall stand indemnified against the claims arising out of failure of sterilization, death or medical complication resulting therefrom upto a maximum amount of Rs. 2 lakh per doctor/health facility per case, maximum upto 4 cases per year. The cover would also include the legal costs and actual modality of defending the prosecuted doctor/health facility in Court, which would be borne by the Insurance Company within certain limits.

2.5.4. Second Year of Scheme : This scheme was renewed with Oriental Insurance Company w.e.f. 29-11-06 with modification in the limits and payment procedure.

The revised package and guidelines are as follows:

Section		Coverage	Limits
I	IA	Death due to Sterilization in hospital or within 7 days from the date of discharge from the hospital.	Rs. 2 lakh.
	IB	Death due to Sterilization within 8 - 30 days from the date of discharge from the hospital.	Rs. 50,000/-.
	IC	Failure of Sterilisation	Rs 25,000/-.
	ID	Cost of treatment upto 60 days arising out of Complication from the date of discharge.	Actual not exceeding Rs 25,000/-.
II		Indemnity Insurance per Doctor/facility but not more than 4 cases in a year.	Upto Rs. 2 Lakh per claim
Total liability of the Insurance Company shall not exceed Rs. 9 crore in a year under each Section.			

2.5.5. Third Year of Scheme : This scheme was renewed with ICICI Lombard Insurance Company and improved w.e.f. 01-01-08 with modification in the limits and payment procedure based on 50 lakh sterilization accepters. The revised packages are as follows:

Section		Coverage	Limits
I	A	Death due to Sterilization in hospital or within 7 days from the date of discharge from the hospital.	Rs. 2 lakh.
	B	Death due to Sterilization within 8 -30 days from the date of discharge from the hospital.	Rs. 50,000
	C	Failure of Sterilization	Rs 30,000
	D	Cost of treatment upto 60 days arising out of Complication from the date of discharge.	Actual not exceeding Rs 25,000/-.
II		Indemnity Insurance per Doctor/facility but not more than 4 cases in a year.	Upto Rs.2 Lakh per claim
Total liability of the insurance Company shall not exceed Rs. 9 crore in a year under each Section.			

For the policy period of 1/1/2008 to 31/12/2008 an amount of Rs. 31741700 was paid as premium. 3786 claims, amounting to Rs. 13.63 crore was paid. Out of which Rs. 9.00 crore was paid by ICICI and Rs. 4.63 crore was paid by the Ministry for claims in excess of Insures liability of Rs. 9.00 crore upto Nov, 2010.

2.5.6. Fourth Year of Scheme : This scheme was renewed with ICICI Lombard Insurance Company based on 45 lakh sterilization accepter's w.e.f. 01-01-09 with modification in procedure as follows:

Section		Coverage	Limits
I	A	Death following Sterilization in hospital or within 7 days from the date of discharge from the hospital.	Rs. 2 lakh
	B	Death following Sterilization within 8-30 days from the date of discharge from the hospital.	Rs. 50,000
	C	Failure of Sterilization	Rs. 30,000
	D	Cost of treatment upto 60 days arising out of complication from the date of discharge.	Actual not exceeding Rs 25,000/-
II		Indemnity Insurance per Doctor/facility but not more than 4 cases in a year.	Upto Rs. 2 Lakh per claim
Total liability of the insurance Company shall not exceed Rs. 9 crore in a year under each Section.			

For the policy period of 1/1/2009 to 31/12/2009 an amount of Rs. 49297951 was paid as premium. 3821 claims, amounting to Rs. 14.40 crore was paid. Out of which Rs. 9.00 crore was paid by ICICI and Rs. 5.40 crore was paid by the Ministry for claims in excess of Insures liability of Rs. 9.00 crore upto Nov, 2010.

2.5.7. Fifth Year of Scheme : This scheme was renewed with ICICI Lombard Insurance Company w.e.f. 01-01-10 with all benefits available as mentioned under Policy-2009 above based on 50 lakh sterilization accepters; however, total Liability of the Insurance Company was amended and shall not exceed Rs. 14.00 crore in total inclusive of both under Section-I & II instead of Rs. 9.00 crore under each Section.

For the policy period of 1/1/2010 to 31/12/2010 an amount of Rs. 143390000 was paid as premium. 3132 claims, amounting to Rs.10.73 crore was paid by the ICICI upto Nov, 2010.

2.5.8. Sixth Year of Scheme : This Scheme is renewed with ICICI Lombard Insurance Company w.e.f. 01.01.2011 based on 50 lakh sterilization accepters; however, total Liability of the Insurance Company is amended and shall not exceed Rs. 25.00 crore under Section-I Rs. 1.00 crore under Section-II. A Premium amounting Rs. 25,90,05,000 including service tax is paid on 31/12/2010. The benefit under the policy is as follows:

Section		Coverage	Limits
I	A	Death following Sterilization in hospital (inclusive of death during process of sterilization operation) or within 7 days from the date of discharge from the hospital.	Rs. 2 lakh
	B	Death following Sterilization within 8-30 days from the date of discharge from the hospital	Rs. 50,000
	C	Failure of Sterilization	Rs. 30,000
	D	Cost of treatment upto 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge.	Actual not exceeding Rs. 25,000
II		Indemnity Insurance per Doctor/facility but not more than 4 cases in a year.	Up-to Rs. 2 lakh per claim
Note: The Liability of the insurance Company shall not exceed Rs. 25.00 crore in a year under Section I and Rs. 1.00 crore under Section II.			

2.6. COMPENSATION FOR ACCEPTORS OF STERILIZATION

With a view to encourage people to adopt permanent method of Family Planning, Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization.

Under the Scheme, compensation for loss of wages to acceptors of sterilization was revised with effect from 31.1-.2006 and has been further improved with effect from 7.9.07 .Revision in the compensation package to boost to male participation in family planning i.e. Vasectomy from existing Rs.800/- to Rs.1500/- and Tubectomy from Rs.800/- to Rs.1000/- in public facilities and to Rs.1500/- for both Vasectomy and Tubectomy in accredited private health facilities to all categories in High Focus States and BPL/ SC/ST in Non- High Focus States with categorization of population as BPL, SC/ST and Above Poverty Line (APL) and health facilities at public/ accredited private institutions has been approved. The details of the revised scheme are as under:-

A. Public (Government) Facilities:

Category	Breakage of the Compensation package	Acceptor	Motivator	Drugs and dressings	Surgeon charges	Anaesthetist	Staff nurse	OT/ technician helper	Refresh-ment	Camp-manage ment	Total
*High focus 18 States	Vasectomy (ALL)	1100	200	50	100	-	15	15	10	10	1500
	Tubectomy (ALL)	600	150	100	75	25	15	15	10	10	1000
**Non High focus 17 States/UTs	Vasectomy (ALL)	1100	200	50	100	-	15	15	10	10	1500
	Tubectomy (BPL + SC/ST only))	600	150	100	75	25	15	15	10	10	1000
**Non High focus 17 States/ UTs.	Tubectomy (NON BPL + NON SC/ST only) i.e. APL	250	150	100	75	25	15	15	10	10	650

B. Accredited Private/NGO Facilities:

Category	Type of operation	Facility	Motivator	Total
*High focus 18 States	Vasectomy(ALL)	1300	200	1500
	Tubectomy(ALL)	1350	150	1500
**Non High focus	Vasectomy (ALL)	1300	200	1500
17 States/UTs.	Tubectomy (BPL + SC/ST)	1350	150	1500

***High Focus States**- Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chattisgarh, Uttrakhand, Orissa, Jammu & Kashmir, Himachal Pradesh, Assam, Arunachal Pradesh, Manipur, Mizoram, Meghalaya, Nagaland, Tripura, Sikkim.

****Non-High Focus States-** Karnataka, Kerala,Tamil Nadu, Andhra Pradesh, Maharashtra, Goa, Gujarat, Punjab, Haryana, West Bengal, Delhi, Chandigarh, Puducherry, Andaman & Nicobar Islands, Lakshadweep & Minicoy Islands, Dadra & Nagar Haveli, Daman & Diu.

No apportioning of the above amount is admissible for creating a miscellaneous purpose fund for payment of compensation in case of deaths, complications and failures as these are already covered under the National Family Planning Insurance Scheme.

2.7. HEALTH INSURANCE SCHEME

A Task Force was established by the MOHFW to explore new health financing mechanisms. The terms of reference for this task force included review of existing mechanisms to include health financing, human resource implications to manage health financing and risk pooling schemes, extent of subsidies required, ensuring equity and non-discrimination, feasibility in various states, suggested design of pilots and sites to launch community based health insurance models, and required modifications of existing structures to introduce health financing schemes.

This Ministry had advised the State/UT Governments to prepare Health Insurance models as per their local prepare Health Insurance models as per their local needs to be run on pilot basis and certain guidelines were sent to all States/UTs for preparation of pilot projects on Health Insurance. Government of India will provide support to State Governments under National Rural Health Mission. The support from Government of India, for paying premium for the Health Insurance Scheme for the BPL families has been fixed as per Universal Health Insurance Scheme of the Ministry of Finance, at Rs. 300/- for a family of five.

The states which are implementing the Health Insurance scheme for BPL population within the NRHM framework, however, piloted and based on the local needs are as under:

Din Dayal Antyoday Upchar Yojana - Madhya Pradesh

The Government of Madhya Pradesh is providing free treatment and investigation facility on hospitalization and investigation facility on hospitalization without any exclusion up to a limit of Rs. 20,000/- per family per annum in all government health facilities to the under privileged section of the society i.e. 57 lakh BPL families and 10 lakh other families under Din Dayal Antyoday Upchar Yojana from 25th September 2004. The benefit is provided for all disease and conditions including delivery, without any exclusion. The Department of Public Health and Family Welfare, Government of MP is the Implementing Agency for the Scheme in the state. The average benefit availed is under Rs. 1,000/- per family per annum.

Mukhya Mantri Raksha Kosh for BPL Population ñ Rajasthan

Government of Rajasthan has launched the Mukhya Mantri Jeevan Raksha Kosh with effect from January 1, 2009 and is being implemented to provide free in-patient care and out-patient care to BPL families. BPL card holder will get cash less health care facilities in Medical Colleges, District hospitals and CHCs of the district for inpatient care for any ailment and OPD care. Further, if high end care facility not available in the state for such ailment, they shall be sent out of the state to AIIMS, New Delhi or PGI, Chandigarh for such treatment.

2.8. HEALTH MINISTERíS DISCRETIONARY GRANT

Financial assistance up to maximum of Rs.50,000/- is available to the poor indigent patients from the Health Minister's Discretionary Grant to defray a part of the expenditure on Hospitalization/treatment in Government Hospitals in cases where free medical facilities are not

available. The assistance is provided for treatment of life threatening diseases i.e. Heart, Cancer, Kidney, Brain-tumor etc.. During the year 2009-10, financial assistance totaling Rs.30.80 lakh was given to 167 patients. A provision of Rs.100.00 lakh has been made during the current financial year 2010-11. Till 3rd 0January, 2011, a sum of Rs.71.20 lakh has been released to 198 patients.

2.9. RASHTRIYA AROGYA NIDHI (RAN)

Rashtriya Arogya Nidhi was set up under Ministry of Health & Family Welfare in 1997 to provide financial assistance to patients, living below poverty line, who are suffering from major life threatening diseases to receive medical treatment in Government Hospitals. Under the scheme of Rashtriya Arogya Nidhi, grants-in-aid is also provided to State Governments for setting up State Illness Assistance Funds. Such funds have been set up by the Governments of Andhra Pradesh, Bihar, Chhattisgarh, Goa, Gujarat, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Madhya Pradesh, Jharkhand, Maharashtra, Mizoram, Rajasthan, Sikkim, Tamil Nadu, Tripura, West Bengal, Uttarakhand, Haryana, Punjab, Uttar Pradesh, NCT of Delhi and Puducherry. The Grants-in-aid released to these Funds are at **Table-A**. Other States/Union Territories have been requested to set up such Fund, as soon as possible.

Applications for financial assistance up to Rs.1.5 lakh are to be processed and sanctioned by the respective State Illness Assistance Fund. Applications for assistance beyond Rs.1.50 lakh and also of those where State Illness Assistance Fund has not been set up are processed in this Department for release from the Rashtriya Arogya Nidhi.

In order to provide immediate financial assistance, to the extent of Rs.1.00 lakh per case, to critically ill, poor patients, who are living below poverty line (BPL) and undergoing treatment, the Medical Superintendents of Dr. RML Hospital, Safdarjung Hospital, Smt. Sucheta Kriplani Hospital, All India Institute of Medical Sciences, New Delhi, PGIMER, Chandigarh, JIPMER, Puducherry, NIMHANS, Bangalore, CNCI, Kolkatta, Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow, RIMS, Imphal and NEIGRIHMS, Shillong have been provided with a revolving fund of Rs.10-40 lakhs. The revolving fund is replenished after its utilization. For cases requiring financial assistance above the Rs.1.00 lakh per case the applications are processed in the Department of Health & Family Welfare through a Technical Committee headed by Special Director General (ME), DGHS before being considered for approval by a duly constituted Managing Committee with Hon'ble Minister for Health & Family Welfare as the Chairman. During the year 2009-10, financial assistance totalling Rs.710.69 lakh was given directly to 228 patients under Rashtriya Arogya Nidhi (Central fund) and further, the revolving fund of amount Rs.325.00 lakhs has been given to the above Hospitals/ Institutes. A provision of Rs.700.00 lakh has been made during the current financial year 2010-11. Till 3rd January, 2011, a sum of Rs.599.63 lakh has been released to 200 patients, and further, revolving fund of amount Rs.130.00 lakh has been released to the above Hospitals/ Institutes.

2.10. HEALTH MINISTERíS CANCER PATIENT FUND

"Health Minister's Cancer Patient Fund" (HMCPF) within the Rashtriya Arogya Nidhi (RAN) has also been set up in 2009. In order to utilize the HMCPF, the revolving fund as under RAN, has been established in the various Regional Cancer Centre(s) (RCCs). Such step would ensure and speed up financial assistance to needy cancer patients and would help to fulfill the objective of HMCPF. The financial assistance to the cancer patient up to Rs.1.00 lakh would be processed by the concerned Institute on whose disposal the revolving fund has been placed. Individual cases which require assistance more than Rs.1.00 lakh but not exceeding Rs.1.50 lakh is to be sent to the concerned State Illness Assistance Fund of the State/UT to which the applicant belongs or to this Ministry in case no such scheme is in existence in the respective State or the amount is more than Rs.1.50 lakh. Initially, 27 Regional Cancer Centres (RCC) were proposed at whose on proposal revolving fund of Rs.10.00 lakh was placed (List of RCCs is at **Table B & C**). During the current financial year 2010-11 i.e. till 3rd January, 2011, a sum of Rs.270.00 lakh have also been released to 14 Regional Cancer Centres.

Year-wise Budget Estimate State/UT amount to which grant was released (Rs. in crore)

TABLE-A

Year	Budget Estimate (B.E) (Rs. in crore)	State/ UTs. (to which grant released)	Amount (Rs. in crore)
1996-97	25.00	Karnataka	5.00
		Madhya Pradesh	5.00
		Tripura	2.00
		NCT of Delhi	0.50
1997-98	25.00	Andhra Pradesh	5.00
		Tamil Nadu	5.00
		Himachal Pradesh	0.25
		Jammu & Kashmir	0.25
		NCT of Delhi	0.25
1998-99	25.00	Maharashtra	2.00
		West Bengal	0.50
		Kerala	1.00
		Mizoram	0.50
		Rajasthan	1.00
		NCT of Delhi	0.50
1999-2000	25.00	Goa	0.15
		Gujarat	1.00
		Rajasthan	1.00
2000-01	6.50	Sikkim	0.25
		Rajasthan	0.50
		J & K	0.125
		Bihar	1.25
		Goa	0.15
2001-02	4.00	Chhattisgarh	0.50
		Andhra Pradesh	2.50
2002-03	2.80	NCT of Delhi	0.40
		Jharkhand	1.50
		Rajasthan	1.00
2003-04	3.50	Uttaranchal	0.25
2003-04	3.50	Uttaranchal	0.25
		Jharkhand	0.50
		Jammu & Kashmir	0.24
		Kerala	1.00
		Rajasthan	1.01
		NCT of Delhi	0.50
2004-05	3.20	Chhattisgarh	2.05
		Karnataka	1.00
		Goa	0.90
		NCT of Delhi	0.25
		Pondicherry	0.25
2005-06	3.00	Rajasthan	1.00
		Mizoram	0.15
		Tamil Nadu	1.05
		Haryana	0.50
		NCT of Delhi	0.30
2006-07	3.00	Andhra Pradesh	0.65
		Jammu & Kashmir	0.125
		Kerala	0.275
		Tamil Nadu	0.95
		Rajasthan	1.00
		NCT of Delhi	0.25
2007-08	5.00	West Bengal	1.1025
		Goa	0.30
		Himachal Pradesh	0.27
		Madhya Pradesh	0.8750
		Rajasthan	1.00
		Punjab	0.4525
		NCT of Delhi	0.70
		Puducherry	0.25
2008-09	5.00	Punjab	0.0475
		Kerala	2.00
		Uttar Pradesh	2.50
		Goa	0.30
		Sikkim	0.4750
2009-10	5.00	West Bengal	2.156
		Chhattisgarh	1.8750
		Haryana	0.25
2010-11	5.00	Tamil Nadu	2.50
		Goa	0.25
		West Bengal	1.25
		Haryana	0.25

List of 27 Regional Cancer Centre and Financial Assistance provided to them during the year 2009-2010 from Health Minister Cancer Patient Fund (HMCPF) within Rashtriya Arogya Nidhi (RAN) Scheme are given below.

List of 27 Regional Cancer Centre(s)

TABLE-B

Sl. No	Name of Institute	Rs. in lakh
1.	Chittaranjan National Cancer Institute, Kolkata, West Bengal	30.00
2	Kidwai Memorial Institute of Oncology, Bangalore, Karnataka	10.00
3.	Regional Cancer Institute (WIA), Adyar, Chennai, Tamil Nadu	20.00
4	Acharya Harihar Regional Cancer Centre for Cancer Research & Treatment, Cuttack, Orissa.	10.00
5	Regional Cancer Control Society, Shimla, Himachal Pradesh	10.00
6	Cancer Hospital & Research Centre, Gwalior, Madhya Pradesh	10.00
7	Indian Rotary Cancer Institute, (AIIMS), New Delhi	10.00
8	R.S.T. Hospital & Research Centre, Nagpur, Maharashtra	10.00
9	Pt. J.N.M. Medical College, Raipur, Chhattisgarh.	10.00
10	Post Graduate Institute of Medical Education & Research, Chandigarh	10.00
11	Sher-I Kashmir Institute of Medical Sciences, Soura, Srinagar.	10.00
12	Regional Institute of Medical Sciences, Manipur, Imphal	10.00
13	Govt. Medical College & Associated Hospital, Bakshi Nagar,Jammu	10.00
14	Regional Cancer Centre, Thiruvananthapuram, Kerala	10.00
15	Gujarat Cancer Research Institute, Ahmedabad, Gujarat	10.00
16	MNJ Institute of Oncology, Hyderabad, Andhra Pradesh	10.00
17	Puducherry Regional Cancer Society, JIPMER, Puducherry	10.00
18	Dr. B.B. Cancer Institute, Guwahati, Assam	10.00
19	Tata Memorial Hospital, Mumbai, Maharashtra	10.00
20	Indira Gandhi Institute of Medical Sciences, Patna, Bihar	10.00
21	Acharya Tulsi Regional Cancer Trust & Research Institute (RCC), Bikaner, Rajasthan.	10.00
22	Regional Cancer Centre, Pt. B.D.Sharma Post Graduate Institute of Medical Sciences, Rotan, Haryana.	10.00
23	Regional Cancer Centre, Pt. B.D.Sharma Post Graduate Institute of Medical Sciences, Rotan, Haryana.	10.00
24	Civil Hospital, Aizawl, Mizoram	10.00
25	Sanjay Gandhi Post Graduate Institute of Medical Sciences,Lucknow	10.00
26	Kamala Nehru Memorial Hospital, Allahabad, Uttar Pradesh	10.00
27	Govt. Arignar Anna Memorial Cancer Hospital, Kancheepuram, Tamil Nadu.	10.00
Total = Rs.280.00 lakh released in 2009-10		
*Fund is yet to be released.		

TABLE-C

List of Regional Cancer Centres and Financial Assistance provided to them during **the year 2010ó2011** from **(HMCPF within RAN)** Scheme, are given below**.**

(in Rs. lakh)

1.	Director, CNCI, Kolkata	Rs .60.00
2.	Chief, AIIMS, New Delhi	Rs. 30.00
3.	Director, RCC, Kerala	Rs. 40.00
4.	Med. Supdt., Rogi Kalyan Samiti, Shimla	Rs. 20.00
5.	Med. Supdt.,Civil Hos. Aizawl, Mizoram	Rs. 20.00
6.	Med. Supdt., Agartala, Tripura	Rs.20.00

7.	Med.Supdt., JIPMER, Puducherry	Rs.10.00
8.	Director & Dean, Chennai	Rs.10.00
9.	Hon. Director, Ahmedabad.(Gujarat.)	Rs.10.00
10.	Tata Memo.Centre, Mumbai	Rs.10.00
11.	Director, Bangaluru	Rs.10.00
12.	Med. Supdt. Kamala Nehru Memorial Hospital, Allahabad. (Uttar Pradesh)	Rs. 10.00
13	MS, PGIMER, Chandigarh	Rs.10.00
14	Director, RCC Raipur, Chhattisgarh	Rs.10.00
	Total=	Rs.270.00 lakh (as on 03.01.11)

2.11. PRE- CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT, 1994.

Adverse Child Sex-Ratio in India

Sex ratio (number of females per thousand males) is one of the most important indicators used for study of population characteristics. The declining trend in sex ratio has been a matter of concern for all in the country. Sex ratio in India has declined over the century from 972 in 1901 to 927 in 1991. The sex ratio has since gone up to 933 in 2001.

In contrast the **child sex ratio** for the age group of 0-6 years in 2001census was **927** girls per thousand boys as against **945** recorded in 1991 Census. The encouraging trend in the sex ratio during 1991-2001 was marred by the decline of 18 points in the sex ratio of children aged 6 years or below.

The Census 2001 figures further reveal that the child sex ratio is comparatively lower in the affluent regions, i.e., **Punjab** (798), **Haryana** (819), **Chandigarh** (845), **Delhi** (868), **Gujarat** (883), **Himachal Pradesh** (896) and **Rajasthan** (909). (These are the seven focus States/ UTs for purposes of the PC&PNDT Act, 1994).

Some of the reasons commonly put forward to explain the consistently low levels of sex ratio are son preference, neglect of the girl child resulting in higher mortality at younger age, female infanticide, female foeticide, higher maternal mortality and male bias in enumeration of population. Easy availability of the sex determination tests and abortion services may also be proving to be catalyst in the process, which may be further stimulated by pre-conception sex selection facilities.

Sex determination techniques have been in use in India since 1975 primarily for the determination of genetic abnormalities. However, these techniques were widely misused to determine the sex of the foetus and subsequent abortions if the foetus was found to be female.

In order to check female foeticide, the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, was brought into operation from 1st January, 1996. The Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994 has since been amended to make it more comprehensive. The amended Act and Rules came into force with effect from 14.2.2003 and the PNDT Act has been renamed as "Pre-conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994" to make it more comprehensive.

The technique of pre-conception sex selection has been brought within the ambit of this Act so as to pre-empt the use of such technologies which significantly contribute to the declining sex ratio. Use of ultrasound machines has also been brought within the purview of this Act more explicitly so as to curb their misuse for detection and disclosure of sex of the foetus lest it should lead to female foeticide. The Central Supervisory Board (CSB) constituted under the Chairmanship of Minister for Health and Family Welfare has been further empowered for monitoring the implementation of the Act. State level Supervisory Boards on the line of the CSB constituted at the Centre have been introduced for monitoring and reviewing the implementation of the Act in States/UTs. The State/UT level Appropriate Authority has been made a multi member body for better implementation and monitoring of the Act in the States. More stringent punishments are prescribed under the Act so as to serve as a deterrent for minimizing violations of the Act. Appropriate Authorities are empowered with the powers of Civil Court for search, seizure and sealing the machines, equipments and records of the violators of law including sealing of premises and commissioning of witnesses. It has been made mandatory to maintain proper records in respect of the use of ultrasound machines and other equipments capable of detection of sex of foetus and also in respect of tests and procedures that may lead to pre-

conception selection of sex. The sale of ultrasound machines has been regulated through laying down the condition of sale only to the bodies registered under the Act.

Punishment under the Act

Imprisonment up to 3 years and fine up to Rs. 10,000/-. For any subsequent offences, imprisonment up to 5 years and fine up to Rs. 50,000 / Rs.1,00,000.The name of the registered medical practitioner is reported by the Appropriate Authority to the State Medical Council concerned for taking necessary action including suspension of the registration if the charges are framed by the court and till the case is disposed off.

Status and Report from States/UTs

As per the reports received from the States and UTs, 39854 bodies using ultrasound, image scanners etc. have been registered under the Act. 462 ultrasound machines have been sealed and seized for violation of the law. As on 30.06.2010, there were 706 ongoing cases in the Courts for various violations of the law. Though most of the cases (223) are for non-registration of the centre/clinic, 216 cases relate to non-maintenance of records, 155 cases relate to communication of sex of foetus, 36 cases relate to advertisement about pre-natal/conception diagnostic facilities and 76 cases relate to other violations of the Act/Rules.

The concerned state governments are regularly requested to take effective measures for speedy disposal of the ongoing cases. Ministry of Health and Family Welfare has taken a number of steps for the implementation of the Act. The major steps taken are as follows:

Meetings of the Central Supervisory Board (CSB)

Meetings of the Central Supervisory Board (CSB) of PC & PNDT Act are being held regularly (every six months) under the Chairpersonship of Union Minister of Health and Family Welfare. So far, 16 meetings have been held.

Sensitization through Members of Parliament

Funds were released to the Governments of Chandigarh, Delhi, Gujarat, Haryana, Himachal Pradesh, Punjab and Rajasthan at the rate of Rs.5.00 lakh per Hon'ble Member of Parliament (both Lok Sabha and Rajya Sabha) of these States/UTs, considered sensitive from the point of view of Child Sex Ratio, for undertaking awareness generation activities like organising exhibitions, seminars, workshops, trainings / orientations programmes for PRIs, public meetings, debates, essay competitions, nukkad nataks, stage shows etc.

On 2.10.2007 on the occasion of the Birth Anniversary of the Father of the Nation, Mahatma Gandhi, a signature campaign was launched to generate awareness regarding the evils of female foeticide. H.E. the President of India appended her signature first on the scroll as the first citizen of the country. Rallies were also organised on 4.10.2007 in every district of the NCT of Delhi to generate awareness among the public.

The National Level Meeting on 'Save the Girl Child' held on 28.4.2008 at Vigyan Bhawan, New Delhi, was inaugurated by Dr. Manmohan Singh, Hon'ble Prime Minister of India, in the presence of the Hon'ble Union Minister of Health & F.W., Hon'ble Union Minister of State (I/C) for Women & Child Development and Hon'ble Minister of State for Health & F.W.. The large turn-out of Ministers, Members of Parliament and senior Health officers from the Central and State/UT Governments and representatives of various organisations active in the area of Child welfare at the day long fruitful deliberations of the National Meet lent the necessary impetus to the 'Save the Girl Child' mission. All the State/UT Governments were requested to replicate such meeting in their respective States/UTs. The message of the above National Level Meet was disseminated through the accredited print and electronic media.

Medical Audit

It is proposed to conduct Medical Audit of the ultrasound clinics in the country in a phased manner to spread awareness of the Act and required procedural formalities so as to prevent violations of the Act. Scrutinizing 'Form F' filled in respect of all pregnant women by the clinics will also help in detecting violations, if any.

Changing Appropriate Authorities

In place of Chief Medical Officer / District Health Officer, District Collectors / District Magistrates have been nominated as District Appropriate Authorities to strengthen the implementation of the Act at the ground level. States of Maharashtra, Tripura, Gujarat, and Chhattisgarh have informed that they have issued the necessary notification in this regard.

Proposed Amendments to PC & PNDT Act.

To make the implementation of the Act more effective and stringent, it is proposed to amend certain provisions of the Act, such as changing the Appropriate Authority at the State level from Director (H&FW) to Secretary (H&FW) to facilitate the reporting of District Appropriate Authority (DAA) to State Appropriate Authority (SAA), inclusion of an officer of or above the rank of Joint Director of H&FW in the SAA, and vesting the power the search and seize records to any Group B Gazetted Officer.

Funding to the State through RCH - II

Funds have been provided to all States/UTs, as requested by them, in their Programme Implementation Plan under RCH – II for undertaking various activities for implementation of the Act at the State level.

Inclusion of the issue under NRHM

Sensitization on sex ratio issue has been made a part of curriculum for ANMs. For tracking delivery of a pregnant woman, ASHAs are now provided a fixed remuneration at the village level (Keeping a track of the ante-natal check-ups and accompanying the pregnant mother to an institution for delivery).

Constitution of National Inspection and Monitoring Committee (NIMC)

A National Inspection and Monitoring Committee (NIMC) has been constituted at the Centre to take stock of the ground realities through field visits to the problem states. During 2006-09, the Committee visited the States of Delhi, Haryana, Maharashtra, UP, Rajasthan, Orissa, Karnataka, Kerala, H.P. and Punjab. It is proposed to strengthen the National Support and Monitoring Cell with induction of appropriate consultants to oversee the implementation of the Act.

Meeting with the manufacturers of ultrasound machines

A meeting with all major manufacturers of the ultrasound machines was held on 20.7.2007. It was learnt that L&T and Wipro GE have developed an effective IEC message on a sticker to put on all ultrasound machines. Wipro GE has set up a PNDT Audit Cell. All the manufacturers have since been sensitizing their engineers on this issue, who in turn, brief the medical practitioners while installing the machines.

Training of Judiciary

With a view to sensitize the judiciary, the National Judicial Academy, Bhopal provided training to trainers from the State Judicial Academies during 2005-06, who in turn would provide training to the judiciary in the area under their jurisdiction. The National Law School of India University, Bangalore, was provided grants for Training of lower judiciary and public prosecutors from State Judicial Academies in a phased manner, beginning with Karnataka during 2007-2008.

Annual Report on implementation of the PNDT Act

Implementation of the PNDT Act is being published in Annual Report since 2005 which gives complete information on the implementation of PC & PNDT Act.

Frequently Asked Questions (FAQs) booklet

The Ministry of Health and Family Welfare, in collaboration with the United Nations Population Fund (UNFPA), have developed a 'Frequently Asked Questions' booklet about the PNDT Act which has proved to be quite useful to the lay persons, medical community and to the Appropriate Authorities in understanding the provisions of the Act for better implementation.

Website on PNDT

In addition to the Union Health & F.W. Ministry's Website, (www.mohfw.nic.in), an independent website, 'pndt.gov.in' for PNDT Division was launched by the Hon'ble Union Minister of Health & F.W. on 28.4.2008. This website, in addition to containing all the relevant information relating to PNDT Act, Rules, Regulations and activities, enables online filing of data right from Clinics (including submission of From-F' online by the Clinics) in the field to the District and State level and their retrieval at the District, State and National levels. An exercise is on to impart training to the user groups on the use of the website in a phased manner beginning with the focused states of Punjab, Haryana, Rajasthan, Gujarat, Himachal Pradesh, Maharashtra and Delhi This training programme will be conducted by the experts from National Informatics Centre.

Toll Free Telephone:

Similarly, the Hon'ble Union Minister of Health & F.W. launched a Toll Free Telephone (1800 110 500) on the same day under the PNDT Division of the Ministry to facilitate the public to lodge complaints anonymously

against any violation of the provisions of the Act by any authority or individual and to seek PNDT related general information. (The service is presently suspended, pending resolution of certain operational issues; mainly unauthorized advertising by the outsourced service provider).

Awareness Generation

The problem has its roots in social behaviour and prejudices and along with the legislation various activities have been undertaken to create awareness against the practice of pre-natal determination of sex and female foeticide through Radio, Television, and Print Media. Workshops and seminars are also organized through voluntary organizations at state/regional/district/block levels to create awareness against this social evil. Cooperation has also been sought from religious / spiritual leaders, as well as medical fraternity to curb this practice. The Government of India has launched 'Save the Girl Child Campaign' with a view to lessen son preference by highlighting achievements of young girls. Shri Kapil Dev, former Captain of the Indian national Cricket Team, has been nominated as the Brand Ambassador for the campaign.

Advt. over the Internet regarding Gender Testing Kits:

A new factor which is threatening to adversely impact the PNDT efforts of the Government, i.e. the advertisements placed on the websites regarding the Gender Testing Kits. The Hon'ble High Court of Punjab and Haryana Suo Motu took congnisance of the above report and issued notices to the State Governments of Haryana and Punjab and also to the Central Government. Affidavit on behalf of UOI has been filed.

On 29.11.2007, the Customs Department was requested by this Ministry to examine the possibility of intercepting such Gender Determination Kits when imported into the country under the Customs Act. They were also requested to furnish details of such importers to facilitate the Ministry to take appropriate action against them under the PC & PNDT Act. This was followed up at the Secretary level, *vide* the letter dated 5.1.2007.

In response to the above request of this Ministry, the Customs Department informed that it has suitably alerted its field formations to seize the Gender Testing Kits imported from abroad. Subsequently, the Central Board of Excise & Customs on 1.4.2008 made certain suggestions for consideration of this Ministry for interception of the Gender Testing Kits effectively. In the light of CBEC's letter dated 1.4.2008 cited above, two rounds of Inter-Ministerial Meetings were held on 7.5.2008 and 16.5.2008 under the Chairmanship of Joint Secretary (PK), where the representatives of the Customs Department, DGFT, DGHS and DCG (I) were invited to find a solution to the problem posed by the import of Gender Testing/Sex-Determination Kits.

It was, inter alia, decided to amend the PC & PNDT Act, 1994 and the Rules/Regulations framed thereunder suitably to provide for establishment of a registration mechanism in the matter of import of 'Gender Testing Kits' and other similar medical kits. On the request of the Customs authorities, DCG (I) and DDG (M) have been requested to frame the required parameters for identification of the 'Gender Testing Kits' from among the similar kits imported into the Country.

Sting operation carried out of BBC in Delhi and NOIDA:

The sting operation conducted recently by BBC at NOIDA and New Delhi revealed that illegal sex determination tests were carried out at Dr. Mangala Telang' clinics on an NRI couple from the U.K. This was reported in the website of BBC News.The Appropriate Authorities of Uttar Pradesh and NCT of Delhi were requested to inquire into the matter and furnish their respective reports thereon. In their respective reports, the State Governments indicated that inspection of the facilities of Dr. Mangala Telang at NOIDA and Delhi were carried out, the Premises and sealed and her registration suspended. In addition to the above, the Government of U.P. has filed a court case against Dr. Mangala Telang at NOIDA.

2.12 IMPROVEMENT IN THE QUALITY OF HEALTHCARE

The improvement in the quality of healthcare over the years is reflected in respect of some basic demographic indicators (Table given below). The Crude Birth Rate (CBR) has declined from 40.8 in 1951 to 29.5 in 1991 and further to 22.8 in 2008. Similarly there was a sharp decline in Crude Death Rate (CDR) which has decreased from 25.1 in 1951 to 9.8 in 1991 and further to 7.4 in 2008. Also, the Total Fertility Rate (average number of

children likely to be born to a woman between 15-44 years of age) has decreased from 6.0 in 1951 to 2.6 in the year 2008 as per the estimates from the Sample Registration System (SRS) of Registrar General India (RGI), Ministry of Home Affairs.

The Maternal Mortality Rate has also declined from 437 per one lakh live births in 1992 – 93 to 254 in 2004-06, according to the SRS Report brought *out by RGI.* Infant Mortality Rate, which was 110 in 1981, has declined to 53 per 1000 live births in 2008. Child Mortality Rate has also decreased from 57.3 in 1972 to 15.2 in 2008.

Table 1
Achievements of Family WelfareProgramme

Sl. No.	Parameter	1951	1981	1991	Current level
1	Crude Birth Rate (Per 1000 Population)	40.8	33.9	29.5	22.8 (2008)
2	Crude Death Rate (Per 1000 Population)	25.1	12.5	9.8	7.4 (2008)
3	Total Fertility Rate (Per woman)	6.0	4.5	3.6	2.6 (2008)
4	Maternal Mortality Rate (Per 100,000 live births)	NA	NA	437 (1992-93) NFHS	254(2004-06) S.R.S.
5	Infant Mortality Rate (Per 1000 live births)	146(1951-61)	110	80	53 (2008)
6	Child (0-4 years) Mortality Rate per 1000 children	57.3(1972)	41.2	26.5	15.2 (2008)
7	Couple protection Rate (%) $	10.4(1971)	22.8	44.1	46.5 (2008)

Source: 1 Office of Registrar General, Ministry of Home Affairs, India.
$ (2) Deptt of Health & FW.

Family Planning Methods:

The total number of acceptors of different Family Planning methods enrolled in the country during the year 2009-10 was 36.29 million. Table 2 below summarizes the position in regard to family planning achievements during 2009-10 and 2010-11 (up to September 2010) at All India Level.

Table 2
Family Planning Acceptors by methods

(Figures in million)

Sl.No.	Methods	Achievement * ó ó ó ó ó ó ó 2009-2010	Achievement * ó ó ó ó ó ó ó 2010-11 (April 2010-Sep 2010)	2009-10 (April 2009-Sep.2009)
1.	Sterilisation	5.02	1.60	1.72
2.	IUD Insertions	5.79	2.46	2.87
3.	Condom Users (Eq.)	17.36	6.49	8.71
i.	Under Free Distribution Scheme (Eq.)	8.33	6.49	8.71
ii.	Under Commercial Distribution scheme(Eq.)	9.03**	NA	NA
4.	Oral Pill Users	8.11$	3.55	4.69
i.	Under Free distributionScheme (Eq.)	4.65	3.55	4.69
ii.	Under Commercial Distribution Scheme(Eq.)	3.47**	NA	NA
	Total Acceptors	**36.29**	**14.1**	**17.99**

*: Provisional figures

Source: HMIS Portal

Eq -Equivalent

** Branded full cost commercial sales figures are not included. The data is still awaited from SSM Division of the Ministry.

$:- Total does not match due to round off.

Immunization Performance for the year 2009-10 vis-à-vis 2008-09 is given in **Table 3**. **Table-4** gives the comparative performance during 2010-11 and 2009-10 for the period April-September of the respective years.

Table 3

Assessed Need of Immunisation vis-‡-vis Achievement during 2009-10 under RCH Programme (All India)

(Figures in 000ís)

Sl.No.	Activity	Assessed Need for 2009-10	Achievement* ó ó ó ó ó ó 2009-10	2008-09	% Change.	% Achvt.of Assessed Need
1	2	3	4	5	6	7
A.	**Immunisation**					
i.	Tetanus Immunisation for Expectant mothers	29264	24717	24348	(+) 1.5	84.5
ii.	DPT Immunisation For Children	25187	25070	23345	(+) 7.4	99.5
iii.	Polio	25187	24964	23916	(+) 4.4	99.1
iv.	B.C.G.	25187	25809	26013	(-) 0.8	102.5
v.	Measles	25187	24007	23443	(+)2.4	95.3
vi.	DT Immunisation For Children	24748	18171	14204	(+) 27.9	73.4
vii.	T.T. (10 Years)	25706	16675	13523	(+) 23.3	64.9
viii.	T.T. (16 Years)	25660	14636	11815	(+) 23.9	57.0
B.	Prophylaxis against nutritional anaemia among women	29264	25568	22663	(+)12.8	87.4
C.	Prophylaxis against Blindness due to Vit. 'A' deficiency $					
i.	1st dose (below 1 year + above 1 year)	25187	24058	18292	(+) 31.5	95.5
ii.	5th dose	24364	20378	11480	(+) 77.5	83.6
iii	9th dose	24748	13504	9603	(+) 40.6	54.6

* Provisional figures received through HMIS Portal as on 22nd Oct., 2010.

Table 4

Assessed Need of Immunisation Vis-‡-vis Achievement During 2010-11 (April,10 to Sept, 10) under RCH Programme (All India)

(Figures in 000ís)

Sl.No.	Activity	Assessed Need for 2010-11	Achievement*		% Change.	% Achvt.of Assessed Need
			2010-11 (Apr.2010 to Sept.2010)	2009-10 April 2009to Sept.2009)		
1	2	3	4	5	6	7
A.	**Immunisation**					
i	Tetanus Immunisation for Expectant mothers	29678	10846	12212	(-) 11.2	36.5
ii	DPT Immunisation For Children	25540	10360	12184	(-) 15.0	40.6
iii.	Polio	25540	10285	12210	(-) 15.8	40.3
iv.	B.C.G.	25540	11260	12498	(-) 9.9	44.1
v.	Measles	25540	10169	11740	(-) 13.4	39.8
vi.	DT Immunisation For Children	25092	4665	10484	(-)55.5	18.6
vii	T.T. (10 years)	26065	6801	8427	(-)19.3	26.1
viii.	T.T. (16 Years)	26013	6132	7296	(-) 16.0	23.6
B.	Prophylaxis against Nutritional Anaemia among Total Women	29678	16629	11436	(+) 45.4	56.0
C.	Prophylaxis against blindness due to Vit. 'A' deficiency					
i.	1st dose (below 1 year+ above 1 year)	25540	11155	12131	(-) 8.0	43.7
ii.	5th dose	24706	9056	9643	(-) 6.1	36.7
iii	9th dose	25092	5991	6242	(-) 4.0	23.9

* Figures are provisional.

Source: HMIS Portal

2.13 HEALTH MANAGEMENT INFORMATION SYSTEM

For capturing information on the service statistics from the peripheral institutions, an exercise was undertaken to rationalize the data capturing format by removing redundant information, reducing the number of forms and focused on facility based reporting. The revised forms were finalized in September 2008 and disseminated to the States. A web based Health MIS (HMIS) portal was also launched in October, 2008 to facilitate data capturing at District level. The HMIS portal has led to faster flow of information from the district level and about 98% of the districts reported monthly data for the fiscal year 2009-10. The Provisional Report for the performance of the States for the year 2009-10 (up to March, 2010) as reported by the States was brought and shared with the stakeholders. Soft copy is also available on the HMIS Portal in public domain. The HMIS portal is now being rolled out to capture information at the facility level. Now that data has started flowing regularly on the HMIS portal, a workshop on improving the quality of data was organized in May 2010. Core M&E teams have been formed in the States to look at the consistency of the HMIS data in finding the gap and providing solutions for strengthening the Health MIS system in States.

2.13.1. Tracking of Mothers and Children

It has been decided to have a name-based tracking whereby pregnant women and children can be tracked for their ANCs and immunisation along with a feedback system for the ANM, ASHA etc to ensure that all pregnant women receive their Ante-Natal Care Check-ups (ANCs) and post-natal care (PNCs); and further children receive their full immunisation. All new pregnancies detected/being registered from 1st April, 2010 at the first point of contact of the pregnant mother would be captured as also all births occurring from 1st December, 2009. The states are putting in place systems to capture such information on a regular basis. Mother and Child Tracking System require intense capacity building at various levels primarily at the Block and Sub-Centre levels. The National Informatics Centre (NIC) has been requested to modify and adapt the Gujarat model of e-Mamta software application to other States. This application is being hosted on servers that are to be procured for the purpose and customisation will be carried out by NIC. The roll-out is being monitored centrally for which dashboards are being prepared for the purpose and it is proposed to integrate the application for a Help Desk that is proposed to be put in place for the health sector.

2.14 SURVEYS AND EVALUATION ACTIVITIES

District level Household Surveys: The Ministry also coordinated the activities of the District Level Household Survey (DLHS)-3 during 2007-08 for assessing the impact of the health programmes and generating various health related indicators at the District and State level. All India, State and District Fact Sheets for the results of the survey have been released and hosted on the HMIS Portal for use by the health officials and other stakeholders. The detailed All India and State Reports have also been released.

Concurrent evaluation of NRHM: In pursuant to a decision taken by the Empowered Programme Committee (EPC) of NRHM, Concurrent evaluation of NRHM has been undertaken by the Ministry in 197 districts of all States/UTs covering activities and programmes initiated under the NRHM through the International Institute of Population Science (IIPS), Mumbai. IIPS acted as the nodal agency for conducting the Concurrent Evaluation and outsourced the field work to independent agencies having experience in conducting surveys / research studies. The Fact sheet for 187 districts have been disseminated in the Ministry in October 2010. National and State reports are being finalised and expected to be released by March, 2011.

Regional Evaluation Teams(RETs): There are 7 Regional Evaluation Teams (RETs) located in the Regional Offices of the Ministry which undertake evaluation of the NRHM activities including Reproductive and Child Health Programme (RCH) on a sample basis by visiting the selected districts and interviewing the beneficiaries. These teams generally visit two adjoining districts in a state every month and see the functioning of health facilities and carry out sample check of the beneficiaries to ascertain whether they have actually received the services. Reports of the RETs are sent to the States for taking corrective measures on issues highlighted in the reports. During 2009-10, 114 districts were visited by the RETs.

Annual Health Survey: The Annual Health Survey (AHS) launched by the Ministry aims to prepare District Health Profile of the 284 districts in the EAG States and

Assam on an annual basis. The AHS is being conducting through the Registrar General of India (RGI), Ministry of Home Affairs. The AHS is a hybrid model where the field work has been outsourced to external agencies and supervision being done by the RGI staff. The Annual Health Survey aims to provide feedback on the impact of the schemes under NRHM in reduction of Total Fertility Rate (TFR), Infant Mortality Rate (IMR) at the district level and the Maternal Mortality Ratio (MMR) at the regional level. These are important indicators of health which are currently being estimated at the national/state level through the Sample Registration System (SRS) by Registrar General of India. The fieldwork of the Survey is in progress and reports likely to be available in early 2011.

2.15 POPULATION RESEARCH CENTRES (PRCs)

The Ministry has established 18 Population Research Centres (PRCs) in various institutions in the country with a view to carry out research on various topics pertaining to population stabilization, demographic and other health related programs. While 12 of these PRCs are located in universities, the remaining six are located in institute of national repute. The Ministry of Health & Family Welfare provide 100% financial grant-in-aid to all PRCs as on a year to year basis towards salaries of staff, books and journals, TA/DA, data processing/stationary/contingency etc., and other infrastructure requirement.

As a statutory requirement, under Rule 212 (2) of the General Financial Rules 2005, the Annual Reports of 17 PRCs for 2009-10 which received Rs. 25 lakhs or above as Recurring Grant during 2009-10, alongwith the audited statement of accounts were laid on the table of both the houses of parliament. The performance of PRC Sagar, which received less than 25 lakhs as Recurring Grant for 2009-10, was also found to be satisfactory.

During the year 2009-10, the studies completed by the Population Research Centres (PRCs) on some of the important topics of research including the studies assigned by the Ministry are given below:

1) Male Involvement in Reproductive Health :Evidence from NFHS-3 and DLHS-2

2) Rapid Appraisal of Critical components of National Rural Health Mission (NRHM) in Karnataka

3) Reproductive Health Status of Adolescent Married girls in Karnataka

4) Convergence of Demographic Indicators in Karnataka :An Exploration

5) Orientation for Senior-level officials on use of Demographic Data for Local Level Planning and Monitoring of Development Programmes.

6) Study on Rapid Appraisal of National Rural Health Mission(NRHM) Implementation in Sambalpur and Kendrapara districts of Orissa

7) Monitoring of Coverage Evaluation Survey (CES) 2009

8) District Human Development Report –Hoshiarpur, Punjab

9) Rapid appraisal of NRHM Ambala District – Haryana

10) An Annotated Bibliography and Abstracts of Research (2002-2007)

11) Rapid Appraisal of National Rural Health Mission (NRHM) in the State of Punjab: Patiala district

12) A Study of Out-of-pocket Expenditure on Medial Services and Drugs: An Exploratory

Analysis of U.P.,Rajasthan and Delhi.

13) Gender and forest conservation: The Impact of women's participation in community forest governance, Ecological Economics,

14) Does women's Proportional Strength affect their Participation: Governing local forests in south Asia

15) 'Exploring Gender Differences in functional disabilities among the Old: Are Women at a Disadvantageous Position

16) Changing Demographic Landscape of South Asia and Emerging Issues of Employment, Ageing and Old Age Security.

17) Challenges for the NRHM: Study of Recent Demographic and Health Profile in NRHM States.

18) Shortages and surpluses: changing Female-male Ratios in Younger and Older Ages: Policy Implications in south Asia.

19) Development, Demographic change and Migration: A study of Two Hilly States of India.

20) Women, Empowerment and the State: Enhancing Capabilities Through Employment –Generation Schemes.

21) Sex Differentials in Child Health and Nutritional Status in Punjab.

22) Education in MDGs: Is India Expected to Achieve its Targeted Goal and How?

23) Rapid Assessment of NRHM in Uttar Pradesh

24) Rapid appraisal of National Rural Health Mission (NRHM) implementation in Koppal district, Karnataka.

25) Facility Assessment of Secondary Level Public Hospitals in Tamil Nadu Phase – I

26) Facility Assessment of Medical college Hospitals and Allied Hospitals in Tamil Nadu Phase – I

27) Rapid Appraisal of NRHM Implementation in Bankura District of West Bengal

28) Rapid Appraisal of NRHM Implementation in Jorhat District of Assam

29) Rapid Appraisal of NRHM Implementation in Sonitpur District of Assam

30) Impact of Literacy in infant Mortality Rate in Assam

31) A study on the Role of Assamese Radio Programme 'Sanjog' in Promoting UEE with Special reference to Alternative Schooling

32) Rapid Appraisal of National Rural Health Mission Implementation on Udham Singh Nagar District of Uttarakhand.

33) Maternal Mortality in districts of Uttar Pradesh: An Illustration through indirect estimation

34) Utilisation of Maternal and Child health (MCH) Care services in India with special reference to EAG states.

35) Improving women's Health in Bihar

36) A Critical Review of Community Participation in Family Welfare Programmes.

37) Trends in contraceptive prevalence and fertility across the different districts of Bihar

38) The Demographic Impact of the Partition of India – With Special Reference to Eastern India

39) Can Beautiful be Backward? Tribes of India in a Long Term Demographic Perspective

40) Employment differentials by Social Groups of India

41) Distributional Pattern of Social Groups in Higher Education: An Analysis of Census Data for Maharashtra, 1991-2001.

42) Disparities in Higher Education Between and Within Social Groups: Analysis by Major States of India, 1999-2000.

43) Rapid Appraisal of National Rural Health Mission: Gadchiroli District,Maharashtra .

44) Rapid Appraisal of NRHM Implementation in Madhya Pradesh – district Anuppur

45) Rapid Appraisal of NRHM Implementation in Madhya Pradesh: District Indore

46) Rapid Appraisal of National Rural Health Mission in Rajouri District of Jammu and Kashmir.

47) Rapid Appraisal of National Rural Health Mission in Baramulla District of Jammu and Kashmir.

48) Role of Men in Reproductive Health in Jammu & Kashmir.

49) Disability Burden and the Need for Social Action: The Role of the Family, Community and the NGOs.

50) National Rural Health Mission Initiatives and Reproductive Child Health Phase-II: An Evaluation.

51) Organisation and Functioning of Health Services in Himachal Pradesh.

52) Reducing Maternal and Child Mortality in Himachal Pradesh

53) Unmet Reproductive Health Needs of the Couples and the Role of the Male Partner in Meeting the Needs.

54) National Rural Health Mission: An appraisal of its rationale, structure and Prospects.

55) Rapid Appraisal of National Rural Health Mission Implementation in Kozhikode district, Kerala 2008-2009.

56) Infertility in India: A Comparative Study by State

57) Suicides in Kerala : What do Trends reveal!

58) A Profile of Adolescence and youth in India .

59) Morbidity among Men and women in India: State wise analysis based on NFHS-III data.

60) Immunization coverage in EAG states and Assam: A comparative study with Kerala based on NFHS-III data.

61) The use of temporary contraception and Discontinuation in Kerala .

62) Household headship and nutritional status of women and children in Kerala

63) People living with HIV/AIDS in India, Inference from NFHS-III.

64) Reproductive Health Status of Tribal Women in Rajasthan.

65) Knowledge and Satisfaction of Patients about NRHM Interventions at Dungarpur district Hospital .

66) Impact Assessment of Institutional Delivery Care Services in Tribal Areas of Rajasthan.

67) Rapid Appraisal of National Rural Health Mission (NRHM) Implementation Banaskantha district, Gujarat

68) Rapid Appraisal of National rural Heath Mission (NRHM) implementation, Surat district, Gujarat.

69) District Level Household Survey (DLHS-3) in Andaman and Nicobar Islands

70) Important RCH Indicators of DLHS-3 of Andaman & Nicobar Islands.

Funding For The Programme

The Ministry of Health & Family Welfare consists of four departments viz. the Department of Health & Family Welfare, Department of AYUSH, Department of Health Research and Department of AIDS Control.

Achieving an acceptable standard of health for general population has been the objective over the plan era in the Health sector. In line with this objective, there has been a steady increase in the allocations made for this sector since from the 1st Plan. The allocation for this sector has been substantially enhanced from Rs. 36378.00 crores in the 10th plan to Rs.1,36,147.00 crores in the 11th Plan. The table below is captured the financial outlays and expenditure for Health & Family Welfare for the 10th Plan (2002-07) and Health, Family Welfare and Health Research for the 11th Plan (2007-12).

(Rupees in Crores)

	Approved Outlay				Expenditure			
Plan Period	**Health**	**F.W. $**	**Health Research**	**Total**	**Health**	**F.W.**	**Health Research**	**Total**
10th Plan Outlay	**10252.00**	**26126.00**	**X**	**36378.00**			**X**	
Actual	**10521.00**	**31064.00**	**X**	**41585.00**	**8694.15**	**26349.23**	**X**	**35048.87**
Status								
2002-03	1550.00	4930.00	**X**	6480.00	1359.82	3916.63	**X**	5276.45
2003-04	1550.00	4930.00	**X**	6480.00	1325.81	4409.27	**X**	5735.08
2004-05	2208.00	5780.00	**X**	7988.00	1772.36	4864.21	**X**	6636.57
2005-06	2908.00	6424.00	**X**	9332.00	2259.21	5672.53	**X**	7931.74
2006-07	2305.00	9000.00	**X**	11305.00	1982.44	7486.59	**X**	9469.03
11th Plan (2007-12) Outlay	**41092.92**	**90558.00**	**4496.08**	**136147.00**				
2007-08	2985.00	10890.00	**X**	13875.00	2183.71	10380.25	**X**	12563.96
2008-09	3650.00	11930.00	420.00	16000.00	3008.82	11260.18	390.56	14659.56
2009-10	4450.00	13930.00	420.00	18800.00	3260.40 (Prov.)	13304.51 (Prov.)	399.90 (Prov.)	16964.86
2010-11	5560.00	15440.00	500.00	21500.00				

$:- Figures shown as NRHM from 2006-07 onwards.
Prov.:- Provisional F.W. :- Family Welfare.

The scheme-wise break up of plan and non plan expenditure during 2009-10 and outlays 2010-11 for Health, NRHM and Health Research is given at statement I and II.

Statement-I

DEPARTMENT OF HEALTH AND FAMILY WELFARE HEALTH SECTOR
Scheme- wise Break- up of Actule Expenditure during 2009-10 and Outlay for 2010-11

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
A.	**CENTRALLY SPONSORED PROGRAMMES**	**23202.50**	**1202.38**	**25.09**	**1227.47**	**2734.75**	**22.05**	**2756.80**
1	National AIDS Control Programme and National S.T.D. Control Programme	5728.00	938.06	0.00	938.06	1435.00	0.00	1435.00
2	Cancer	2871.92	69.65	25.09	94.74	225.00	22.05	247.05
	(i) National Cancer Control Programme	2400.00	28.25	11.59	39.84	180.00	9.05	189.05
	(ii) Tobacco Control Programm	471.92	16.40	0.00	16.40	45.00	0.00	45.00
	(iii) Rastriya Arogya Nidhi	0.00	25.00	13.50	38.50	0.00	13.00	13.00
3	National Mental Health Programme	1000.00	51.60	0.00	51.60	120.00	0.00	120.00
4	Assistance to State for Capacity Building(Truma Care)	732.95	52.66	0.00	52.66	115.00	0.00	115.00
	(i) Truma Care	0.00			52.66	113.00	0.00	113.00
	(ii) Prevention of Burn Injury	0.00			0.00	2.00	0.00	2.00
5	Assistance to States for Drug & PFA Control	260.00	0.00	0.00	0.00	0.00	0.00	**0.00**
	New initiatives under CSS (Others)	12609.63	90.41	0.00	90.41	839.75	0.00	839.75
6	Telemedicine (E- Health)	183.00	0.00	0.00	0.00	17.00	0.00	17.00
7	National Programme for Prevention and Control of Diabetes, Cardiovascular Disease and Stroke	1660.50	3.44	0.00	3.44	100.00	0.00	100.00
8	National Programme for Health for the Elderly	400.00	0.00	0.00	0.00	60.00	0.00	60.00
9	District Hospitals	1500.00	16.00	0.00	16.00	225.00	0.00	225.00
	(i) Strengthening of MCH wing/Hospitals and other wing in District Hospitals	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	(ii) Upgradation of States Govt. Medical Colleges(NE)	1500.00	16.00	0.00	16.00	225.00	0.00	225.00
10	Human Resource for Health	4000.00	17.22	0.00	17.22	351.00	0.00	351.00
	(i) Upgradation/Strengthening of Nursing Services	2900.00	17.22	0.00	17.22	250.00	0.00	250.00
	(ii) Strengthening/Creation of Paramedical Institutes	1000.00	0.00	0.00	0.00	100.00	0.00	100.00
	(iii) Strengthening/ Upgradation of Pharmacy Schools	100.00	0.00	0.00	0.00	1.00	0.00	1.00

Statement-I

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
11	Health Insurance (National Urban Health Mission)	4495.00	0.00	0.00	0.00	10.00	0.00	10.00
12	Pilot Projects	371.13	53.75	0.00	53.75	76.75	0.00	76.75
	Sport Medicines/Sport Injiry	90.00	40.23	0.00	40.23	30.00	0.00	30.00
	Deafness	100.00	7.36	0.00	7.36	11.50	0.00	11.50
	Leptospirosis Control	4.48	0.52	0.00	0.52	0.85	0.00	0.85
	Control of Human Rabies	8.65	0.67	0.00	0.67	1.60	0.00	1.60
	Medical Rehabilitation	50.00	1.12	0.00	1.12	13.30	0.00	13.30
	Ogran Transplant	25.00	0.30	0.00	0.30	11.00	0.00	11.00
	Oral Health	25.00	0.00	0.00	0.00	3.50	0.00	3.50
	Fluorosis	68.00	3.55	0.00	3.55	5.00	0.00	5.00
B.	**CENTRAL SECTOR SCHEMES**	**17890.42**	**2058.02**	**3055.77**	**5113.79**	**2825.25**	**2438.50**	**5263.75**
1	Oversight Committee	1827.00	30.00	0.00	30.00	300.00	0.00	300.00
	Strengthening of the Institutes for Control of Communicable Diseases	531.23	63.21	57.69	120.90	77.48	64.06	141.54
2	National Institute of Communicable Diseases	60.00	16.88	20.49	37.37	18.05	22.48	40.53
	National Tuberculosis Institute, Bangalore	9.48	1.16	6.36	7.52	1.95	5.66	7.61
3	Others Research Institutes	461.75	45.17	30.84	76.01	57.48	35.92	93.40
	i B.C.G. Vaccine Laboratory, Guindy, Chennai	80.00	0.39	4.35	4.74	5.75	12.50	18.25
	ii Pasteur Institute of India, Coonoor	280.00	11.26	0.00	11.26	16.27	0.00	16.27
	iii Lala Ram Sarup Institute of T.B. and allied diseases, Mehrauli, Delhi	78.75	30.37	14.41	44.78	30.00	11.00	41.00
	iv Central Leprosy Training & Research Institute Chengalpattu (including Integrated Vaccine complex & Media Park) (Tamil Nadu)	10.00	0.48	7.07	7.55	2.73	6.65	9.38

Statement-I

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
	v Regional Institute of Training, Research & Treatment under Leprosy Control Programme	13.00	2.67	5.01	7.68	2.73	5.77	8.50
	(a) R.L.T.R.I., Aska (Orissa)	3.00	0.03	1.88	1.91	0.50	2.35	2.85
	(b) R.L.T.R.I., Raipur (M.P.)	2.00	0.18	3.13	3.31	0.50	3.42	3.92
	(c) R.L.T.R.I., Gauripur (W.B.)	8.00	2.46	0.00	2.46	1.73	0.00	1.73
4	Strengthening of Hospitals & Dispensaries:	1162.34	202.68	1231.69	1434.37	241.75	1027.05	1268.80
	i Central Government Health Scheme (including Health Insurance)	565.80	57.93	608.89	666.82	67.65	500.00	567.65
	ii Medical Treatment of CGHS Pensioners	0.00	0.00	449.74	449.74	1.00	377.87	378.87
	iii Central Institute of Psychiatry, Ranchi	100.00	20.73	27.28	48.01	27.25	24.18	51.43
	iv All India Institute of Physical Medicine & Rehabilitation, Mumbai	56.00	4.11	7.91	12.02	5.00	8.00	13.00
	v Dr. R.M.L. Hospital, New Delhi	351.00	103.07	127.39	230.46	118.00	107.00	225.00
	vi Others	89.54	16.84	10.48	27.32	22.85	10.00	32.85
	Institute for Human Behaviour & Allied Sciences, Shahdara, Delhi	8.00	0.00	0.00	0.00	1.00	0.00	1.00
	Grant to New Delhi TB Centre	0.00	0.00	2.48	2.48	0.00	2.00	2.00
	All India Institute of Speech & Hearing, Mysore	81.54	16.84	8.00	24.84	21.85	8.00	29.85
5	Strengthening of Institutions for Medical Education, Training & Research:	2350.95	209.58	140.52	350.10	224.62	132.28	356.90
	(a) Medical Education:	1749.67	166.19	75.52	241.71	171.40	59.15	230.55
	i Indira Gandhi Institute of Health & Medical Sciences for NorthEast Region at Shilong*	1266.38	65.00	0.00	65.00	67.85	0.00	67.85
	ii N.I.M.H.A.N.S., Bangalore	266.38	54.38	71.31	125.69	58.35	55.03	113.38
	iii Kasturba Health Society, Wardha	106.91	28.60	0.00	28.60	27.00	0.00	27.00

Statement-I

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
	iv National Medical Library, New Delhi	100.00	18.21	4.21	22.42	17.70	4.12	21.82
	v National Board of Examinations, New Delhi	10.00	0.00	0.00	0.00	0.50	0.00	0.50
	(b) Training:	288.65	18.56	6.32	24.88	22.38	6.77	29.15
	i Upgradation/ Development of Nursing Services	280.65	17.55	0.00	17.55	21.00		21.00
	ii Nursing Colleges	8.00	1.01	6.32	7.33	1.38	6.77	8.15
	(i) R.A.K. College of Nursing, New Delhi	5.00	0.71	4.82	5.53	0.82	4.77	5.59
	(ii) Lady Reading Health School	3.00	0.30	1.50	1.80	0.56	2.00	2.56
	(c) Research:	10.00	3.12	11.60	14.72	5.00	16.44	21.44
	(i) Indian Council of Medical Research, New Delhi # Membership for International Organization	10.00	3.12	11.60	14.72	5.00	16.44	21.44
	#- ICMR merged with department of Health Research from 2008-09							
	(d) Public Health	108.81	7.78	29.30	37.08	10.72	35.19	45.91
	i Institute of Public Health (PHFI)	22.00	0.00	0.00	0.00	1.00		1.00
	ii All India Institute of Hygiene & Public Health, Calcutta (AIIH&PH) and Serologist and Chemical Examiner, Calcutta	86.81	7.78	29.30	37.08	9.72	35.19	44.91
	a. AIIH&PH, Calcutta	85.81	7.59	25.88	33.47	9.22	30.98	40.20
	b. Serologist & Chemical Examiner, Calcutta	1.00	0.19	3.42	3.61	0.50	4.21	4.71
	(e) Others	193.82	13.93	17.78	31.71	15.12	14.73	29.85
	i Indian Nursing Council	10.00	0.15	0.12	0.27	0.25	0.12	0.37
	ii V.P. Chest Institute, Delhi	158.00	12.00	17.00	29.00	12.00	13.00	25.00
	iii National Academy of Medical Sciences, New Delhi	7.72	0.78	0.37	1.15	0.87	0.42	1.29
	iv Medical Council of India, New Delhi	10.00	1.00	0.00	1.00	1.00	0.80	1.80

Statement-I

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
	v Medical Grants Commission	8.10	0.00	0.00	0.00	1.00	0.00	1.00
	vi Dental Council of India	0.00	0.00	0.19	0.19	0.00	0.19	0.19
	vii Pharmacy Council of India	0.00	0.00	0.10	0.10	0.00	0.20	0.20
6	System Strengthening including Emergency Medical Relief/ Disaster Management	1106.58	273.36	137.66	411.02	198.71	148.32	347.03
	i (a) Health Education, Research & Accounts	32.33	0.56	2.42	2.98	3.28	3.55	6.83
	Health Education Bureau, New Delhi	11.65	0.12	2.42	2.54	1.00	2.20	3.20
	Health Intelligence and Health Accounts	20.68	0.44	0.00	0.44	2.28	1.35	3.63
	a. Intelligence	10.68	0.44	0.00	0.44	1.68	1.35	3.03
	b. Accounts	10.00	0.00	0.00	0.00	0.60		0.60
	ii Strengthening of D.G.H.S./ Ministry:	25.00	2.84	77.12	79.96	4.23	78.80	83.03
	a. Strengthening of Deptts under the Ministry	15.00	2.24	39.76	42.00	2.60	42.05	44.65
	b. Strengthening of DGHS	10.00	0.60	37.05	37.65	1.63	35.75	37.38
	Other(Discretionary Grant)		0.00	0.31	0.31	0.00	1.00	1.00
	iii Emergency Medical Relief	564.82	207.20	0.00	207.20	100.00	0.00	100.00
	Health Sector Disaster Preparedness and Management	447.25	2.03	0.00	2.03	38.40	0.00	38.40
	Emergency Medical Relief (including Avian Flu)	117.57	205.17	0.00	205.17	61.60	0.00	61.60
	iv (d) Others	484.43	62.76	58.12	120.88	91.20	65.97	157.17
	i Central Research Institute, Kasauli	292.92	6.51	22.57	29.08	30.00	28.12	58.12
	ii National Institute of Biological, NOIDA (U.P.)	62.65	11.00	0.00	11.00	17.25	0.00	17.25
	iii Prevention of Food Adulteration (including project of Feasibilities Testing sheme of Vitamins and Mineral)	25.36						
	iv Food Safety & Standards Authority of India		21.00	2.80	23.80	12.65	2.54	15.19

Statement-I

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
	v Central Drug Standard & Control Organization (CDSCO)	88.50	14.59	11.00	25.59	10.00	13.68	23.68
	vi Indian Pharmacopeia Commission		8.82	3.56	12.38	20.00	2.75	22.75
	vii National Pharmaccopoeia	0.00	0.00	0.00	0.35		0.35	
	viii Port Health Authority	15.00	0.84	18.19	19.03	0.95	18.88	19.83
	i) Jawaharlal Nehru Port Sheva	8.20	0.55	0.00	0.55	0.60	0.00	0.60
	ii) Setting up of offices at 8 newly created international Airports	6.80	0.29	18.19	18.48	0.35	18.88	19.23
7	Pradhan Mantri Swasthya Suraksha Yojana	3955.00	474.49	0.00	474.49	750.00	0.00	750.00
8	New Initiatives under CS	6957.32	804.70	1487.80	2291.64	1032.69	1066.26	2098.95
	i Forward Linkages to NRHM (New Initiatives in NE)	900.00	0.86	0.00	0.86	60.00	0.00	60.00
	ii National Centre for Disease Control	450.00	0.97	0.00	0.97	18.69	0.00	18.69
	iii Advisory Board for Standards	22.00	0.00	0.00	0.00	2.00	0.00	2.00
	iv Programme for Blood and Blood Products	450.00	0.00	0.00	0.00	20.00	0.00	20.00
	v Medical Store Organisation	0.00	0.00	39.11	39.11	0.00	40.00	40.00
	vi Procurement of Meningitis Vaccine for Inoculation of Haj Pilgrims	0.00	0.00	3.76	3.76	0.00	6.00	6.00
9	Redevelopment of Hospitals / Institutions	6035.32	802.87	1444.93	2247.80	992.00	1020.26	2012.26
	i All India Institute of Medical Sciences & its Allied Departments, New Delhi	1461.00	250.51	636.00	886.51	400.00	400.00	800.00
	ii P.G.I.M.E.R., Chandigarh	625.00	75.00	317.00	392.00	90.00	220.00	310.00
	iii J.I.P.M.E.R., Pudicherry	564.00	115.00	160.00	275.00	132.00	120.00	252.00
	iv Lady Harding Medical College & Smt. S.K. Hospital, New Delhi	383.83	44.19	114.07	158.26	79.00	97.00	176.00
	v Kalawati Saran Children Hospital, New Delhi	74.88	20.29	25.57	45.86	24.00	23.26	47.26

Statement-I

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
	vi RIMS, Imphal, Manipur	589.92	109.70	0.00	109.70	80.50	0.00	80.50
	vii LGBRIMH, Tejpur, Assam	267.07	36.00	0.00	36.00	41.40	0.00	41.40
	viii RIPANS, Aizwal, Mizoram	69.62	17.00	0.00	17.00	19.50	0.00	19.50
	ix Safdarjung Hospital and College, New Delhi	2000.00	135.18	192.29	327.47	125.60	160.00	285.60
10	Other Schemes (Award of Prizes in Hindi, Treatment of Ex-VIPs, Grants to Indiam Red Cross Society & John's Ambulance	0.00	0.00	0.41	0.41	0.00	0.53	0.53
	TOTAL(HEALTH)	**41092.92**	**3260.40**	**3080.86**	**6341.26**	**5560.00**	**2460.55**	**8020.55**
III	**Depart of Health Research**	**4296.08**	**399.90**	**184.07**	**583.97**	**500.00**	**160.00**	**660.00**
	Indian Council of Medical Recearch (ICMR)	4296.08	399.90	184.07	583.97	500.00	160.00	660.00
	GRAND TOTAL	**45389.00**	**3660.30**	**3264.93**	**6925.23**	**6060.00**	**2620.55**	**8680.55**

Statement-II

DEPARTMENT OF HEALTH AND FAMILY WELFARE NRHM AND MEDICAL RESEARCH INSTITUTE
Scheme- wise Break- up of Actul Expenditure during 2009-10 and Outlay for 2010-11

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
I	**CENTRALLY SPONSORED SCHEMES**	**88451.22**	**13120.72**	**9.96**	**10231.41**	**15127.64**	**13.16**	**15140.80**
A.	**Disease Control Programmes**	**6645.63**	**971.40**	**7.53**	**978.93**	**1132.32**	**6.95**	**1139.27**
	1 National Vector Borne Disease Control Programme	3190.00	338.20	7.53	345.73	418.00	6.95	424.95
	2 National T.B Control Programme	1447.00	311.56	0.00	311.56	350.00	0.00	350.00
	3 National Leprosy Eradication Programme	268.70	34.83	0.00	34.83	45.32	0.00	45.32
	4 Iodine Deficience Disorder Control Programme (IDDCP)	155.40	21.20	0.00	21.20	45.00	0.00	45.00
	5 National Programme for Control of Blindness	1550.00	252.60	0.00	252.60	260.00	0.00	260.00
	6 National Drug De-Addiction Control Programme(NDDPC)	34.53	13.01	0.00	13.01	14.00	0.00	14.00
B.	**Free Distribution & Social Marketing of Condoms for NACO**	**2200.00**	**222.85**	**0.00**	**222.85**	**304.00**	**0.00**	**304.00**
C.	**Family Welfare**	79605.59	11926.47	2.43	9029.63	13691.32	6.21	13697.53
	Infrastructure Maintenance	20448.70	3149.98	0.00	3149.98	3781.63	0.00	3781.63
	i Direction & Administration	1955.28	281.31	0.00	281.31	375.00	0.00	375.00
	(i) Maintenance of State & Distt.FW Bureaus	1955.28	281.31	0.00	281.31	375.00	0.00	375.00
	ii Rural Family Welfare Services (Sub Centres)	16865.00	2649.24	0.00	2649.24	3108.06	0.00	3108.06
	iii Urban Familiy Welfare Services	958.84	138.17	0.00	138.17	182.00	0.00	182.00
	iv Grants to State Training Institutions	669.58	81.26	0.00	81.26	116.57	0.00	116.57
	(a) Basic Training for ANM/LHVs	520.48	59.40	0.00	59.40	85.18	0.00	85.18
	(b) Maintenance & Strengthening of HFWTCs	93.01	13.61	0.00	13.61	19.05	0.00	19.05
	(c) Basic Training for MPWs Worker (Male)	56.09	8.25	0.00	8.25	12.34	0.00	12.34

Statement-II

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non- Plan	Total
1	2	3	4	5	6	7	8	9
2	Free distribution of Contraceptives	330.00	35.39	0.00	35.20	55.00	0.00	55.00
3	RCH Programme (Procurement of Supplies & Materials)	1500.00	159.44	0.00	159.44	200.00	0.00	200.00
4	Routine Immunization (Supply of vaccine etc)	2457.16	350.31	0.00	350.31	450.00	0.00	450.00
5	Pulse Polio Immunization	3994.18	1198.47	0.00	1198.47	1067.08	0.00	1067.08
	(a) Procurement of Vaccines	1964.48	605.02	0.00	605.02	581.51	0.00	581.51
	(b) Operating cost	2029.70	593.45	0.00	593.45	485.57	0.00	485.57
6	IEC (Inf., Edu. and Communication)	1001.50	155.13	2.43	157.56	204.94	6.21	211.15
7	Area Projects	463.51	17.87	0.00	17.87	31.67	0.00	31.67
	(a) USAID assisted Projects	463.50	11.96	0.00	11.96	25.00	0.00	25.00
	(b) EC assisted Projects	0.01	0.00	0.00	0.00	0.00	0.00	0.00
	(c.) Projects through Vol.Orgns/ Sociaties/Autonomous	0.00	5.91	0.00	5.91	6.67	0.00	6.67
8	Flexible Pool for State PIPs	49410.54	6859.88	0.00	6859.88	7901.00	0.00	7901.00
	(i) RCH Flexible Pool	16229.47	3479.11	0.00	3479.11	3850.00	0.00	3850.00
	(ii) Mission Flexible Pool	33181.07	3380.77	0.00	3380.77	4051.00	0.00	4051.00
II	**CENTRAL SECTOR SCHEMES**	**2106.78**	**183.79**	**56.63**	**240.42**	**312.36**	**61.29**	**373.65**
A.	**DISEASE CONTROL PROGRAMME**	**300.45**	**40.02**	**0.00**	**40.02**	**35.00**	**0.00**	**35.00**
1	Integrated Disease Survillance Project	300.45	40.02	0.00	40.02	35.00	0.00	35.00
B.	**FAMILY WELFARE**	**1806.33**	**143.77**	**56.63**	**200.40**	**277.36**	**61.29**	**338.65**
1	Social Marketing Area Project	50.00	0.00	0.00	0.00	0.50	0.00	0.50
2	Social Marketing of Contraceptives	450.00	21.86	0.00	21.86	40.00	0.00	40.00
3	F.W Training and Res. Centre, Mumbai	18.80	2.04	1.93	3.97	5.50	2.43	7.93
4	NIHFW, New Delhi	34.00	14.82	19.03	33.85	15.30	20.40	35.70
5	IIPS, Mumbai	24.00	3.00	11.30	14.30	20.00	9.90	29.90
6	RHTC, Najafgarh	23.65	0.00	7.61	7.61	0.02	9.35	9.37
7	Population Research Centres	53.50	9.73	0.00	9.73	14.20	0.00	14.20
8	CDRI, Lucknow	23.15	4.58	0.00	4.58	4.90	0.00	4.90

Statement-II

(Rs.in crores)

Sl. No.	Name of the schemes / Institutes	11th Plan Approved Outlay	Annual Plan 2009-10 Expenditure			Outlay for 2010-11		
			Plan	Non -Plan	Total	Plan	Non-Plan	Total
1	2	3	4	5	6	7	8	9
	9 Travel of Exp./Conf/Meetings etc.	6.00	0.11	0.00	0.11	1.00	0.00	1.00
	10 International Cooperation	8.95	2.62	0.00	2.62	3.50	0.00	3.50
	11 NPSF/National Commission on Population	30.00	0.59	0.00	0.59	4.00	0.00	4.00
	12 NGOs (PPP)	100.00	1.74	0.00	1.74	2.65	0.00	2.65
	13 FW Linked Health Insurance Plan	40.00	18.33	0.00	18.33	15.00	0.00	15.00
	14 RCH Training	51.62	4.58	0.00	4.58	7.00	0.00	7.00
	15 Management Information System (MIS)	750.00	34.49	0.00	34.49	100.00	0.00	100.00
	16 Central Procurement Agency					5.00		5.00
	17 Other Schemes	142.66	25.28	16.76	42.04	38.79	19.21	58.00
	(a) Research & Study	30.00	0.58	0.00	0.58	2.20	0.00	2.20
	(b) Role of Men in Planned Parenthood	16.05	0.45	0.00	0.45	3.92	0.00	3.92
	(c) Training in Recanalisation	4.20	0.00	0.00	0.00	0.40	0.00	0.40
	(d) Assistance to I.M.A.	1.00	0.35	0.00	0.35	0.50	0.00	0.50
	(e) Testing Facilities for IUD and Fallopian	4.50	1.10	0.00	1.10	1.20	0.00	1.20
	(f) Expenditure at HQs (RCH)	30.00	5.19	0.00	5.19	6.22	0.00	6.22
	(g) Regional Offices	24.00	14.86	5.87	20.73	20.00	8.75	28.75
	(h) Information Technology	20.00	1.17	0.00	1.17	1.30	0.00	1.30
	(i) FW Programme in Other Ministries	7.00	0.27	0.00	0.27	1.20	0.00	1.20
	(j) Gandhigram Institute	5.91	1.31	0.00	1.31	1.85	0.00	1.85
	(k) Technical Wing (HQ)		0.00	10.89	10.89		10.46	10.46
	Total (NRHM)	**90558.00**	**13304.51**	**66.59**	**13371.10**	**15440.00**	**74.45**	**15514.45**
III	**Depart of Health Research**	**200.00**	**0.00**	**0.00**	**0.00**			
	ICMR & IRR	200.00	0.00	0.00	0.00			
	GRAND TOTAL	**90758.00**	**13304.51**	**66.59**	**13371.10**	**15440.00**	**74.45**	**15514.45**

Maternal Health Programme

4.1. INTRODUCTION

Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programme in India. Under the NRHM (2005-2012) and the Reproductive and Child Health(RCH) Programme Phase-II (2005-10) the Government of India is actively pursuing the goals of reduction in Maternal Mortality by focusing on the 4 major strategies of essential obstetric and new born care for all, skilled attendance at every birth, emergency obstetric care for those having complications and referral services. The other major interventions are provision of Safe Abortion Services and services for RTIs and STIs. This policy recommends a holistic strategy for bringing about total intersectoral coordination at the grass root level and involving the NGOs, Civil Societies, Panchayati Raj Institutions and Women's Group in bringing down Maternal Mortality Ratio and Infant Mortality Rate.

The National Rural Health Mission and the 11th Five Year Plan have set the goal of reducing MMR to less than 100 per 100,000 live births by the year 2010. Accordingly, schemes and programmes have been developed for various interventions focused on reducing maternal deaths. The Maternal Mortality Ratio in India is 254 per 100,000 live births (SRS, RGI: 2004-06 Maternal Mortality Report).

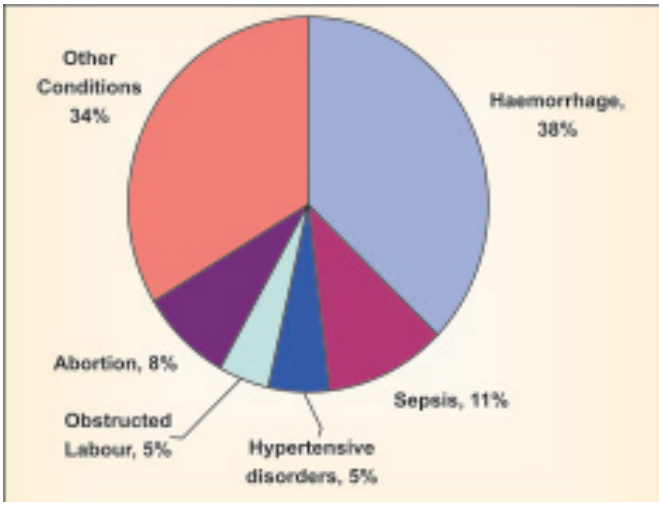
4.2. MATERNAL MORTALITY RATIO (MMR)

MMR is defined as the number of maternal deaths per 100,000 live births due to causes related to pregnancy or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy.

MMR India: The national average of MMR is 254 per 100,000 live births (SRS-2004-06), which in itself is very high compared to the international scenario like Sweden (5), USA (24), Brazil (58) and even in neighbouring countries like Bangladesh (340), Pakistan (260), Sri Lanka (39) and Thailand (48) (Source- 'Trends in Maternal Mortality; 1990-2008 -Estimates developed by WHO, UNICEF, UNFPA and the World Bank'). Some of the States with high Maternal Mortality as per the RGI-SRS report of 2004-06 are:

States	MMR
Uttar Pradesh/Uttarakhand	440
Rajasthan	388
Madhya Pradesh/Chhattisgarh	335
Bihar/Jharkhand	312
Assam	480

Causes of Maternal Mortality: The major causes of Maternal Mortality have been identified as haemorrhage (both ante and post partum), toxemia (Hypertension during pregnancy), anemia, obstructed labour, puerperal sepsis (infections after delivery) and unsafe abortion as given below:



Heamorrhage accounts for more than one- third of all deaths followed by puerperal sepsis and abortion. Anaemia which has been included in “other conditions” is a major contributory factor. Most of these deaths are preventable with good ante natal care, timely identification and referral of pregnant women with complications of pregnancy and timely provision of emergency obstetric care. Moreover

social factors like Illiteracy, low socio-economic conditions, poor access to health facilities are also contributing factors leading to higher maternal mortality.

4.3. MATERNAL HEALTH INDICATORS

The estimates of maternal mortality at State/UTs levels not being very robust, MMR can only be used as a rough indicator of the maternal health situation in any given country. Hence, other indicators of maternal health status like antenatal checkup, institutional delivery and delivery by trained personnel etc. are used for this purpose. These reflect the status of the ongoing programme interventions as well as give a reflection on the situation of Maternal Health. All India figure for these indicators as per the District Level Household Survey (DLHS II and III) are tabled below:

	DLHS II (2002-04) (%)	DLHS III (2007-08) (%)
Any Antenatal Checkup	73.6	75.2
Three or more Antenatal check-up	50.4	49.8
Total Institutional Delivery	40.9	47.0
Safe Delivery	48	52.7
IFA tablets Consumed for 100 days	20.5	46.6
PNC within 2 weeks of delivery	N.A	49.7

From November, 2009 - January, 2010 a nationwide survey called the Coverage Evaluation Survey (CES) was conducted by the United Nations Children Emergency Fund (UNICEF) & ORG- Centre for Social Research. This study was monitored independently by the National Institute of Health and Family Welfare (NIHFW) and Population Resource Centre. According to the CES report, the maternal health indicators are showing significant improvement as given in table below:

Major Indicators	Achievement (%) CES 2009-10
3+ ANC is reported	68.7%
Institutional delivery	73%
Skilled Birth Attendance (Institutional+ Home)	76.2%

4.4. SCHEMES FOR IMPROVING OBSTETRIC CARE

4.4.1 Services:

Under the NRHM, several initiatives are under implementation to achieve the goal of reduction in Maternal Mortality. These interventions are as follows:

4.4.1.a.Essential Obstetric Care:

This includes quality ante-natal care including prevention and treatment of anaemia, institutional/safe delivery services and post natal care. To provide essential obstetric care services Government of India is operationalizing the PHCs for 24 X 7 services and also training the Staff Nurses (SNs)/ Lady Health Visitors (LHVs)/ Auxiliary Nurse Midwives (ANMs) in Skilled Attendance at Birth.

4.4.1.b. Quality Ante-natal care:

Quality ANC includes minimum of at least 4 ANCs including early registration and 1st ANC in first trimester along with physical and abdominal examinations, Hb estimation and urine investigation, 2 doses of T.T Immunization and consumption of Iron Folic Acid (IFA) tablets for 100 days.

4.4.1.c.Prophylaxis and treatment of Nutritional Anemia:

As per NFHS III (2005-06), 55.3% of women aged 15-49 years are anaemic in the country. The problem is more severe during pregnancy, with 58.7% of pregnant women (15-49 years) being anemic and 63.2 % of lactating women. Under the NRHM /RCH II Programme all pregnant and lactating women are provided with one tablet (containing 100 mg of elemental iron and 0.5 mg of Folic Acid) daily for 100 days. Those who have severe anaemia are provided with double dose of these tablets. IFA in the form of tablets and liquid formulations are currently being supplied by the Government of India in RCH Kit A and are distributed through the Sub-Centres and through outreach activities at Village Health and Nutrition Days (VHNDs) to women and children. These are also available at other health facilities like PHCs, CHCs, District Hospitals throughout the country. Details

regarding interventions for anemia are given below:

Interventions for Anemia under NRHM

	Children		Pregnant and lactating women
	6mths -5 years	6-10 years	
IFA supplementation.	20 mg elemental iron and 100 mcg folic acid per ml of liquid formulation.	30 mg elemental iron and 250 mcg folic acid per child per day	• 100 mg of elemental iron and 0.5 mg of folic acid for at least 100 days for prevention of Anaemia. • Those who have anaemia are provided with double dose of these tablets • Health & Nutrition education to promote dietary diversification, inclusion of iron-folate rich food and food items that promote iron absorption.

Long Lasting Insecticide Nets (LLINs)/Insecticide Treated Bed Nets (ITBNs) to households in endemic areas particularly to pregnant women and children

4.4.1.d Provision of 24 Hrs Delivery Services at PHC:

Under RCH – II, all the CHCs and 50% of the PHCs are being operationalized for providing round the clock delivery services by placing at least 3 -5 Staff Nurses and 1 Medical Officer in these facilities.

4.4.1.e.Post natal care for Mother and Newborn:

Ensuring post natal care within first 24 hours of delivery and subsequent home visits on 3rd, 7th and 42nd day are important components for identification and management of emergencies occurring during post natal period. The ANMs, LHVs and staff nurses are being oriented and trained for tackling emergencies identified during these visits.

4.4.2 Skilled Attendance at Birth:

Government of India is commited to provide skilled attendance at every birth both at community and institution level. SNs/ANMs/LHVs are trained in Skilled Attendance at Birth for a period of 3 weeks. For this curriculum and technical guidelines have been revised and training is being implemented accordingly in all the States and UTs.

4.4.3. Provision of Emergency Obstetric and Neonatal Care at First Referral Units (FRUs):

Provision of Emergency Obstetric and Neonatal Care at FRUs is being done by operationalizing all FRUs in the country. While operationalization the thrust is on the critical components such as manpower, blood storage units and referral linkages etc. Availability of trained manpower (Skill Based Training for MBBS doctors) is linked with operationalization of FRUs. The initiatives being undertaken are:

4.4.3.a Training of MBBS Doctors in Life Saving Anaesthetics Skills for Emergency Obstetric Care:

Provision of adequate and timely Emergency Obstetric Care (EmOC) has been recognized globally as the most important intervention for saving lives of pregnant women who may develop complications during pregnancy or childbirth. The operationalization of FRUs, at sub- district i.e. CHC level for providing EmOC to pregnant women is a critical strategy of RCH-II, which needs focused attention. It has not been possible to operationalize these FRUs till now due to various factors most pertinent being shortage of specialist manpower, i.e. Gynaecologist and Anaesthetist, particularly at district and sub district level.

For effective and better management of Emergency Obstetric needs at the grass root level, Government of India has taken a policy decision and is implementing 18 weeks programme for training of MBBS doctors in life saving anaesthetic skills for Emergency Obstetric care at FRU. The training programme is being implemented in nearly 100 medical colleges across all the major States including NE Region.

4.4.3.b Training in Obstetric Management Skills:

Government of India has introduced training of MBBS doctors in Obstetric Management & Skills in collaboration with Federation of Obstetric and Gynaecological Society of India (FOGSI). A 16 weeks training programme in obstetric management & skills including Caesarian Section operation is being implemented at the level of Medical Colleges and District Hospitals in nearly 25 medical colleges of the States.

4.4.3.c Referral Services at both Community and Institutional level:

Establishing referral linkages between the community and FRUs is an essential component for access of services particularly during emergencies. Since emergencies during the process of birth cannot be predicted, it is essential to place effective referral linkages which can be accessed by all pregnant women in case of emergency. States have been given the flexibility to establish assured referral systems.

4.4.4. Other Major Interventions are:

4.4.4.a. Safe Abortion Services/ Medical Termination of Pregnancy (MTP):

Abortion is a significant medical and social problem in India. An ICMR study (1989) documented that the rates of safe (legal) and unsafe (Illegal) abortions were 6.1 and 13.5 per 1000 pregnancies, respectively. It is evident that perhaps two-thirds of all abortions take place outside the authorized health services by unauthorized, often unskilled providers.

The Medical Termination of Pregnancy (MTP) Act was passed by the Indian Parliament in 1971 and came into force from April 1, 1972. The aim of this Act was to reduce maternal mortality and morbidity due to unsafe abortions. The MTP Act, 1971 lays down the conditions under which a pregnancy can be terminated and the place where such terminations can be performed. A recent amendment to the Act (2003) includes decentralization of power for approval of places, as MTP centers, from the states to the district level with the aim of enlarging the network of safe MTP service providers. The amendment also provides for specific punitive measures for performing MTPs by unqualified persons and in places not approved by the government.

Whether spontaneous or induced, abortion has been a matter of concern over many decades now, particularly because of sepsis and other complications associated with it. Eight percent of maternal deaths are attributed to complicated abortions. This is a preventable tragedy. This is also an indication of the unmet need for safe abortions. The National Population Policy 2000 underlines the provision of safe abortions as one of the important operational strategies. Provision of MTP services at 24 X 7 PHCs, CHCs and FRUs are being strengthened by training of medical manpower in techniques of MTP by the States. The following are the strategies to promote safe abortions:

- **Community level:**
  - ✓ Spread awareness regarding safe MTP in the community and the availability of services thereof.
  - ✓ Enhance access to confidential counseling for safe MTP; train ANMs, AWWs and link workers/ ASHAs to provide such counseling.
  - ✓ Promote post-abortion care through ANMs, link workers/ASHAs and AWWs while maintaining confidentiality.
- **Facility level:**
  - ✓ Provide quality MVA (Manual Vacuum Aspiration) facilities at all CHCs and at least 50% of PHCs that are being strengthened for 24-hour deliveries.
  - ✓ Provide comprehensive and high quality MTP services at all FRUs.
  - ✓ Encourage private and NGO sectors to establish quality MTP services.

Guidelines for Manual Vacuum Aspiration (MVA) upto 8 weeks of pregnancy for Medical Officers for performing safe abortions at primary health care facilities have been disseminated to the states for implementation. Comprehensive safe abortion guidelines including medical abortion and providing services for medical abortion through the peripheral health care infrastructure have also been disseminated.

4.4.4.b. RTI/STI Services

Reproductive Tract and Sexually Transmitted Infections (RTI/STI) were not recognized as a public health problem until recently. Research conducted in India to document the magnitude of reproductive morbidity, has made the

incidence of these infections more visible and brought them into the reproductive health agenda. Several studies conducted in India during the past decade suggest high prevalence of reproductive morbidity among women. As per DLHS-III (2007-2008), about one-fifth (18.3%) of women reported some symptoms of RTI/ STI, however there is no data regarding the percentage who sought treatment. The spread of HIV infection and the role that RTI/STI plays in the transmission of HIV have also brought urgency to the problem. The identification and management of reproductive tract infections is an important objective of the RCH programme. The following are the strategies under RCH II programme.

- The prevention, early detection and effective management of common lower reproductive tract infections have been included as a component of essential care through the existing primary health care infrastructure.
- Convergence with the National AIDS Control Programme (NACP) is being sought for the provision of these services, in terms of utilization of services for case management, laboratory services, counseling services, drugs, equipment's, blood safety etc.
- Under RCH - II RTI/STI services are being implemented at sub-district level i.e. in at least 50% of the PHCs and all FRUs, including drugs, training, disposable equipment, and provision for laboratory technicians.
- National Guidelines for Management of RTIs/ STIs have been developed in coordination with National Institute for Research in Reproductive Health, Mumbai (under ICMR) and have been disseminated to States.

4.4.4.c.Setting up of Blood Storage Centers (BSC) at FRUs:

Timely treatment of complications associated with pregnancy is sometimes hampered due to non-availability of Blood Transfusion services at FRUs. The Drugs and Cosmetics Act has been amended to facilitate establishment of Blood Storage Centers at such FRUs.

4.5. JANANI SURAKSHA YOJANA (JSY)

4.5.1. Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of promoting institutional delivery among the poor pregnant women. Launched on 12th April 2005, JSY is being implemented in all States and UTs and integrates JSY benefits with delivery and post-delivery care. The scheme focuses on poor pregnant woman with special dispensation for states having low institutional delivery rate namely, the States of Uttar Pradesh, Uttrakhand, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Assam, Orissa, Rajasthan and Jammu & Kashmir. While these states have been classified as Low Performing States (LPS), the remaining states have been named as High Performing States (HPS). Besides the maternal care, the scheme provides cash assistance to all eligible mothers for delivery care.

ASHA, the Accredited Social Health Activist acts as an effective link between the Government and the poor pregnant women. Her role is to facilitate pregnant women to avail services of maternal care and arrange referral transport.

In Low performing States, all women including those from SC and ST families, delivering in Government health centres like Sub-centre, PHC/ CHC/FRU/general wards of District and State Hospitals or accredited private institutions are eligible to receive the cash assistance. In High Performing States, BPL pregnant women, aged 19 years and above and the SC and ST pregnant women are eligible to receive the cash assistance under the Yojana.

The scale of Cash Assistance (in Rs.) for Institutional Delivery is as under:-

Category	Rural Area		Urban Area	
	Motherís	ASHA package	Motherís	ASHA package
In LPS	1400	600	1000	200
In HPS	700	200*	600	200

** In HPS Tribal area (Notified by Ministry of Tribal Affairs), the ASHA package is Rs. 600 in Rural Area w.e.f. 15.6.2010. & in North East States the ASHA package is Rs. 600 in Rural Area w.e.f. September, 2006.*

State Category	Eligibility
LPS States	In All births, delivered in a health centre –Government or Accredited Private Health Institutions.
HPS States	In Up to 02 live births

The scale of Cash Assistance (in Rs.) for Home Delivery is as under:-

Category	Rural Area		Urban Area	
	Motherís	ASHA package	Motherís	ASHA package
In LPS & HPS **	500	Nil	500	Nil

*** In LPS and HPS States, all BPL pregnant women, aged 19 years and above, delivery at home are entitled to cash assistance of Rs.500/ -per delivery, up to two live births.*

ASHA package of Rs. 600/- available in LPS, NE States and in Tribal Districts of all States/UTs in the rural areas includes the following three components:-

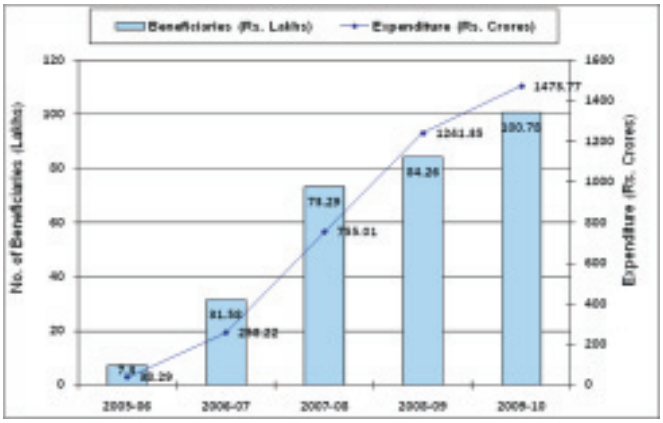
- Cash assistance, over and above the mother's package, for referral transport to go to the nearest health centre for delivery. The state will determine the amount of assistance (should not be less than Rs.250/- per delivery) depending on the topography and the infrastructure available in their state. It would, however, be the duty of the ASHA and the ANM to organize or facilitate in organizing referral transport, in conjunction with Gram Pradhan, Gram Sabha etc.
- Cash incentive to ASHA should not be less than Rs.200/- per delivery in lieu of her work relating to facilitating institutional delivery. Generally, ASHA should get this money after her post-natal visit to the beneficiary and that the child has been immunized for BCG.
- Transactional cost (balance out of Rs. 600/-) is to be paid to ASHA in lieu of her stay with the pregnant woman in the health centre for delivery to meet her cost of boarding and lodging etc. Therefore, this payment should be made at the hospital/ heath institution itself.

The Yojana subsidizes the cost of Caesarean Section or for the management of obstetric complications, up to Rs. 1500/- per delivery to the Government Institutions, where Government specialists are not in position.

LPS and HPS States, all such BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs.500/-per delivery, up to two live births.

The progress on implementation of JSY during the last five years is as reflected in the chart below:-

JSY Physical and Financial progress in past 5 years



4.5.2. Village Health and Nutrition Day

Village Health & Nutrition Day (VHNDs) is organized at the Anganwadi Centre at least once every month to provide ante natal/ post-partum care for pregnant women. Promotion of institutional delivery, immunization, family planning & nutrition are the other various services being provided during VHNDs.

4.5.3. Other simultaneous steps being undertaken are:

- Funds are provided to States to hire staff including doctors and nurses, on a contractual basis wherever necessary.
- SBA skills have been incorporated in the pre-service curriculum of SNs/ANMs/LHVs.
- Bed strength of health facilities are being increased to cope up with the demand of services.
- All Districts and selected high focus blocks have been strengthened with persons with expertise in managerial skills, data management and financial management so that planning and implementation of services can be ensured.
- States have identified difficult, most difficult and inaccessible areas as per geographical location, tribal population, underserved area, left wing affected areas etc. or in terms of difficulty in finding human resource for these areas and special incentives for specialists and MOs for such areas have been proposed by the States to overcome the shortage of medical officers and specialists in these areas.

- Flexibility funding to states and districts through untied funds, AMGs and corpus funds.

4.5.4. Involvement of professional associations for skill based training under PPP

- The services of private health facilities for providing reproductive health services are being mobilized under various demand side financing schemes through the mode of Public Private Partnership (PPP). Many states such as Gujarat (Chiranjeevi Yojana), Jharkhand (Mukhya Mantri Janani Shishu Swasthya Abhiyan), West Bengal (Ayushmati Scheme) are being implemented under Public Private Partnership. For better implementation of this, GOI guidelines have been issued to the states. GOI Guidelines to the States for engaging the services of private health facilities for up-scaling SBA training for ANMs/ SNs/LHVs have also been issued.

4.6. NEW INITIATIVES

4.6.1. Maternal Death Review(MDR):

It has been decided to review every maternal death both at the health facilities and in the community through formation of MDR Committees at district level and a task force at State Level. The purpose of the review is to find gaps in the service delivery which leads to maternal deaths and take corrective action to improve the quality of service provision. The process of Maternal Death Review has been initiated by the states for which guidelines and tools have been disseminated to the states by the Ministry.

4.6.2 Maternal & Child Health (MCH) Centres:

The Government of India is facilitating the States in identifying the delivery points /MCH centres (for basic and emergency obstetric management) for quality care during pregnancy, child birth and in post-natal period and commensurate family planning services, operationalization of these facilities along-with rational deployment of existing manpower, training of doctors and specialists in these identified MCH centres/ delivery points and providing funds for strengthening and up gradation of these centres.

4.6.3 Name Based Tracking of Pregnant Women:

Government of India has taken a policy decision to track every pregnant woman by name for provision of timely ANC, institutional delivery, and PNC along-with immunization of the new- born.

4.6.4 Monitoring and Evaluation of Service Delivery:

To monitor the performance and quality of the health services being provided for maternal and child health under the NRHM/RCH II program, several mechanisms like performance statistics, surveys, community monitoring, quality assurance, field visits etc have been placed to strengthen the monitoring and evaluation of the key indicators and strategies under these programs.

4.6.5. Health Management Information System (HMIS):

A web-based system has been established by the M&E Division of the Ministry for flow of information of both physical and financial progress from District to State and there in up to the national level. Comprehensive set of formats for reporting by health facilities i.e. SCs/PHCs/ CHCs/DHs are available for monthly/quarterly and annual reporting. Mode of e-governance is being used for quick data sharing and evaluation of key indicators.

4.7. CHALLENGES/CONSTRAINTS:

4.7.1. Human resources for health: There is a huge shortfall in the number of human resources required and currently in position.

4.7.2. Governance issues: Tenure of key officers, including Principal Secretaries, State NRHM Mission Directors, Directorate officials at the state levels, Chief District Medical Officers and Block Medical Officers, is not assured. This affects programme ownership and continuity of interventions.

4.7.3. Decentralized Planning: Decentralized planning capacities are inadequate, including capacity to utilize locally available data for district planning. Facility surveys have been carried out by most states; however these have not been systematically analyzed by the states to map out the resources and gaps, and prepare facility-wise micro plans for operationalization/strengthening.

4.7.4. Village Health and Sanitation Committees: These need to be strengthened and activated for improved outcomes.

4.7.5. Monitoring & Supervision: Supervisory structures at the state and district level are weak. At many places, there is no mechanism for monitoring and supervision.

4.7.6. Public Private Partnership (PPP): PPP in RCH services are not up to the expected levels and needs to be scaled up.

Child Health Programme

5.1. INTRODUCTION

5.1.1 Under the National Rural Health Mission (NRHM), Child Health Programme comprehensively integrates interventions that improve child health and addresses factors contributing to infant and under–five mortality. The major components of child health programme are: i) Establishment of New Born Care facilities and Facility Based Integrated Management of Neonatal and Childhood Illnesses (F-IMNCI), ii) Navjaat Shishu Suraksha Karyakram iii) Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and Pre-Service IMNCI iv) Home Based Care of Newborns v) Universal Immunization vi) Early detection and appropriate management of Acute Respiratory Infections, Diarrhoea and other infections vii) Infant and young child feeding including promotion of breast feeding viii) Management of children with malnutrition ix) Vitamin A supplementation and Iron and Folic Acid supplementation x) School Health Programme

5.1.2 Child Health Goal under RCH II/NRHM:

Child HealthCurrent StatusRCH II/NRHM:

MDG indicator	SRS (2008)	2010-2012	2015
IMR (infant mortality rate)	53	<30	28
Neonatal mortality rate	36	<20	<20
Under 5 mortality rate	69	-	<39

The strategies for child health intervention focus on improving skills of the health care workers, strengthening the health care infrastructure and involvement of the community through behavior change communication.

5.2. THE PROGRESS OF VARIOUS COMPONENTS OF CHILD HEALTH PROGRAMME ARE AS FOLLOWS

5.2.1 Integrated Management of Neonatal & Childhood Illnesses (IMNCI) is being implemented in 323 districts and 3.13 lakh personnel have been trained. F – IMNCI launched to multi skill doctors and staff nurses with special skills required to manage new born and child hood illnesses at facilities. Moreover IMNCI has been introduced in the curriculum of 79 Medical colleges and more than 4000 medical students have been trained on various aspects of IMNCI.

5.2.2 A total of 192 **Sick New Born Care Units** (SNCUs), 366 stabilization units and 1524 new born care corners has been established.

5.2.3 Under the **Navajat Shishu Suraksha Karyakram** (NSSK), 14490 health personnel have been trained. This scheme launched to address issues of care at birth and to reduce neonatal mortality.

5.2.4 Totally, 1898 **Nutritional Rehabilitation Centres** (NRCs) have been set up across States for treatment of acute malnutrition.

5.2.5 School Health Programme (SHP) has been launched nationwide and is currently being implemented in 33 States/UTs. Health check-up, treatment of minor ailments, health education, micronutrient supplementation and immunization services are being offered in close conjunction with the ministry of HRD.

5.2.6 Vitamin A supplementation is being implemented for all children of 9 months to 5 years of age with the objective of decreasing the prevalence of Vitamin A deficiency to levels below 0.5%. During 2009-10 the coverage of 1st, 5th and 9th dose of vitamin A was 80.8%, 71% and 45.9% respectively.

5.3 UNIVERSAL IMMUNIZATION PROGRAMME

5.3.1 Immunization Programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. Under the Universal Immunization Programme, vaccination is carried out to prevent seven vaccine preventable diseases i.e. Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B. Since

2006, 1 dose of SA-14-14-2 JE vaccine has been introduced under routine immunization in the high burden districts in phased manner.

5.3.2 The immunization coverage has seen an improvement over the years. However, there is further need for improvement especially in DPT3 & OPV3 coverage and reducing drop outs. Following table outlines under the programme:

(Figures in %)

Source	Coverage Evaluation Survey (CES)		District Level Household Survey (DLHS)	
Time Period	2006	2009	DLHS 2 (2002-04)	DLHS 3 (2007-08)
Full Immunization	62.4	61.0	45.9	53.5
BCG	87.4	86.9	75.0	86.7
OPV3	67.5	70.4	57.3	65.6
DPT3	68.4	71.5	58.3	63.4
Measles	70.9	74.1	56.1	69.1
No Immunization	-	7.6	19.8	4.6

5.3.3 To strengthen routine immunization, some newer initiatives have been introduced as part of the State Programme Implementation Plan (PIP). These initiatives are provision of Auto Disable (AD) Syringe to ensure injection safety, support for alternate vaccine delivery from PHC to Sub-Centres and outreach sessions, provision for deploying additional manpower to carryout Immunization activities in urban slums and underserved areas where services are deficient and support for mobilization of children to immunization session sites by Accredited Social Health Activist (ASHA), Women Self Help Groups etc.

5.3.4 Expansion of Hepatitis B Vaccine: Hepatitis B vaccination was introduced in UIP in the financial year 2002-03 as a pilot in 33 districts and 15 cities and was further expanded to all the districts of 10 states namely Andhra Pradesh, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu and West Bengal. Following the recommendation of National Technical Advisory Group on Immunization (NTAGI), it has been decided to provide Hepatitis B vaccination all over the country.

5.3.5 Introduction of Measles Second Opportunity: Measles immunization directly contributes to the reduction of under-five child mortality and hence to the achievement of Millennium Development Goal number 4. In order to accelerate the reduction of measles related morbidity and mortality, second opportunity for measles vaccination is being implemented. The NTAGI has recommended the introduction of another dose of measles vaccine through measles Supplementary Immunization Activity (SIA) for States where evaluated coverage for measles vaccine is less than 80% while for the remaining States where coverage is more than 80%, NTAGI recommended a second dose through routine immunization. The 14 states with measles coverage of less than or equal to 80%, viz. Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Nagaland, Rajasthan, Tripura and Uttar Pradesh are being covered through Supplementary Immunization Activity, in a phased manner followed by introduction of second dose at 16-24 months in routine immunization.

5.3.6 Introduction of Japanese Encephalitis (JE) Vaccine: JE vaccination was started in 2006 to cover 109 endemic districts in phased manner, using SA 14-14 -2 vaccine, imported from China. Single dose of JE vaccine was given to all children between 1 to 15 years of age through campaigns followed by one dose at 16-24 months under routine immunization to cover the newer cohort. By the end of 2009-10, 90 districts have been covered under the JE vaccination programme; and remaining 19 districts are being covered in 2010-11. In

addition, in 2010-11 re campaign has been planned in 9 districts; 7 in Uttar Pradesh and two in Assam, in view of their low coverage as per the coverage evaluation survey conducted in 2008. The JE vaccine is being integrated into routine immunization in the districts where campaign had already been conducted to immunize the new cohort of children by vaccinating with single doses at 16 -24 months.

5.4 PULSE POLIO IMMUNIZATION(PPI)

In the pursuance of the World Health Assembly resolution of 1988, the Pulse Polio Immunization (PPI) Programme was started nation-wide from 1995 to eradicate polio in India covering children in the age group 0-3 years. In order to accelerate the pace of polio eradication, all children under the age of 5 years were targeted since 1996-97. The annual strategy on polio eradication is decided on the basis of recommendation of India Experts Advisory Group (IEAG) which constituted of Indian experts and international experts. The National Polio Surveillance Project (NPSP) provides technical support for high quality Acute Flaccid Paralysis (AFP) surveillance & assists the government in micro planning, training & monitoring of polio immunization campaign.

Since the PPI initiative in 1995, significant success has been achieved in reducing the number of polio cases in the country & total cases decline gradually. Of the 3 types of polio causing viruses, type 2 (WPV-2) has already been eradicated in 1999. The bivalent vaccine (bOPV) was introduced in the country for the first time in 2010. In 2010, two National Immunization Days (NIDs) and six sub-national Immunization Days (SNIDs) have been conducted. The NID rounds covers approximately 170 million children and SNID rounds cover 40-80 million children. In addition, large scale multi-district mop-ups have been conducted in response to detection of the WPVs. As a result of these interventions remarkable progress has been made towards polio eradication with only 41 polio cases detected (as on 24th December 2010) compared to 650 cases detected during the same period in 2009. Details are given in the table below. The most significant progress is seen in the endemic states with no type 1 case detected in UP since November 2009 and one type 1 case detected in 2010 in Bihar with onset of July 2010.

Table:
State-wise details of polio cases in 2010 (as on 24th December 2010)

S. No	State	WPV-1	WPV-3	Total
1	Uttar Pradesh	0	10	10
2	Bihar	3	6	9
3	West Bengal	5	2	7
4	Jharkhand	3	5	8
5	Maharashtra	5	0	5
6	Haryana	0	1	1
7	Jammu & Kashmir	1	0	1
	Total	**17**	**24**	**41**

The major risks to eradication of type 1 polio are transmission in West Bengal and Jharkhand areas and re-introduction of type 1 polio from neighboring Nepal or West Bengal through extensive migration and population movements.

5.5 INFANT AND YOUNG CHILD FEEDING (IYCF)

5.5.1 Promotion of infant and young child feeding (IYCF) practices. The following are emphasized under IYCF:

- Early initiation of breastfeeding within one hour of delivery
- Exclusive breastfeeding of the first six months of life
- Timely and adequate complementary feeding along with continuation of breast feeding up to two years of life

Comparison of indicators of child feeding practices:

	NFHS I (1992-93)	NFHS II (1998-99)	NFHS III (2005-06)		
Indicators			Rural	Urban	Total
Children under 3 years breastfeeding within one hour of birth (%)	9.5	16.0	21.5	28.9	23.4
Children aged 0-5 months exclusively breastfeeding (%)	N.A	N.A	40.7	31.1	38.4

5.6 IRON AND FOLIC ACID SUPPLEMENTATION

5.6.1 To manage the widespread prevalence of anaemia in the country, Iron and Folic Acid supplementation is provided for at least hundred days in a year for all age groups, i.e infants above six months of age up to adolescence and pregnant and lactating mothers as well as IUD users.

5.6.2 Infant from the age of 6 months onwards up to the age of five years shall receive iron supplements in liquid formulation in doses of 20 mg elemental iron and 100 mcg folic acid (per day) for 100 days in a year. Children 6-10 years of age shall receive iron in the dosage of 30 mg elemental iron and 250 mcg folic acid for 100 days in a year and adolescents 11-18 years shall receive supplements at the same dosage and durations as adults.

5.7 COLD CHAIN SYSTEM VACCINE STORAGE AT PHC/CHC LEVEL

5.7.1 The cold chain system consists of a series of transportation & storage facilities for vaccines from the manufacturers to the beneficiaries at a recommended temperature. Now this year nearly 15000 equipments were procured and are being supplied to states for upgradation of cold chain system in the country. More than 87000 units consisting of the following equipments are there in the states for storing the vaccines at various levels.

I. **Walk ñin Coolers and Walk-in - Freezers Rooms:** These are supplied at State/Regional Level to maintain a vaccine stock required for 3 months in its catchment area. There are at present 161 walk in coolers and 36 walk in freezers installed at various location of the states in the country.

II. **Ice Lined Refrigerators (Large) and Deep Freezers (Large) at the district Level:** 8700 number ILRs (L) and Deep Freezers (L) have been supplied. At the district stores Deep Freezers are also used for storing Polio Vaccine at below (-) 15 Centigrade.

III. **A Twin Set of ILR/Deep Freezers:** These have been supplied in pairs to all PHCs, where a stock of one month's requirement of vaccines is maintained. 79000 such units have been supplied to different health institutions.

IV. Skill based training to cold chain technicians was provided to equip with repair management skills on CFC free equipments. Cold chain stores renovation has also been initiated in the States as per their requirements.

National Programmes Under NRHM

6.1 INTRODUCTION

Several National Health Programmes such as the National Vector Borne Diseases Control, Leprosy Eradication, TB Control, Blindness Control and Iodine Deficiency Disorder Control have now come under the umbrella of National Rural Health Mission.

6.2. NATIONAL VECTOR BORNE DISEASES CONTROL PROGRAMME (NVBDCP)

The National Vector Borne Disease Control Programme is a comprehensive programme for prevention and control of vector borne diseases namely Malaria, Filaria, Kala-azar, Japanese Encephalitis (JE), Dengue and Chikungunya which is covered under the overall umbrella of NRHM. The States are responsible for implementation of programme whereas the Directorate of NVBDCP, Delhi provides technical assistance, policies and assistance to the States in the form of cash & commodity, as per approved pattern. Malaria, Filaria, Japanese Encephalitis, Dengue and Chikungunya are transmitted by mosquitoes whereas Kala-azar is transmitted by sand-flies. The transmission of vector borne diseases in any area is dependent on frequency of man-vector contact, which is further influenced by various factors including vector density, biting time, etc.

The general strategy for prevention and control of vector borne diseases under NVBDCP is described below:

(i) **Disease Management** including early case detection and complete treatment, strengthening of referral services, epidemic preparedness and rapid response.

(ii) **Integrated Vector Management** including Indoor Residual Spraying (IRS) in selected high risk areas, use of Insecticide Treated Bed Nets (ITNs), Long Lasting Insecticidal Nets (LLINs), use of larvivorous fish, anti larval measures in urban areas including bio-larvicides and minor and environmental engineering.

(iii) **Supportive Interventions** including Behaviour Change Communication (BCC), Public‘ Private Partnership (PPP) & Inter-sectoral Convergence, Human Resource Development through capacity building, Operational Research including studies on drug resistance and insecticide susceptibility and Monitoring & Evaluation.

6.2.1. Malaria

a. Malaria is an acute parasitic illness caused by *Plasmodium falciparum* or *Plasmodium vivax* in India. Nine major species of anopheline mosquitoes transmit malaria in India. The main clinical presentation is with fever with chills; however, nausea and headache can also occur. The diagnosis is confirmed by microscopic examination of a blood smear and Rapid Diagnostic Tests for Pf cases. Majority of the patients recover from the acute episode within a week. Malaria continues to pose a major public health threat in different parts of the country, particularly due to *Plasmodium falciparum* as it is sometimes prone to complications and death, if not treated early.

b. There are 9 species of Malaria vectors in India, out of which the major vector mosquito for rural malaria viz. *Anopheles culicifacies*, is distributed all over the country and breeds in clean ground water collections. Other important Anopheline species namely *An.minimus* and *An.fluviatilis* breed in running channels, streams with clean water. Some of the vector species also breed in forest areas, mangroves, lagoons, etc, even in those with organic pollutants.

c. In urban areas, malaria is mainly transmitted by *Anopheles stephensi* which breeds in man-made water containers in domestic and peri-domestic situations such as tanks, wells, cisterns, which are more or less of permanent nature and hence can

maintain density for malaria transmission throughout the year. Increasing human activities, such as urbanization, industrialization and construction projects with consequent migration, deficient water and solid waste management and indiscriminate disposal of articles (tyres, containers, junk materials, cups, etc.) create mosquitogenic conditions and thus contribute to the spread of vector borne diseases.

The National Health Policy (2002) has set the goal of reduction in mortality on account of malaria by 50% by 2010. Reduction of malaria morbidity and mortality is also important to meet the overall objectives of reducing poverty and is included in the Millennium Development Goals (Goal 6 and target 8).

Epidemiological Situation:

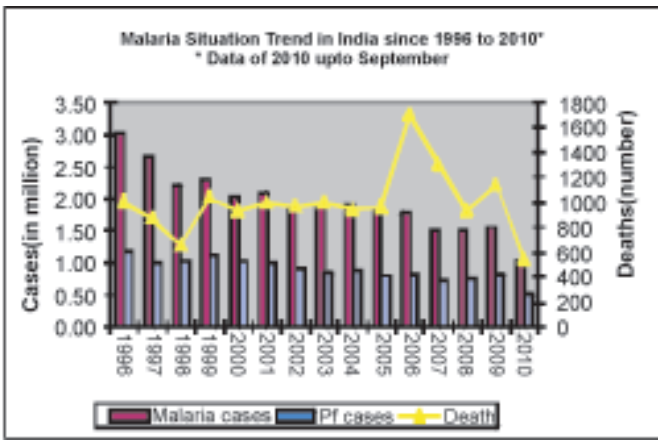
The status of total cases, Pf cases, deaths and API from 1996 to 2010 (up to September) is given in the table and the Graph as follows. The state-wise data on malaria cases & deaths since 2007 is at **Appendix- 1**.

Malaria Situation in the country during 1996-2010*

Year	Cases (in million)		Deaths	API
	Total	Pf		
1996	3.03	1.18	1010	3.48
1997	2.66	1.01	879	3.01
1998	2.22	1.03	664	2.44
1999	2.28	1.14	1048	2.41
2000	2.03	1.04	932	2.09
2001	2.09	1.01	1005	2.12
2002	1.84	0.90	973	1.82
2003	1.87	0.86	1006	1.82
2004	1.92	0.89	949	1.84
2005	1.82	0.81	963	1.68
2006	1.79	0.84	1707	1.66
2007	1.50	0.74	1311	1.39
2008	1.53	0.78	1055	1.36
2009	1.56	0.84	1144	1.36
2010*	1.04	0.53	547	

* Data for 2010 up to September

Pre-independence estimates of Malaria were about 75 million cases and 0.8 million deaths annually. The problem was virtually eliminated in the mid sixties but resurgence led to an annual incidence of 6.47 million cases in 1976. Modified Plan of Operation was launched in 1977 and annual malaria incidence started declining. The cases were contained between 2 to 3 million cases annually till 2001 afterwards the cases have further started declining. During 2009, the malaria incidence was around 1.56 million cases, 0.84 million Pf cases and 1144 deaths. About 92% of malaria cases and 97% of deaths due to malaria are reported from high disease burden states namely, north eastern (NE) States, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Andhra Pradesh, Maharashtra, Gujarat and Rajasthan, West Bengal and Karnataka. However, other States are also vulnerable and have local and focal outbreaks. Resistance in *Plasmodium falciparum* to Chloroquine is being detected from more areas and Artesunate Combination Therapy has been introduced in such areas as first line treatment. For strengthening surveillance, Rapid Diagnostic Test (RDT) for diagnosis of *P.falciparum* malaria has also been introduced in high endemic areas. In these areas, ASHAs have been trained in diagnosis and treatment of malaria cases and are thus involved in early case detection and treatment.



The Government of India provides technical assistance and logistics support including anti malaria drugs, DDT, larvicides, etc. under the National Vector Borne Disease Control Programme. State Governments have to meet other requirements of the programme and operational costs and to ensure the implementation of programme. North-eastern states are provided 100 per cent central assistance for programme implementation that includes operational cost.

The major externally supported projects:

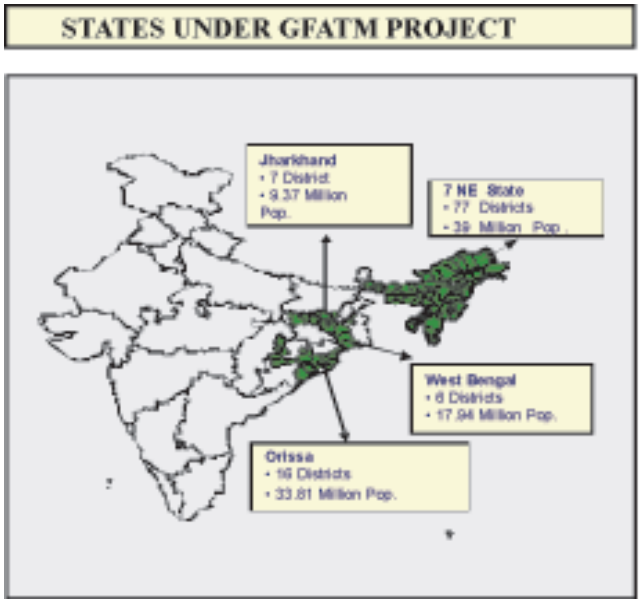
Additional support for combating malaria is provided through external assistance in high malaria risk areas. There are two such externally funded projects which are currently being implemented for malaria control:

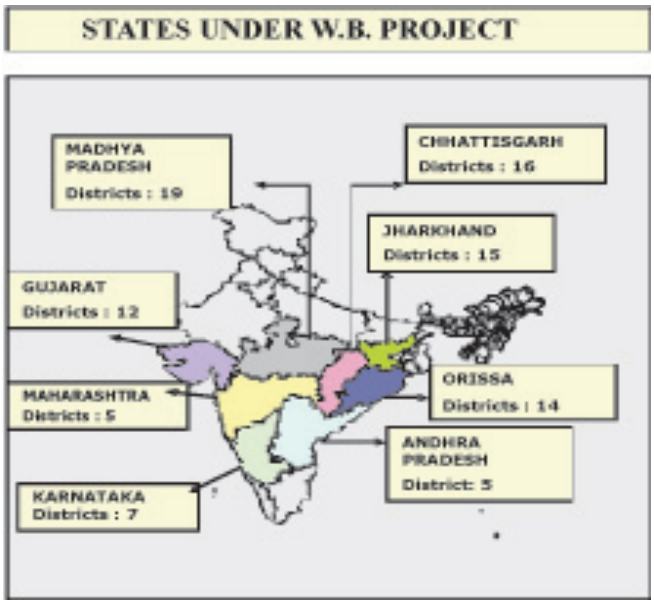
(i) Global Fund Supported Intensified Malaria Control Project (IMCP)

(ii) World Bank Supported Project on Malaria Control & Kala-azar Elimination.

The areas covered under these projects are as under:

TWO PROJECTS WITH EXTERNAL ASSISTANCE





The Global Fund supported Intensified Malaria Control Project (IMCP)

This project is for a period of 5 years starting from July, 05 to June, 2010. The total financial outlay of this project is Rs. 277.20 crores. The project is being implemented in 106 districts in 10 States namely, 7 North-Eastern States and in selected high risk areas of Orissa, Jharkhand and West Bengal covering a population of about 100 million. The goal of the project is to reduce malaria morbidity and mortality in 100 million populations in 10 States by 30% in 5 years.

Additional Support provided in project area is listed below:

- Human resource such as Consultants and support staff for project monitoring units.
- Capacity building of Medical Officers/Lab. Technicians/ Fever Treatment Depots/Volunteers etc.
- Commodities such as Synthetic Pyrethroid liquid formulation insecticide for treatment of bednets, Long-Lasting Insecticidal Nets (LLINs), Rapid Diagnostic tests for quick diagnosis of Malaria, alternate drugs (Artesunate Combination Therapy, Inj. Arteether) for treating malaria cases resistant to Chloroquine.
- Planning & administration including mobility support, monitoring, evaluation and operational research (studies on drug resistance and entomological aspects).

This project has ended in June 2010. This Intensified Malaria Control Project–II (IMCP-II) will be implemented for a period of five years (2010-2015).

Achievements of IMCP: (Project end): Under this project in five years followings have been achieved:

(i) Provision of 5145475 ITNs (including 6,75,004 LLINs) to targeted population in project areas

(ii) 2,16,42,050 bed nets treated with insecticides in project area during the project period

(iii) Treatment with SP-ACT in 970450 uncomplicated Pf cases

(iv) Treatment with artemisinin injections in 343930 severe malaria cases

(v) 4890 medical officers of public and private healthcare sectors trained

(vi) 137 recruited and trained for the supervision in project areas

(vii) 3261 LTs trained in malaria microscopy

(viii) 9601 service deliverers of local NGOs/CBOs identified and trained

(ix) 2,13,997 community volunteers trained in malaria control strategies

(x) 70860 awareness camps organized at village level for treating bed-nets.

The impact in terms of epidemiological indicators for the project areas based on the data received up to July 2009 are shown in the following table:

malaria incidence by 23.4%, with overall declining trend in SPR, SfR with improvement in process indicator ABER indicating improved surveillance.

The World Bank Supported Project on Malaria Control & Kala-azar Elimination

This project has been approved for 5 years effective from March 2009 to December 2013. The total financial outlay for this project is Rs.1000 crore. This project is being implemented in 93 malarious districts of eight (8) states namely Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Orissa & Karnataka and 46 Kala-azar districts in three states namely Bihar, Jharkhand and West Bengal. The project will be implemented in two phases. Phase one is covering 50 most malaria endemic districts in five States namely Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Orissa and Jharkhand and 46 kala-azar districts in Bihar, Jharkhand & West Bengal. From 3rd year, phase two shall be implemented in remaining (43) malaria districts.

Additional support provided in this project are:

Table: Status of Epidemiological Indicators of malaria In IMCP (2002-09)

Indicator	2002	2003	2004	2005	2006	2007	2008	2009	% Change from 2002
Population (In,000s) Project	83838	89619	90807	93533	101887	103925	106004	105645	26.0
ABER Project	7.76	7.72	7.20	8.87	9.28	8.61	8.47	9.89	27.45
Annual Parasite Incidence (API)	5.25	5.33	4.98	4.88	4.95	4.05	3.43	4.02	-23.42
Project Slide Positivity Rate (SPR) Project	6.77	6.90	6.79	5.51	5.33	4.70	4.05	4.07	-39.88
Slide falciparum Rate (SfR) Project	3.41	3.33	3.32	2.55	2.79	2.52	2.41	2.63	-22.87
Malaria Mortality Project	478	484	395	426	1124 **	691	389	563	+17.78

*** Due to epidemic situation in Assam*

The enhanced inputs under the project ie, introduction of RDT for early diagnosis and complete treatment with ACT (SP + Artesunate) regimen and injection Artemisinine derivatives along with use of ITN/LLINs as personal protective measures have helped to achieve decline in

i) Provision of Human Resource like Consultants & Support staff at National, State, District & Sub District level for surveillance & monitoring.

ii) Promotion & use of long lasting Insecticide Nets (LLINs) in high malaria endemic areas.

iii) Social mobilization and vulnerable community plan to address the issues of marginalized sections.

iv) Strong BCC/IEC activities at Sub district level through identified agencies.

v) The project also envisaged the safe guard policies by undertaking Environmental Management Plan (EMP) on safe disposal & environmental hazards.

vi) Capacity building of Medical Officers /Lab Technicians/Fever Treatment Depots/Volunteers etc.

vii) Supply of rapid kits for Malaria and drug Artesunate combination therapy (ACT) for treatment of PF cases.

6.2.2. Urban Malaria Scheme

The Urban Malaria Scheme (UMS) under NVBDCP is being implemented in 131 towns in 19 States and Union Territories protecting 115.1 million population.

Objectives:

The main objectives were reduction of the disease to a tolerable level in which the human population in urban areas can be protected from malaria transmission with the available means.

The Urban Malaria Scheme aims at:

a). To prevent deaths due to malaria.

b). Reduction in transmission and morbidity.

Epidemiological Situation

About 10% of the total cases of malaria are reported from urban areas. Maximum numbers of malaria cases are reported from Ahmedabad, Chennai, Kolkata, Mumbai, Vadodara, Vishakapatnam, Vijayawada etc. The comparative epidemiological profile of malaria during 2008-2010 in all urban towns of the country is given below:

Year	Population	Total cases	P.f	P.F %	SPR	SFR	Deaths
2008	113334073	113810	18963	13.42	1.66	0.22	102
2009	114699850	166065	31134	18.75	2.98	0.56	213
*2010	115159555	111486	15332	13.75	2.81	0.39	118

*Provisional up to October, 2010

Control Strategy:

Under UMS, Malaria Control strategies are for**:** (i) Parasite control & (ii) Vector control

(i) Parasite control: Treatment is done through passive agencies viz. hospitals, dispensaries both in private & public sectors. In mega cities malaria clinics are established by each health sector/ malaria control agencies viz. Municipal Corporations, Railways, Defence services

(ii) Vector control comprises of source reduction, use of larvicides, use of larvivorous fish, space spray, minor engineering and Legislative measures.

The control of urban malaria depends primarily on the implementation of urban bye-laws to prevent mosquito breeding in domestic and peri-domestic areas or residential blocks and government/commercial buildings, construction sites. Use of larvivorous fish in the water bodies such as natural water bodies, slow moving streams, lakes, ornamental ponds/fountains etc. is also recommended. Larvicides are used for water bodies, which are unsuitable for use of larvivorous fish. Awareness campaigns are also undertaken by Municipal Bodies/Urban area authorities.The Bye-laws have been enacted and implemented in Delhi, Mumbai, Chandigarh, Ahmedabad, Bhavnagar, Surat, Rajkot, Bhopal, Agartala and Goa.

Central Cross Checking Organization (CCCO): The Central Cross Checking Organization of the Directorate of National Vector Borne Disease Control Programme regularly cross check of anti-larval operations in Municipal Corporation of Delhi (MCD), New Delhi Municipal Council (NDMC), Northern Railways, Cantonment Areas as well as Zoological Park, Indian Institute of Technology Delhi, All India Radio, Jawahar Lal Nehru University and Presidents Estate in NCT Delhi and near by townships /localities of National Capital Region namely Ghaziabad and Noida in Uttar Pradesh, Faridabad, Gurgaon and Sonepat in Haryana to provide feedback about the larval density/ breeding indices and remedial measures to be undertaken by them. The monthly