Government of India
Institute of Secretariat Training and Management
(Department of Personnel & Training)

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Reading Material

ORIENTATION TRAINING PROGRAMME
of
ASSISTANTS, SECTION OFFICERS, UNDER SECRETARIES
of
MINISTRY OF HEALTH AND FAMILY WELFARE

Sponsored by
DEPARTMENT OF ADMINISTRATIVE REFORMS & PUBLIC GRIEVANCES
As part of the
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September 2009

Reading Material

Prepared by

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FOREWORD

The utility and need for training in any organization is universally accepted. This is more so in Ministries and Departments of Government of India, where apart from rules and regulations on various subjects, policies in the area of social welfare at National, State and grass-root level are formulated and implemented.

2. The focus of training is generally directed towards foundational level, where the newly recruited officials are required to undergo intensive training on various aspects of administration. Also, the concept of in-service training at various levels focusing on requirements as and when such officials move up on promotion is also firmly established.

3. However, one aspect, which generally goes un-noticed, is when officials are moved from one Ministry/Department to another, as a result of routine transfer policy or on promotion and also, officials directly recruited are allotted Ministries/Departments and join after receiving Foundational Training on general subjects. Such officials are faced with the problem of familiarizing and learning the working of the new Ministry/Department. The concept of any kind of Orientation training, focusing on the need of the Ministry/Department, is by and large not in place. The problem of such officers is more acute in Ministries/Departments implementing National Level policies in various social welfare sectors like Health and family welfare, where the policies/schemes are formulated at National Level but implemented through States at District, Block and Panchayat level.

4. The newly posted officials find it extremely difficult to come to terms with the situation at the ground levels, like rural health needs etc., learn about the important components of the policy/schemes and also with the ground realities at the block and village level.

5. DARPG as part of the DFID funded Capacity Building for Poverty Reduction Programme has taken initiative to bridge this gap by providing Orientation Training to the officials posted to a ministry on promotion, transfer, deputation or direct recruitment. The task of identifying training needs for such orientation training programme and based on the same, designing training and development of training material has been assigned to ISTM as Consultant.

6. To undertake the task assigned, ISTM has constituted a consultancy team consisting of Sh. M.S. Kasana, Joint Director, Sh. P.S. Sareen, Deputy Director and Sh. S.K. Dasgupta, former Director, DOPT (as External Consultant).

7. It gives me great pleasure that the consultancy team has conducted extensive research and studies to conduct Training Needs Analysis, design training programme and develop qualitative training material to enable the participants to master the organisation structure and co-ordination mechanisms for activities of various departments within the ministry, appreciate the sectoral scenario and major policies and programme in operation, etc.

8. I am confident that this training material prepared by the consultancy team for orientation training programme for the target group (Chapters 1 to 8 in Part I, Chapters 1 - 3 in Part – II and one chapter in Part - III) will prove to be useful reference material for the capacity building initiative in the area which has remained unattended till now.

(KHWAJA M. SHAHID)
DIRECTOR

September 2009

PREFACE

This reading material is an outcome of DARPG initiative as implementing agency for DFID funded Capacity Building for Poverty Reduction Programme to operationalise Orientation Training Programme for Assistants, Section Officers and Under Secretaries on their posting to the Ministry of Health and Family Welfare. DARPG assigned the task to ISTM as Consultant, which in turn constituted a consultancy team consisting of the undersigned along with Sh. P.S. Sareen, Deputy Director and Sh. S.K. Dasgupta, former Director, DOPT (as External Consultant) to conduct training needs analysis , design training and develop training material. The consultancy team undertook extensive research and studies to conduct training needs analysis, design training programme and develop training material.

2. Subsequent to the training needs identification and design of the programme, task of compiling the reading material pertaining to Ministry of Health & Family Welfare was undertaken. This monograph containing 12 chapters (in three parts) is an endeavour in that direction.

3. To begin with, details about the ministry and its departments, list of abbreviations relating to the ministry followed by overview of health sector has been prepared. This training material consists of Part I, II and III. While Chapter 1 / Part I of the monograph provides the overview of the Ministry and its functions, Chapter 2 covers national rural health mission giving details about health and population policies, etc.

4. Chapters 3, 4 and 5 cover maternal health programme, child health problem and national programme under NRHM.

5. Chapter 6 gives details on information, education and communication. Chapter 7 and 8 provides an overview on family planning and other national health programmes.

6. In Part - II, Chapter 1 provides an overview of Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH). Chapter 2 and 3 provides information on department of AYUSH and its national policy.

7. Part - III of the training material provides an overview of Department of Health Research.

8. The members of the Consultancy Team have scanned substantive amount of literature made available by the ministry and have compiled this reading material with the objective that the learning of the participants is supplemented in providing domain specific knowledge and skills.

8. We look forward to constructive suggestions / comments for making this monograph richer both in content and context. Please feel free to give us feedback on this monograph.

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The initiative taken by Department of Administrative Reforms and Public Grievances to institutionalize a system of Orientation Training as a pilot project in five Ministries will go a long way in increasing efficiency and productivity of the concerned Ministries. The Institute of Secretariat Training and Management (ISTM) and the Consultancy Team express their deep gratitude to Department of Administrative Reforms and Public Grievances for entrusting this responsibility to them, which involves the entire gamut of collection of data, identification of training needs, design of training and also preparing the training material.

2. The Consultancy team is grateful to Secretary, Department of Administrative Reforms and Public Grievances and all other officers of the Department for their guidance and assistance extended to the team from time to time.

3. The Consultancy Team is grateful to Shri Karnail Singh, Director (Administration), Ministry of Health and Family Welfare and also, the Nodal Officer nominated for this purpose, for coordinating the visit of the team to the Ministry for collection of statistical data and for facilitating meeting with other officers to ascertain their views. The Team is also grateful to Shri Karnail Singh and all the officers of his Division for providing relevant material pertaining to the Ministry and also, copies of various circulars issued by the Ministry from time to time.

4. The Consultancy Team is grateful to Shri H. R. Joshi, Director and Shri R. K. Kalra, Deputy Director, Ministry of Health and Family Welfare, for sparing their valuable time for interacting with the Team and providing valuable suggestions and information relating to Orientation Training in the Ministry.

5. Dr. Khwaja M. Shahid, Director, ISTM has been a great source of strength and morale-booster by providing necessary guidance and assistance to the Consultancy Team as and when required. The Team is grateful to Dr. Shahid for guidance in undertaking the task.

6. Finally, the Consultancy Team acknowledges the contribution and assistance provided by the supporting staff consisting of Smt. R. Mahalakshmi, PA, Smt. Smitha Viju, PA. and Shri Ravi Shankar, Peon. It was due to their untiring efforts, the Team could submit this training material.

M. S. Kasana,
P.S. Sareen and
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LIST OF ABBREVIATIONS

1.	AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy
2.	NRHM	National Rural Health Mission
3.	PMSSY	Pradhan Mantri Swasthya Suraksha Yojana
4.	DGHS	Directorate General of Health Services
5.	NUHM	National Urban Health Mission
6.	ULB	Urban Local Body
7.	RCH	Reproductive Child Health
8.	ASHA	Accredited Social Health Activists
9.	JSY	Janani Suraksha Yojana
10.	ETF	Electronic Transfer of Funds
11.	NHP	National Health Policy
12.	TFR	Total Fertility Rate
13.	NCP	National Commission on Population
14.	EAG	Empowered Action Group
15.	JSK	Janasankhya Sthirata Kosh
16.	AHS	Annual Health Survey
17.	LPS	Low Performing States
18.	HPS	High Performing States
19.	UIP	Universal Immunization Programme
20.	ARI	Acute Respiratory Infections
21.	IMNCI	Integrated management of Neonatal and Childhood Illness
22.	HBNC	Home Based Newborn Care
23.	NNF	National Neonatology Forum
24.	NVBDCP	National Vector Borne Disease Control Programme
25.	NLEP	National Leprosy Eradication Programme
26.	NIDDCP	National Iodine Deficiency Disorders Control Programme
27.	IDD	Iodine Deficiency Disorders
28.	NSV	No Scalpel Vasectomy
29.	NCCP	National Cancer Control Programme
30.	DCCP	District Cancer Control Programme
31.	NGO	Non-government organisations
32.	IDSP	Integrated Disease Surveillance Project
33.	PHFI	Public Health Foundation of India
34.	CME	Continuing Medical Education
35.	ROTP	Reorientation and Training Programme
36.	CCIM	Central Council of Indian Medicine
37.	NMPB	National Medicinal Plants Board

38.	SMPB	State Medicinal Plants Boards
39.	TKDL	Traditional Knowledge Digital Library
40.	CCIM	Central Council of Indian Medicine
41.	CCH	Central Council of Homeopathy
42.	CCRAS	Central Council for Research for Ayurveda and Siddha
43.	CCRUM	Central Council for Research in Unani Medicine
44.	CCRH	Central Council for Research in Homeopathy
45.	CCRYN	Central Council for Research in Yoga and Naturopathy
46.	NIA	National Institute of Ayurveda
47.	NIH	National Institute of Homeopathy
48.	NIN	National Institute of Naturopathy
49.	NIUSM	National Institute of Unani System of Medicine
50.	MDNIY	Morarji Desai National Institute of Yoga
51.	PLIM	Pharmacopoeial Laboratory for Indian Medicine
52.	HPL	Homeopathic Phamacopoeial Laboratory
53.	IMPCL	Indian Medicines Pharmaceutical Corporation Ltd.
54.	MPC	Medicinal Plants Cell
55.	IPR	Intellectual Property Rights
56.	IEC	Information, Education and Communication
57.	ICMR	Indian Council of Medical Research

MINISTRY OF HEALTH & FAMILY WELFARE

Details of departments, subordinate offices, autonomous bodies, boards, councils, PSUs, joint ventures, etc.

Ministry

- Ministry of Health and Family Welfare

Departments

- Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)
- Department of Health Research

Subordinate Offices

- Central Institute of Psychiatry (CIP)
- Homoeopathic Pharmacopoeia Laboratory (HPL)
- National Institute of Communicable Disease (NICD)
- Pharmacopoeial Laboratory for Indian Medicine (PLIM)

Autonomous Bodies

- All India Institute of Medical Sciences (AIIMS)
- International Institute for Population Sciences (IIPS)
- Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER)
- Lala Ram Swarup Institute of Tuberculosis and Respiratory Diseases
- Morarji Desai National Institute of Yoga (MDNIY)
- National Institute of Ayurveda
- National Institute of Homoeopathy (NIH)
- National Institute of Mental Health and Neuro Sciences (NIMHANS)
- National Institute of Naturopathy (NIN)
- National Tuberculosis Institute (NTI)
- North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS)
- Post Graduate Institute of Medical Education and Research, Chandigarh
- Rashtriya Ayurveda Vidyapeeth

Boards

- National Board of Examinations
- National Medicinal Plants Board (NMPB)

Councils

- Central Council for Research in Ayurveda and Siddha (CCRAS)
- Central Council for Research in Homoeopathy (CCRH)
- Central Council for Research in Unani Medicine (CCRUM)
- Indian Council of Medical Research (ICMR)
- Medical Council of India (MCI)

PSUs and Joint Ventures

- Hindustan Latex Limited (HLL)
- Hospital Services Consultancy Corporation (I) Limited (HSCC)
- Indian Medicines Pharmaceutical Corporation Limited (IMPCL)

Others

- Central Government Health Scheme (CGHS), Allahabad
- Central Government Health Scheme (CGHS), Kolkata
- Central Government Health Scheme (CGHS), Mumbai
- CODEX India
- Food Safety, India
- National AIDS Control Organisation (NACO)
- National Family Health Survey (NFHS)
- National Vector Borne Disease Control Programme (NVBDCP)

Overview of Health Sector

India has made substantial progress in health determinants over the past decades. The critical indicators of health, including infant Mortality Rate, Maternal Mortality ratio, Disease prevalence, morbidity as well mortality rates have shown consistent decline over the years. These achievements are the cumulative result of several interconnected changes. The improved coverage and efficiency of public Health delivery system as well as expanding private health sector have contributed equal measures to ameliorating the suffering associated with adverse health events. The over all economic upturn as well as improvement in collateral determinants of health has assisted the country achieve critical milestones like elimination of leprosy and reducing the burden of Tuberculosis.

In spite of the impressive progress made, a high proportion of population, especially in rural areas, continues to be deprived of quality health care on equitable basis at affordable costs. Precious man days are still being lost to preventable diseases. The deficient availability of basic maternal and child care services continues to create unacceptably high levels of morbidity and mortality. Levels of malnutrition and rates of infant maternal deaths have stagnated during the 1990s. Currently, life expectancy at birth, infant and under-five mortality levels are worse than those of many other developing countries. Although we account for 16.5% of global population, we contribute to a fifth of the world's share of diseases: a third of the diarrhoeal diseases, TB, respiratory and other infections and parastitic infestations, and perinatal conditions; a quarter of maternal conditions, a fifth of nutritional deficiencies, diabetes, CVDs, and the second largest number of HIV/AIDS cases after South Africa. There is wide interstate and inter district disparity with respect to key indicators of IMR, MMR and TFR in the same state.

In addition to old unresolved problems, health system in the country is now facing emerging threat and challenges. India is in the midst of an epidemiological and demographic transition with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates lading to an ageing of the population. The large load of HIV/AIDS cases has potential to undermine the health and developmental gains which India has made since its independence. Non-communicable diseases such as cardio-vascular diseases, cancer, blindness, mental illness and tobacco use related illnesses have imposed the chronic diseases burden on the already over-stretched health care system in the country. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on

the poor, and on women, scheduled castes and tribes especially those who live in rural areas of the country. The inequity is also reflected in the skewed availability of public resources between the advanced and less developed states.

Public spending on health in India is amongst the lowest in the world, whereas its proportion of private spending on health is one of the highest. More than Rs.100,000 crores is being spent annually as household expenditure on health, which is more than three times the public expenditure on health. In fact the Public spending (i.e. expenditures incurred by health departments of Central and State Governments) on health gradually accelerated from 0.22% in 1950-51 to 1.05% during the mid-1980s, and stagnated at around 0.9% of the GDP during the later years. The allocation for health in the revenue budget of almost all the states has also been much less than what is required to maintain the health delivery system in the respective state. The 11th Plan provides an opportunity to restructure policies to achieve equitable coverage of welfare measures, reduce poverty and malnutrition and focus on compensating long standing deficiencies in Social Sector programmes. The principle premise of inclusive growth is provisioning of basic facilities such as health, education, clean drinking water etc. to all citizens in all parts of the country. In the short run these essential public services impact directly on well being of the population. In the longer run they determine future of the country.

In this context the remarkable rejuvenation brought about in the Public Health System under the National Rural Health Mission (NRHM) needs to be noted. NRHM has shifted the focus from vertically designed health programmes / schemes to the development of state health systems. In partnership with states and through State led innovations, NRHM is rapidly expanding accessible, affordable and accountable quality care for every household in the country. The Mission was started in the year 2005-06 and Budget Estimates for 2007-08 is Rs.10,890 crores.

The journey of NRHM has been crafted by responses of the States. 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 Insitutions, 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.

More than 5.5 lakh ASHA or link workers are connecting households to health facilities. More than 1.75 lakh Village Health & Sanitation Committees have been made functional to bring about community ownership and planning in the health sector. Rogi Kalyan Samities set at various levels have been made the custodian of the untied funds and annual maintenance grant for health facilities. Untied funds at various levels have introduced functional flexibility in proper upkeep of health institutions and ensuring the availability of the quality services to the citizens. Detailed facility survey for community health centres have been undertaken to prepare a roadmap for upgradation to First Referral Units, and eventually, Indian Public Health Standards. Detailed integrated District Health Action Plans have been prepared in over 509 districts, and convergence of key health and health related initiatives is being ensured through the District Health Mission and the State Health Missions.

Substantially higher funding for the health sector by the Government of India and commensurate response by various State Governments has ensured that the allocation for health in the public domain keeps up with the expanding economy and remains on course for reaching two to three percent of the Gross Domestic Product by 2012.

The existing public sector health care system provides comprehensive coverage for primary, secondary as well as tertiary Health Care. While rejuvenation of Primary and Secondary Health Care is being undertaken under NRHM the Tertiary Health Care services are being strengthened under Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). The PMSSY comprise establishment of 6 new AIIMS like institutions and upgradation of 13 medical college institutions to the level of AIIMS. The work on these projects is in progress.

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 allocations made for this Sector from very beginning of the plan era. Allocation for Health & Family Welfare during 10th Plan was of the order of Rs.36,378 crores. This has been substantially enhanced to Rs.1,36,147 crores for the XI plan showing a step up of 227% against the actual allocations made for the 10th Plan. We hope that substantially enhanced funding along with rationalization of policies and systematic corrections initiated under NRHM would help establish a robust Public Health System which would respond to the expectations of the citizens of India.

1. Organisation

1.1 Introduction

1.1.1 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 land like population control and family welfare, medical education, prevention of food adulteration, quality control in manufacture of drugs, etc. have been included in the Concurrent list.

1.1.2 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 & Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. Apart from these, the Ministry also assists states in preventing and controlling the spread of seasonal disease outbreaks and epidemics through technical assistance.

1.1.3 Ministry of Health & Family Welfare incurs expenditure either directly under Central Schemes through its two departments, including the attached offices of DGHS and its various subordinate offices, 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 and 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 and 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.

1.1.4 The Union Ministry of Health & Family Welfare comprises the following 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

1.1.5 Directorate General of Health Services (Dte.GHS) 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. The organisation Chart of the Directorate General of Health Services is at Annexure III. In order to implement the policies and programmes of the Ministry in an effective manner, there are three subordinate offices, viz., Family Welfare Training and Research Centre, Mumbai, Homoeopathic Pharmacopeia Laboratory, Ghaziabad and Pharmacopeia Laboratory for Indian Medicine, Ghaziabad which function directly under the Ministry. Besides, there are 34 autonomous statutory bodies and three Public Sector Undertaking under the Administrative control of the Ministry.

1.2 National Urban Health Mission

1.2.1 To address health needs of the urban poor Mission Document on National Urban Health Mission (NUHM) has been approved by Secretary (H&FW) on 10th January 2008.

1.2.2 The proposed National Urban Health Mission (NUHM) aims to address primary health needs of marginalized urban poor in 429 cities with a population of 1.00 lakh and above. This includes six capital cities with less than 1 lakh population. It is proposed to initiate the Mission in 100 cities in the first year commencing from 2008-09. This mission would complement the activities undertaken by NRHM in urban areas. The objectives of the programme would be achieved through rationalizing extant public systems, Public Private Partnership for expanding reach and community based Health Insurance measures.

1.2.3 Photo Family Welfare Cards will be issued to urban poor families, slum dwellers, migrant workers and extremely vulnerable population who would be identified by the Urban Local Body (ULB) concerned or any other State Specific mechanism. Though no person would be denied service in the public health facilities, however the marginalized urban families identified under the scheme would receive service on special terms of concession under NUHM. Synergies are envisioned with JNNURM, SJSRY, ICDS, etc. and with the ongoing National Health Programmes for optimizing the gains.

1.2.4 Special Schemes

Special schemes are one of the centrally sponsored plan schemes of National Family Welfare Programmes that provide urban health services in the States as a package of Reproductive Child Health (RCH) Programme by integrating all interventions of fertility regulation, maternal and child health with reproduction health of both men and women. The following network of infrastructure provides these services under the "Special Schemes":-

- Urban Health Posts
- Urban Family Welfare centers

1.2.5 Urban Health Posts

This scheme was introduced following the recommendation of the Krishnan Committee in 1983. The main focus was to provide services through setting up of Health Posts mainly in slum areas. The services provided are mainly outreach of RCH services, preventive services, First Aid and referral services including distribution of contraceptives. Four types of health posts were set up depending on the allotted population in the catchments' area of the Centre covered i.e. for Type A, the criterion is less than 5000 population. For Type B it varies between 5-10 thousands whereas for Type C it is 10-25 thousands. For Type D the limit is 25-50 thousand population. Only Type D Health Posts have a post of Medical Officer. These were established during the period of 1983-84 to 1988-89. A total number of 871 posts comprising of four types, i.e. A,B,C and D have been sanctioned by States. Financial assistance is given to States for salary of staff, contingencies and rent as per norms admissible under the schemes.

1.2.6 Urban Family Welfare Centres

The scheme was launched during the first Five Year Plan and subsequently expanded and established in a phased manner. At present there are 1083 centres functioning in various States under the scheme to provide outreach services, primary health care, MCH and distribution of contraceptives. There are three types of centre, i.e. I, II and III, depending on the population covered by these centres, i.e. Type I covers a population of 10000 to 25000, Type II covers 25000 to 50000 and Type III covers more than 50000 populations. These are manned by 2 para-medical staff in type I and II centres and by 6 persons including Medical Officer in Type III centres. The financial assistance under this component is given for the salary of staff, contingency and rent as per approved norms.

2. *NRHM, Health & Population Policies*

2.1 National Rural Health Mission

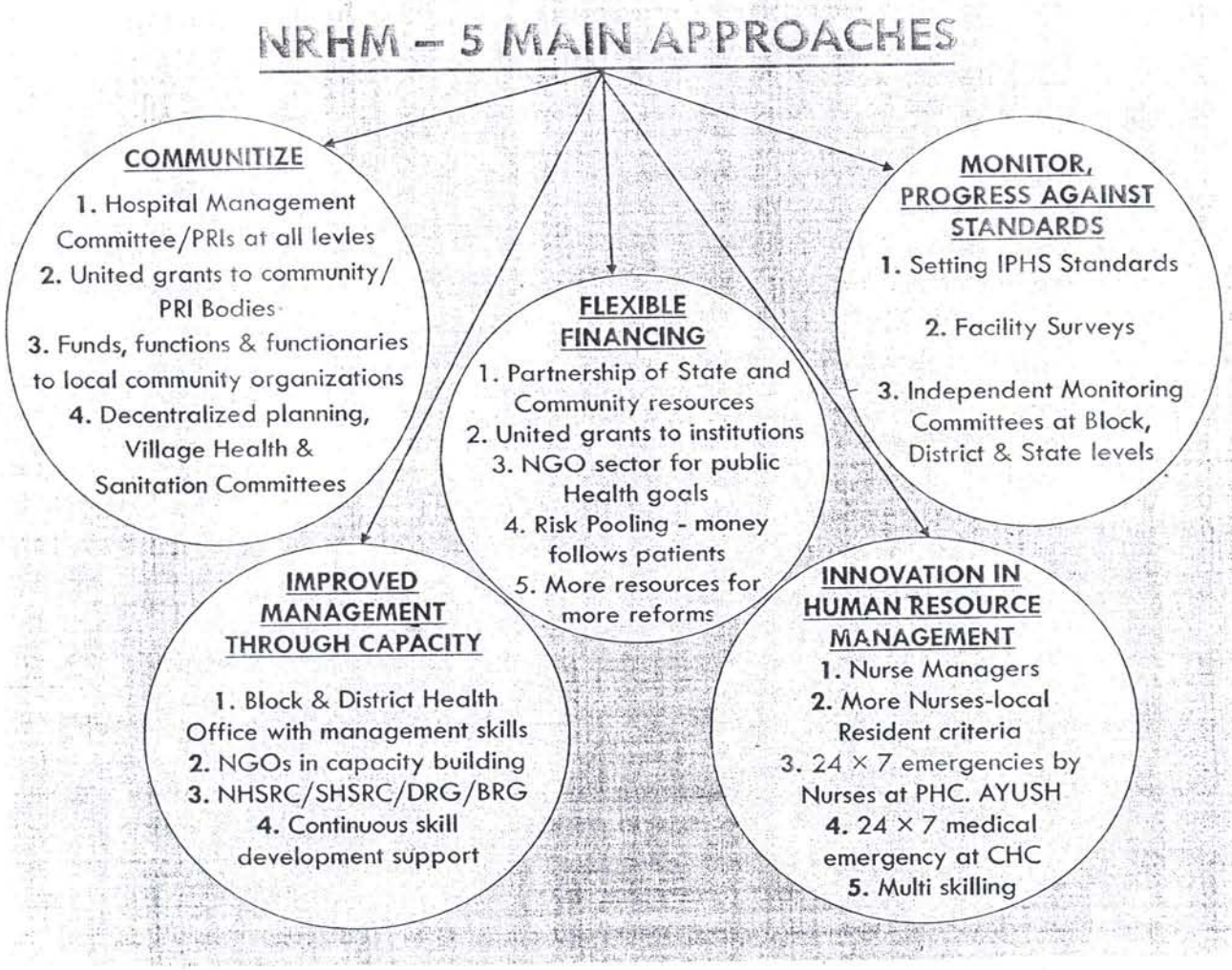
The National Rural Health Mission was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The detailed framework for implementation that facilitated a large range of interventions under NRHM was approved by the Union Cabinet in July 2006 (less than a year ago). 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 was 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 was shifting the focus to a functional health system at all levels, from the village to the district.

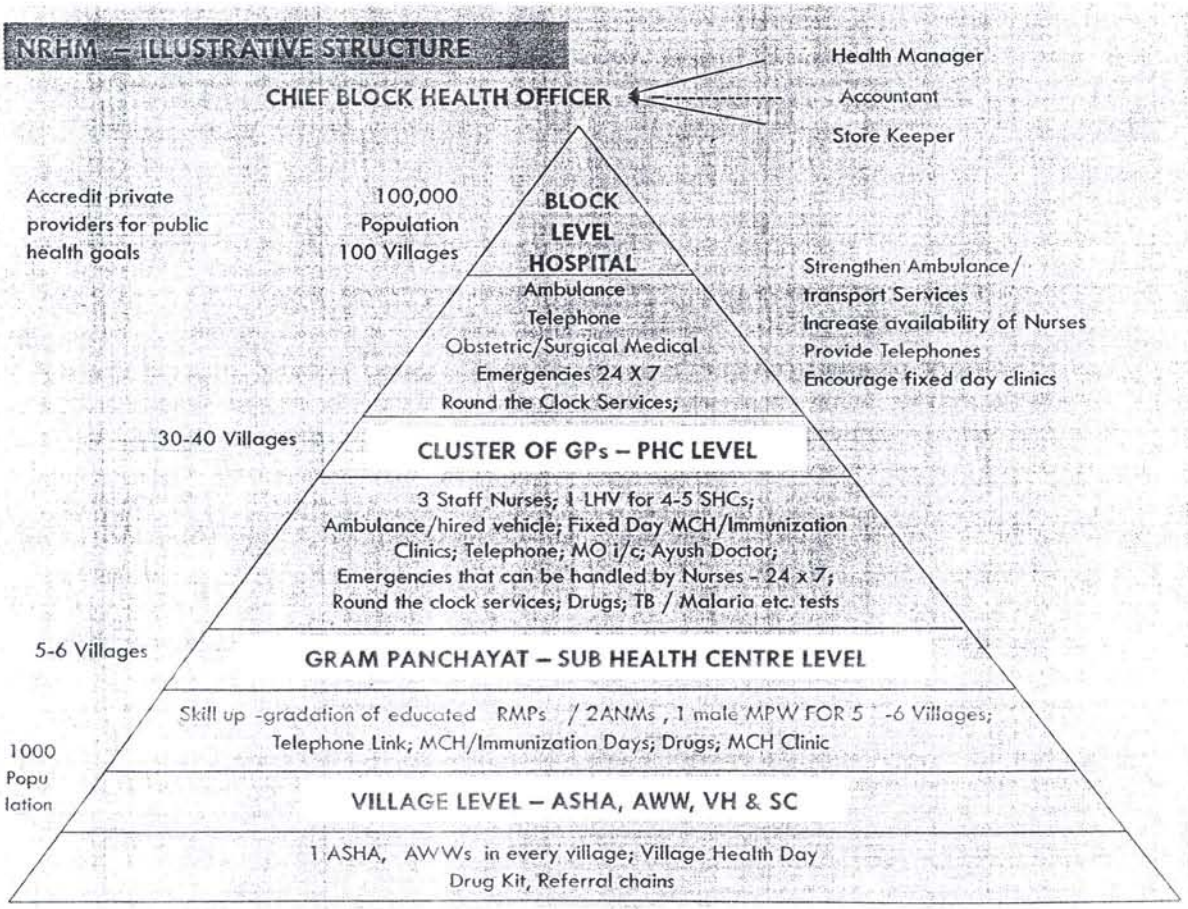
The NRHM is about increasing public expenditure on health care from the current 0.9% of the GDP to 2 to 3% of the GDP. The corollaries of such a policy directive are not only an increased central government budgetary outlay for health, but that the states also make a matching increase at least 10% of the budget annually including a 15% contribution into the NRHM plan, and that the centre 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 absorbing these funds, and the poorest performing states which require the largest infusion of resources have some of the greatest problems in being able to expend the funds already with them. This is one of the main reasons why a process of reforming and strengthening the state health system 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 organised 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

The NRHM approach is summed up in the figures below:





programme, the village health and sanitation committee, increased public participation in hospital development committees and district health societies and in the district and village health planning efforts and by a special community monitoring initiative, and through a greater space for NGO participation.

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

c) **Flexible Financing**. The central strategy of this pillar is the provision of united funds to every level - to the village health and sanitation committee, to the sub-center, to the PHC, to the CHC and district hospital. Even the strategy of providing a resource envelope to each district and state which the district/state has to use against an approved plan that it develops is an unprecedented level of financing flexibility. Financing packages for demand side financing and various forms of risk pooling where money follows the patient are also major strategies declared by the NRHM. The Janani Suraksha Yojana is one major, almost overwhelming example of the demand side financing option.

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. Expansion of professional and technical education and increasing access of weaker sections to such education are also a core strategy.

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 closing the gaps so identified.

Many path breaking initiatives have been operationalised under the NRHM.

1. More than 5.4 lakh Accredited Social Health Activists (ASHAs) and link workers 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 (SJY) has brought poor households to public sector health facilities on a scale never witnessed before. Over 50 lakh women have been covered under JSY so far since its introduction in 2005.

2. A second ANM in Sub centres, 3 nurses in PHCs for 24x7 services along with diagnostic services, co-locating 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 recruit nurses and other para medic staff on contract and 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 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.

3. By forming 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 on opportunity to provide cashless hospitalized 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 united 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 public system.

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 anti-natal care and other health care services. Sub Centres look like sub centres and provide services which many of them were not doing on account of lack of regular resources. The constitution of the Village Health and Sanitation Committees itself is taking a little time in many States as the effort is to set up these Committees within the umbrella of Panchayat Raj Institutions. The intention fo 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.

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. The efforts to provide opportunities for ASHAs and Aagnanwadi Workers to become ANMs has also been emphasized 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 recruitment.

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.

7. While in some regions government health facilities have geared up by utilizing flexible finances under NRHM to cope with the increased workload, in may 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.

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.

9. From the village to the district level all requirements of the health system can be met through 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.

10. Improved Financial Management: Under NRHM, Electronic Transfer of Funds (ETF) has been started from GoI to States and also States to Districts. This has reduced the time log in transfer of funds from 1-2 months to 1 to 2 days. E-Banking has been operationalised for real time financial reporti8ng and monitoring. As a result of this the financial management reports are now being received on time. Detailed guidelines for Delegation of Administrative & Financial powers under NRHM have been given to states. Financial Managers and accountants have been

recruited at State & District levels under NRHM. A system for concurrent audit has been set up in SHS and DHS.

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.

2.2 Health Policy

The National Health Policy -2002 (NHP) 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 organisational 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.

Health Care Delivery System

The existing public sector health care system caters to Primary Health Care, Secondary Health Care and Tertiary Health Care. While a comprehensive Primary Health Care and Secondary Health Care is under the fold of National Rural Health Mission (NRHM), the Tertiary Health Care services are being strengthened under Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). The PMSSY scheme has two components:

(a) Establishment of 6new AIIMS like institutions; and
(b) Upgradation of 13 medical college institutions to the level of AIIMS.

The AIIMS like institution are to be set up in each of the States of Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneshwar), Rajasthan (Jodhpur) and Uttaranchal (Rishikesh). The 13 medical colleges identified for upgradation are:

- Government Medical College, Jammu (J&K)
- Government Medical College, Srinagar (J&K)
- Kolkata Medical College, Kolkata (WB)
- Sanjay Gandhi Post Graduate Insitute of Medical Sciences, Lucknow (UP)
- Institute of Medical Sciences, BHU, Varanasi (UP)
- Nizam Institute of Medical Sciences, Hyderabad (AP)
- Sri Venkateshwara Institute of Medical Sciences, Tirupati (AP) (50% cost of upgradation will be borne by the TTD Trust)

- Government Medical College, Salem (TN)
- Patliputra Medical College and Hospital, Dhanbad (Jharkhand)
- B.J. Medical College, Ahmedabad (Gujarat)
- Bangalore Medical College, Bangalore (Karnataka)
- Grants Medical College & Sir JJ Group of Hospitals, Mumbai (Maharashtra)
- Medical College, Thiruvananthapuram (Kerala)

Health Plan

The trend of annual allocations for 2002-03 to 2006-07 and 2007-08 are given below:

Year	Allocation (RE) for D/o Health & Family Welfare (Rs. Crore)	% increase over last year
2002-03	5525	
2003-04	6111	10.6
2004-05	7477	22.3
2005-06	8500	13.7
2006-07	10000	17.6
2007-08	12500	25.0

2.3 National Population Policy

The National Population Policy 2000 (NPP 2000) affirms the commitment of Government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services and continuation of the target free approach in administering family planning services. The policy provides a framework for advancing goals and prioritizing strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement level i.e. Total Fertility Rate (TFR) of 2.1 by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child health services with government, industry and the voluntary non-government sector, working in partnership.

The immediate objective of the National Population Policy, 2000 is to address the unmet needs of contraception, health infrastructure and health personnel and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the Total Fertility Rate to replacement level by 2010 through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve population stabilization by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environment protection.

The 42nd Constitutional Amendment has frozen the number of representative in the Lok Sabha (on the basis of population) at 1971 Census level. The freeze serves as an incentive for State Governments to fearlessly pursue the agenda for population sterilization. It has been extended until 2026.

The four structures recommended by the NPP were:

(a) A National Commission on Population;

(b) State / UT Commissions on Population;

(c) A Coordination Cell in the Planning Commission; and

(d) Technology Mission in the Department of Family Welfare, to enhance performance - particularly in States with below average socio-demographic indices.

As recommended by NPP

- National Commission on Population (NCP) has been constituted.
- In place of Coordination Cell, a policy convergence group has been created in Planning Commission.
- In place of Technology Mission, an Empowered Action Group (EAG) giving focused attention to 8 demographically weaker States viz., Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan, Uttar Pradesh, Uttaranchal and Orissa was created.
- The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister in Delhi on 12th April 2005. The EAG has been subsumed under the National Rural Health Mission.

2.4 National Commission on Population

In pursuance of the objectives of the National Population Policy (NPP), the National Commission on Population (NCP) was constituted in May 2000 under the Chairmanship of Hon'ble Prime Minister to promote inter-sectoral coordination across agencies of the Central and State Governments, to involve the civil society and the private sector in planning and implementation and to explore the possibilities of international cooperation in support of the goals set out in the National Population Policy, 2000. The National Population Policy had recommended that the Department of Family Welfare would provide the Secretariat of the NCP. However, the NCP was constituted under the Planning Commission with the approval of the Prime Minister on 11th May 2000. Its unwieldy composition, lock of funds and implementing structures mainly due to its divorcing from the Janasankhya Sthirata Kosh (JSK) and the Ministry of Health & Family Welfare reduced its effectiveness. Government has, therefore, relocated the NCP in the Ministry of Health & FW, as originally envisaged in the NPP 2000 on 11th February 2005 for comprehensive and multi-sectoral coordination of planning and implementation between health and family welfare on one hand, and with the schemes of the related Departments on the other hand.

The National Commission on Population has been reconstituted on 11th April 2005 with 40 members under the chairmanship of the Hon'ble Prime Minister. Minister of Health & FW and the Deputy Chairman of the Planning Commission are Vice Chairmen of the Commission. The membership also includes the Chief Ministers of the States of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Jharkhand, Kerala and Tamil Nadu. The terms of reference of the reconstituted National Commission on Population are as under:-

(i) To review, monitor and give directions for the implementation of the National Population Policy with a view to achieve population stabilization by promoting synergy between demographic, educational, environmental and developmental programmes.

(ii) To promote inter-sectoral coordination in planning and implementation across government agencies of the Central and State Governments.

(iii) To facilitate the development of a vigorous people's movement in support of the National efforts at Population Stabilization.

(iv) To facilitate initiatives to improve performance in the demographically weaker States in the country.

Commission on Population held under the chairmanship of Hon'ble Prime Minister on 23rd July 2005, the following decisions were taken:-

(i) Conduct of an 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.

(ii) 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.

In accordance with the above decision, the following measures have been taken to implement the decisions:-

(i) Five Experts Groups have been constituted on 29th September, 2005 for studying the population profile of the States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Orissa in order to identify weaknesses in the health delivery systems and to suggest measures that would be taken to improve the health and demographic status of these States. This Group of Experts has already deliberated the issue pertaining to Health Delivery System and Demographic Status of these. The reports of these Groups of Experts are in the final stages of preparation.

(ii) Ministry of Health & Family Welfare had wide ranging discussion with Office of Registrar General and Planning Commission for conducting Annual Health Survey (AHS) and Office of Registrar General has been identified as the nodal organisation for conducting the AHS. Third meeting of the Mission Strategy Group (MSG) under National Rural Health Mission (NRHM) was held on 17th July 2007 to discuss technical issues such as coverage, sample size, creation of posts under Office of Registrar General, etc. In pursuance to the decisions taken by the MSG, a Steering Committee has been constituted on 6th September 2007 under the Chairmanship of Mission Director (NRHM), Ministry of Health & Family Welfare to coordinate the content of the survey, its methodology and comparability with the existing National level surveys. The first meeting of the Steering Committee was held on 16th October 2007 under the Chairmanship of Mission Director (NRHM).

3 *Maternal Health Programme*

3.1 Introduction

3.1.1 Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programme in India. The current Reproductive and Child Health Programme (RCH) Phase - I was launched in October 1997. The RCH programme incorporates the components covered under the Child Survival and Safe Motherhood Programme and includes an additional component relating to reproductive tract infection and sexually transmitted infections. This policy recommends to holistic strategy for bringing about total inter-sectoral 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 Population Policy 2000 and National Health Policy 2002 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 and various interventions focused on reducing maternal deaths. Over 77,000 women in India continue to die of pregnancy related causes every year. The Maternal Mortality Ratio in India is 301 per 100,000 live births (SRS, RGI: 2001-03 Maternal Mortality Report). However, reliable estimates of maternal mortality are not available.

3.2 Maternal Mortality Ratio (MMR)

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

MMR India: The national average of MMR is 301 per 100,000 live births, which in itself is very high compared to the international scenario like Sweden (8), UK(10), Greece (2) and even in neighbouring countries like Sri Lanka (60), china (60) and Thailand (54).

3.2.2 **Causes of Maternal Mortality**: Maternal Mortality is a cause of great concern. The major causes of these deaths have been identified as hemorrhage (both ante and post partum), toxemia (Hypertension during pregnancy), anemia, obstructed labor, puerperal sepsis (infection after delivery) and unsafe abortion. As can been hemorrhage accounts for more than one-third of all deaths followed by puerperal sepsis and abortion. Besides these, anemia 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.

Maternal Health Indicators: The estimates of maternal mortality at State / UTs level 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 check up, 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 National Family Health Survey (NFHS III) conducted in the period 2003-2005 and the District Level Household Surveys (DLHS II) in 2002-04 are:

	NFHS III(2005-06)	DLHS II (2002-04)
Any antenatal check-up	77	73.4
Three or more antenatal check-up	50.7	50.1
Total institutional delivery	41	40.5
Safe delivery	48.2	47.6
IFA tablets consumed for 90 days	22.3	-
PNC within 2 days	36.4	-

3.3 Schemes for Improving Obstetric Care Services

Several specific initiatives are under implementation to achieve the goal of reduction in Maternal Mortality. These interventions are as follows:

3.3.1 Essential Obstetric Care

- This includes antenatal care, institutional / safe delivery services and post natal care. For timely and early detection of emergencies it is of utmost importance that minimum of three antenatal check ups be conducted wherein all the components of essential obstetric care be provided to the women. Government has instructed all states and UTs to focus on these services and monitor it closely.
- **Provision of 24 Hrs Delivery Services at PHC**: Under RCH II, all the CHCs and 50% of the PHCs are proposed to be operationalised for providing round the clock delivery services. The States and UTs have been advised to make a comprehensive plan and the central Government is investing large amount of money for operationalizing these PHCs.
- **Post natal care for mother and newborn**: Ensuring post natal care within first 24 hours of delivery and subsequent home visits on day 3 and 7 are the important components for identification and management of emergencies occurring during post natal period. The ANMs, LHVs and

staff nurses are being made aware of and also oriented for tackling emergencies identified during these visits.

- **Skilled Attendance at Birth**: To manage and handle some common obstetric emergencies at the time of birth, the Government of India has taken a policy decision to permit Staff Nurses and ANMs to give certain injections and also perform certain interventions under specific emergency situations to save the life of the mother. GOI has a commitment to provide skilled attendance at every birth both at institution and community level and for implementing this training of SNs and LHVs/ANMs is being undertaken by States for 2-3 weeks and 3-6 weeks respectively.

3.4 Janani Suraksha Yojana

3.4.1 Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being impelemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005 is being implemented in all states and UTs. JSY is a 100% centrally sponsored scheme.

3.4.2 The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in 10 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. Her main role is to facilitate pregnant women to avail services of maternal care and arrange referral transport.

3.4.3 The scheme focuses on poor pregnant women with special dispensation for states having low institutional delivery rate namely the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Orissa, Rajasthan and Jammu and Kashmir. While these states have been classified as Low Performing States (LPS), the remaining states have been named as High Performing States (HPS).

3.4.4 Eligibility for Cash Assistance:

In LPS 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.
In HPS States	BPL pregnant women, aged 19 years and above and the SC and ST pregnant women.

4 Child Health Programme

4.1 Introduction

The Department of Health & Family Welfare is implementing several important programmes and schemes to address the issue of high infant and child mortality in the country. Notable amongst these are (i) Universal Immunization Programme (UIP), where immunization of children is carried out against six vaccine preventable diseases, (ii) control of deaths due to acute respiratory infections (ARI) and (iii) control of diarrhoeal diseases and (iv) provision of essential newborn care to address the issue of the neonates. In addition to the above, the Department implements programmes for the prevention and treatment of two micronutrient deficiencies relating to (i) Vitamin A and (ii) iron.

4.2 Current Status of Infant Mortality Rate

4.2.1 Infant Mortality Rate, one of the most sensitive indicators of the health status of a population, is currently at 58 per 1000 live births (SRS, 2005, office of RGI). It is lower in the urban areas of the country, 40/1000 live births than in the rural areas 64/1000 live births (SRS, 2005, Office of the RGI). Kerala has the lowest IMR (14/1000 live births) and Madhya Pradesh is the highest at 76/1000 live births. Higher rates of antenatal, delivery and post natal care are usually associated with lower infant mortality. Such an inverse relationship is observed with higher education status of mothers and a higher standard of living index.

4.2.2 Goals

	Current Status	NRHM 2012	MDG 2015
IMR (Infant Mortality Rate)	58 (SRS 2005)	30	27
NMR (Neonatal Mortality Rate)	37 (SRS 2004)	<20*	<19*

**estimated.*

4.2.3 Action being taken under the second phase of the RCH programme, the activities being undertaken to achieve the goals of the NRHM are:

(i) Integrated management of Neonatal and Childhood Illness (IMNCI)

(ii) Home Based Newborn Care(HBNC)

(iii) Promotion of breastfeeding and complementary feeding

(iv) Control of deaths due to acute respiratory infections (ARI) and

(v) Control of deaths due to diarrhoeal diseases and

(vi) Supplementation with micronutrients: Vitamin A & Iron

(vii) Universal Immunization Programme (UIP)

These activities are budgeted for under the flexi-pool funds of the Reproductive and Child Health Programme which is in it's second phase (RCH II). CH Division has no funds.

4.3 Integrated Management of Neonatal and Childhood Illnesses

Integrated Management of Childhood and Neonatal Illness (IMNCI) strategy encompasses a range of interventions to prevent and manage five major childhood illnesses-i.e. Acute Respiratory Infections, Diarrhoea, Measles, Malaria and Malnutrition and the major causes of neonatal mortality prematurity, and sepsis. In addition, IMNCI teaches about nutrition including breastfeeding promotion, complementary feeding and micronutrients. It focuses on preventive, promotive and curative aspects, i.e. it gives a holistic outlook to the programme.

The major components of this strategy are:

- Strengthening the skills of the health care workers
- Strengthening the health care infrastructure
- Involvement of the community

The first two components are the facility based IMNCI and the third is the community based IMNCI.

The initiative was started on a pilot basis in 2004 though UNICEF in five of the forty nine districts included under the Border District Cluster Strategy scheme. It has been incorporated into RCH since 2005. The programme is being introduced throughout the country in a phased manner.

4.4 Home Based New Born Care

The Government of India has recently approved the implementation of Home Based New Born Care (HBNC) based on the Gadchirolli model, where appreciable decline in infant mortality rates has been documented on the basis of

work done by SEARCH, a NGO. ASHAs will be trained in identified aspects of newborn care during the second year of their training. The modules have been finalized, state sensitization workshops have been held. In the five high focus states to be covered under the Indo Norway Initiative (NIPI), the HBNC shall be implemented by SEARCH with support from ICMR. Permission has been accorded in 2 districts in each of these five states (MP, UP, Orissa, Rajasthan and Bihar) for ASHAs to use injectable antibiotics for neonatal sepsis and childhood pneumonia.

In addition facility based assessment of the needs for newborn care is being carried out in 10 states (1 district each) so that an appropriate facility based newborn care model can be initiated. This activity includes assessment of the newborn care programme carried out in RCHI.

With the National Neonatology Forum (NNF), and support from the development partners, neonatal are being set up at district headquarters in various states, with focus on the states with the weakest indicators.

4.5 Immunization Programme

4.5.1 Immunization programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. Immunization Programme in India was introduced in 1978 as Expanded Programme on Immunization. This gained momentum in 1985 as Universal Immunization Programme (UIP) and implemented in phased manner to cover all districts in the country by 1989-90. UIP became a part of Child Survival and Safe Motherhood Programme in 1992. Since 1997, immunization activities have been an important component of National Reproductive and Child Health Programme.

4.5.2 Under the immunization programme vaccines are given to infants and pregnant women for controlling vaccine preventable diseases namely childhood tuberculosis, diphtheria, pertussis, poliomyelitis, measles and neonatal tetanus. Except polio vaccine, which is administered orally all other vaccines are given as injections.

4.5.3 Significant achievement has been made under the programme. At the beginning of the programme in 1984, vaccine coverage level ranged between 24% of BCG and 45% of DPT3. The recent UNICEF survey conducted in 2005 indicated that the coverage at National level for BCG is 83.4%, DPT (3rd dose) 67.3%, OPV (3rd dose) 61.3%, Measles 78.1% and full immunization at 54.5%. The latest NFHS data shows that number of fully immunized children have increased to from 42% (NFHS-2) to 43.5 (NFHS 3). These coverage data indicates that the

coverage of immunization programme has improved over the previous years with strengthening of immunization programme under NRHM.

4.6 The European Commission Supported Health & Family Welfare Sector Investment Programme

4.6.2 The European Commission supported health and family welfare sector investment programme known as sector investment programme was being implemented as a part of overall RCH programme. The programme has been successfully completed and total grant of Rs.1182.39 crores received from EC has been fully utilized. Negotiations are going on for the next phase funding by EC for the NRHM / RCH II Programme.

5. *National Programmes under NRHM*

5.1. 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.

5.2 National Vector Borne Disease Control Programme (NVBDCP)

5.2.1 The National Vector Borne Disease Control Programme (NVBDCP) is implemented in the State / UTs for prevention and control of vector borne diseases namely Malaria, Filariasis, Kala-azar, Chikungunya. The Directorate of NVBDCP is the nodal agency for planning, policy making and technical guidance and monitoring and evaluation of programme implementation in respect of prevention and control of these vector borne diseases. The States are responsible for planning, implementation and supervision of the programme. The vector borne diseases, viz., Malaria, Filaria, Japanese Encephalitis, Dengue and Kala-azar are major public health problems in India. Chikungunya fever which has re-emerged as epidemic outbreaks after more than three decades has added to the problem. The prevention and control of vector borne diseases is complex; as their transmission depends on interaction of numerous ecological, biological, social and economic factors including migration.

5.2.2 Out of the six vector borne diseases, Malaria, Filariasis, Japanese Encephalitis, dengue and chikungunya are transmitted by different kind of vector mosquitoes, while 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. Mosquito density is directly related with water collection clean or polluted in which the mosquitoes breed.

5.2.3 Under NVBDCP, the three pronged strategy for prevention and control of VBDs is as follows: (i) Disease Management including early case detection and complete treatment, strengthening of referral services, epidemic preparedness and rapid response (ii) Integrated Vector Management (For transmission risk reduction) including indoor residual spraying in selected high risk areas, use of insecticide treated bed nets, use of larvivorous fish, anti larval measures in urban areas, source reduction and minor environmental engineering (iii) Supportive Interventions including Behaviour Change Communication (BCC), Public Private Partnership & Inter-sectoral convergence, Human Resource Development

through capacity building, Operational research including studies on drug resistance and insecticide susceptibility, monitoring and evaluation through periodic reviews / field visits and web based Management Information System.

5.3 Malaria

5.3.1 Malaria is an acute parasitic illness caused by *Plasmodum falciparum* or *Plasmodium vivax*. Mosquitoes, of which there are 9 major species, transmit malaria in India. The main clinical presentation is fever with chills; nausea and headache can also occur. The diagnosis is confirmed by microscopic examination of a blood smear. Majority of the patients recover from the acute episode within 7 to 10 days. Malaria continues to pose a serious public health threat in different parts of the country, particularly due to *Plasmodum falciparum*, as it is sometimes prone to complications, if not treated early.

5.4 Elimination of Lymphatic Filariasis

5.4.1 Filariasis is transmitted by mosquito species i.e *Culex quinquefasciatus* and *Mansonia annulifera / M. uniformis*. The vector mosquitoes breed in polluted water in drains, cesspits etc., in areas with inadequate drainage, sanitation. The disease is endemic in about 250 districts in 20 states and UTs. The population at risk is over 500 million is at risk of lymphatic Filariasis. The disease causes personal trauma to the affected persons and is associated with social stigma, even though it is not fatal.

5.5. Kala-azar

5.5.1 Kala-azar is a slow progressing indigenous disease caused by a protozoan parasite Leighmania donovani and spread by sand fly, which breeds in shady, damp and warm places, in cracks and crevices in the soft soil, in masonry and rubble heaps, etc. Therefore, proper sanitation and hygiene are critical to prevent sand fly breeding. The National Health Policy (2002) of GOI has set the goal for elimination of Kala-azar from the country by 2010. The Government has also signed a Memorandum of Understanding with Bangladesh and Nepal to eliminate Kala-azar from South East Asia Region by 2015.

5.6 Japanese Encephalitis

5.6.1 Japanese Encephalitis is a zoonotic disease which is transmitted by vector mosquito, mainly belonging to *Culex, Culex vishnui* group. The transmission cycle is maintained in the nature by animal reservoirs of JE virus like pigs and water birds. Man is the dead and host, i.e. JE is not transmitted from the infected person to others. Outbreaks are common in those areas where there is close

interaction between animals/birds and human beings. The vector of JE breeds in large water bodies such as paddy fields. The population at risk is about 300 million.

5.7 Dengue Fever / Dengue Hemorrhagic Fever

5.7.1 Dengue / Dengue Hemorrhagic Fever is an acute viral infection transmitted by *Aedes aegypti* mosquitoes that breed in man made containers, viz., cement tanks, overhead tanks, underground tanks, tyres, desert coolers, pitchers, discarded containers, junk materials, etc, in which water stagnates for more than a week. Usually dengue is prevalent in different parts of the country and focal outbreaks are reported mainly in urban areas having high population density, unplanned development activities with out health assessment, deficient water management, and inadequate sanitation infrastructure are at high risk and report cases every year. But the rural spread of Aedes and increasing risk of dengue are relatively recent occurrences due to rapid urbanization, life style change.

5.8 Cross-cutting Interventions

5.8.1 Monitoring and Evaluation: Programme review, assessments are continuous processes. It is estimated that the NAMMIS should be integrated with IDSP for wider cross exchange of data and information. Regular review of programme implementation and meetings are held with the State Programme Officers, partner organisations. Extensive field visits are undertaken at National, State and District levels in collaboration with the ROH & FW and Partner Institutions NIMR and RMRC. The Hon'ble Prime Minister on 2.11.2006 reviewed the situation arising out of the recent chikungunya epidemic and other vector borne diseases. The Hon'ble Union Minister for Health and Family Welfare, have also reviewed programme and progress made on implementation of the NVBDCP in the current year in addition to the meeting taken by the senior officials. A consultative workshop on review of NVBDCP strategies was held in Delhi on 21 - 22 March 2006 followed by independent evaluation by Joint Monitoring Mission in December, 2006 to March 2007.

5.9 Capacity Building

The Directorate of NVBDCP has initiated three tier capacity building programme at primary, secondary and tertiary levels to strengthen health care delivery system for prevention and control of vector borne diseases so as to ensure the quality of health manpower development; rational use of drugs, improve timely referral services for appropriate management of severe and complicated cases; provide technical support in outbreak investigations etc. Guidelines on Integrated Training on Vector Borne Disease Control Programme have been

circulated to all States / UTs and other stakeholders. Besides, training of Private Medical Practitioners and other inter-sectoral partners are also being conducted to sensitize them about the National Strategies for VBD control. Specialized trainings for entomologists and laboratory technicians are also being conducted separately. State core team f trainers in most of the states has already been developed and trained. At national level 57 trainings have been conducted in which, about 1500 medical and para-medicals have been trained. Of these 25 trainings were conducted to involve private practitioners across the country, training about 800 such practitioners. At state level, about 62000 health care functionaries have been trained.

5.10 Facilities for Vulnerable Sections – Scheduled Castes / Scheduled Tribes

National Vector Borne Disease Control Programme is in operation throughout the country for prevention and control of malaria, kala-azar, filarial, Japanese encephalitis, dengue / dengue hemorrhagic fever and chikungunya. Additional inputs are being provided to highly malarious areas. These are far flung remote areas and are dominated by tribal population. The seven North Eastern States having tribal population are being provided 100% central assistance since December 1994 which includes operational cost of the programme. 100% central assistance is also provided to Sikkim since 2003.

1045 PHCs in 100 districts of 8 States (Andhra Pradesh, Chattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Rajasthan and Orissa) predominantly inhabited by tribal population were being provided 100% support including operation expenses under the Enhanced Malaria Control Project (EMCP) with World Bank assistance from 1997 to 2005. Presently, a comprehensive Vector Borne Disease Control Project is under preparation with World Bank assistance. Under the proposed Vector Borne Disease Control Programme with World Bank support, the states/districts would continue to get enhanced support.

Intensified Malaria Control Project (IMCP) with assistance from Global Fund to fight against AIDS, Tuberculosis and Malaria (GETM) is being implemented in 10 States (07 NE states & selected high risk areas including tribal areas of Orissa, Jharkhand and West Bengal) under which the assistance is provided to increase access to rapid diagnosis and treatment in remote and inaccessible areas, reduce malaria transmission risk by use of insecticide treated bed nets (ITNs) and enhance community awareness about malaria control and promote community, NGO and private sector participation.

5.11 National Leprosy Eradication Programme (NLEP)

5.11.1 Leprosy a chronic infectious disease with long incubation period affects all age groups and is classified mainly as Pauci Bacillary (PB) and Multi Bacillary (MB). Since the leprosy bacilli affect the peripheral nerves, the patients lose sensation by and large in their hands, feet and eyes if not properly cared for. Injuries to these insensitive parts may lead to disfigurement, the main consequence of this disease which generates fear and stigma. Thus early detection and prompt treatment of leprosy with prescribed Multi Drug Therapy (MDT) not only cures leprosy, but also interrupts its transmission to others.

5.12 National Iodine Deficiency Disorders Control Programme (NIDDCP)

Introduction

Iodine is an essential micronutrient with an average daily requirement of 100-150 micrograms for human growth and development. There is an increasing evidence of distribution of environmental iodine deficiency in various parts of the country. On the basis of surveys conducted by the Directorate General of Health Services, Indian Council of Medical Research and the State Health Directorates, it has been found that out of 324 districts surveyed in 28 states and all the 7 UTs, 263 districts are endemic, i.e. where the prevalence of IDDs is more than 10%. It is also estimated 71 million people are suffering from Goiter and other iodine deficiency disorders. These disorders include abortions, stillbirth, mental retardation, deaf mutism, squint and goiter and neuromotor defects.

Objectives of NIDDCP

1. Surveys to assess the magnitude of Iodine Deficiency Disorders (IDDs).
2. Supply iodated salt in place of common salt.
3. Resurveys to assess the impact of control measures after every 5 years.
4. Monitoring the quality of iodated salt and assess urinary iodine excretion pattern.
5. Health education and publicity. (information, education & communication - IEC).

6 *Information, Education and Communication*

6.1 Introduction

Public policy and communication strategies influence both individual and collective change. The interface between these two components provides the framework to position behaviour change. In other words, the balance between communication and policy facilitates health seeking behaviour over the year; the thrust of the Department has been to place IEC as an intervention tool to generate demand for the range of services under the umbrella framework of National Rural Health Mission (NRHM).

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

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

Under the framework for implementation in the National Rural Health Mission, norms have also been outlined for supporting IEC activities. The framework incorporates a variety of activities involving communities and also the media.

News IEC initiatives under NRHM:-

- To position focused visibility through multi media tools
- Branding of the key IEC interventions under NRHM
- To create enabling environment for health providers through an intra communication process
- Communication tools to inter-link demand generation with access and availability of services
- Strong emphasis on integrated IEC for focused content delivery
- Combination of mass media, social mobilization and inter-personal communication methods

- Close monitoring of actual media utilization and behavioural outcomes along with financial allocations
- Designing innovative strategies

The following tools used during the year:

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

The target audiences include:

- Direct Healthcare Providers (ANM, ASHA, AWW)
- Healthcare Managers / Administrative functionaries
- Health Communicators
- Grass-root functionaries
- Other Government Departments, e.g. Panchayati Raj, WCD, Water & Sanitation
- NGOs, Civil Society stake holders and Media

During the current year, the following issues are being highlighted through multi-media tools –

- Janani Suraksha Yojana
- ASHA
- Age at marriage
- Routine immunization
- PNDT and Girl child
- Contraceptive choice and spacing
- Breast feeding
- Use of iodized salt
- Care of new born
- Institutional delivery
- Maternal care
- Adolescent health
- RCH and HIV / AIDS
- Communicable and non-communicable diseases platform for integration

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

7 *Family Planning*

7.1 Introduction

The National Family Planning Programme launched in 1952 was primarily aimed at population stabilization and the strategy was to regulate birth by providing fertility control methods both for limiting and spacing. The programme is presently being repositioned not only to achieve population stabilization but also to reduce maternal mortality and infant and child mortality. The birth rate has been brought down to 24.8 to TFR to 2.9 due to the successful intervention of this programme. However there still remains a huge unmet need for family planning methods with concomitant interstate variations. The main reasons for the high unmet need and unwanted fertility are the non-availability of quality services, lack of skilled providers and gender biased programme with poor male participation.

ICPD in 1994 identified and emphasized the relevance of bringing about population stabilization by integrating the various health determinants in a wholesome manner thereby ensuring population development. Another reproductive need to be addressed is the fertility promotion for the infertile couples who constitute nearly 10 to 15% of the total population in India.

The Family Planning Division has formulated many interventions for increasing contraceptive choices and meeting the unmet need in contraception thereby reducing the TFR.

7.2 Quality Assurance in Family Planning

Quality assurance in family planning services is a major decisive factor in the acceptance of the service. The guidelines to be followed on quality care and standards in FP services in the implementation of the national programme are provided by the division. The quality assurance committee set up at the state and district level monitors the sterilization services and conducts medical audits and at the central level these activities are monitored through reports and field visits.

7.3 Male Participation in Planned Parenthood including no Scalpel Vasectomy (NSV)

With the aim to bring men to the forefront in population and reproductive health programmes special budgetary provisions have been made in the tenth plan under the Male Participation.

The No Scalpel Vasectomy (NSV), a modified male sterilization technique, was introduced in 1997 in the NFWP as a simple and safe technique with very little change of complications compared to female sterilization.

The camp approach adopted by states like MP, AP, Punjab and UP has shown that a well conceived and intensive advocacy, combined with assured service provision, results in significantly increased acceptance. Based on the experiences of these states, a strategy on advocacy and community mobilization for increasing NSV acceptance through camps has been introduced in the Family Planning Programme in 2005. The guidelines have been sent to all states / UT Government. The camp approach is gradually becoming popular in many districts.

One of the main problems hampering the resurgence of male sterilization in the country is the absence of skilled NSV providers in the states. The problem is compounded by the fact that NSV is not taught at the undergraduate and postgraduate level in most medical colleges in the country since the surgical faculty itself is not familiar with the technique. To address this issue a systematic action plan for training of surgical faculty of medical colleges has been initiated at seven centres in the country.

7.4 Ensuring availability of Family Planning Services at all levels of Health Care Delivery System

Under NRHM efforts are being made to strengthen CHC, PHCs, Subcentres with infrastructure and human resource to IPHS standards. This will also ensure the provision of various types of terminal and spacing methods of fertility regulation at Government institutions. In addition to the government functionaries ASHA, the accredited social health activist, is seen as a major catalyst for bringing about behavioural change in the community in all matters related to RCH services including contraception.

8 Other National Health Programmes

Several National Health Programmes are now under the umbrella of NRHM. Details of other National Health Programmes are as under:

8.1 National Cancer Control Programme

Cancer is an important public health problem in India with nearly 7-9 lakh new cases occurring every year in the country. It is estimated that there are 20-25 lakh cases of cancer in the country at any given point of time. With the objectives of prevention, early diagnosis and treatment, the National Cancer Control Programme (NCCP) was launched in 1975-76. In view of the magnitude of the problem and the requirement to bridge the geographical gaps in the availability of cancer treatment facilities across the country; the Programme was revised in 1984-85 and subsequently in December 2004. There are five schemes under the revised programme:

Recognition of New Regional Cancer Centres (RCCs): In order to augment comprehensive cancer care facilities in regions of the country lacking them, new RCCs are being recognized. A one-time grant of Rs.5.00 crore is being provided for new RCs.

Strengthening of Existing RCCs: A one-time grant of Rs.3.00 crores is provided to the existing RCCs in order to further strengthen the cancer treatment facilities in the existing centres. Financial assistance has been given to three institutions under the scheme.

Development of Oncology Wing: The scheme aims to correct the geographical imbalance by providing financial assistance to Government institutions (Medical Colleges as well as government hospitals) for enhancing the cancer care facilities. The one-time grant has been enhanced from Rs.2.00 crores to Rs.3.00 crores. Financial assistance has been given to four institutions under the scheme.

District Cancer Control Programme (DCCP): The DCCP is being implemented by the nodal agency, which may be an RCC or an Oncology Wing. The aim is to strengthen district hospitals in 2-3 congruent districts for early detection and appropriate treatment referral. The grant-in-aid has been increased to Rs.90.00 lakhs spread over a period of 5 years. 8 DCCP proposals has been sanctioned in different parts of the country.

Decentralized NGO scheme: This scheme has been devised to promote prevention and early detection of cancer. Non-government organisations (NGO) will implement these activities under the coordination of the Nodal Agency,

which can be RCC or a Govt. Medical College / Hospital with Oncology Wing. A grant of Rs.8000/- per camp will be provided for organising camps for IEC and early detection activities.

Guidelines for the various schemes are available on the official website of Ministry of Health & Family Welfare at www.mohfw.nic.in

Regional Cancer Centre: In all, there are 25 Regional Cancer Centres in the country to provide specialized treatment and undertake research in the filed of cancer. Regional Institute of Medical Sciences, Imphal has been recognized as Regional Cancer Centres for the State of Manipur.

Up-gradation of the existing RCCs into Centre of Excellence: Grant-in-aid amount of Rs.5.00 crore has been provided to each of the selected RCC namely KNMH, Allahabad; KMIO, Bangalore; RCC, Trivandrum; GCRI, Ahmedabad and BB Cancer Institute, Guwahati after obtaining the necessary approval of the Competent Authority.

IEC Activities at the Central level: Health education is an important tool for prevention an early detection of cancers and hence suitable importance is accorded to the same under the NCCP. The programme supports activities of the health magazine "Kalyani" telecast by the Prasar Bharti in eight states. It is an interactive programme which provides an interface to the people with the experts on various health issues. In addition, IEC materials in the form of audio-video spots, posters, leaflets, flipcharts, etc. have been developed for dissemination across the country.

8.2 National Mental Health Programme

8.2.1 Severe mental disorders that include schizophrenia, bipolar disorder, organic psychosis and major depression affect nearly 20 per 1000 population. This is a population that needs continuous treatment and regular follow-up attention. Close to ten million severely mentally ill are in our in our country without adequate treatment by this estimate. More than half remain never-treated. Lack of knowledge on the treatment availability and potential benefits of seeking treatment are important causes for the above. With a large population in our country on one hand and very few psychiatrists being available on the other hand, less than one psychiatrist is available for every 3 lakh population. The psychiatrist / population ratio in rural areas that account for 70% of country's population could be well under one for every million.

8.2.2 To address this huge burden NMHP was started in 1982 with the following three objectives:

- To ensure availability and accessibility of minimum mental health care for all in the near foreseeable future, particularly to the most vulnerable sections of the population.

- To encourage mental health knowledge and skills in general health care and social development.

- To promote community participation in mental health service development and to stimulate self help in the community.

8.3 Integrated Disease Surveillance Project (IDSP)

Background: Integrated Disease Surveillance Project (IDSP) was launched in November 2004. It is a decentralized, State based Surveillance Programme in the country. It is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. It is also expected to provide essential data to monitor progress of on-going disease control programme and help allocate health resources more efficiently. As on 28th August 2007, all States except UP, Bihar and Jharkhand are implementing IDSP.

8.4 Drug De-Addiction Programme

Drug addiction in India has of late emerged as a matter of great concern both due to the social and economic burden caused by substance use and due to its established linkage with HIV/AIDS. The onus of responding to the problems associated with drug use lies on the central and state governments. The Constitution of India under Article 47 enjoins that the state shall endeavour to bring about prohibition of the consumption, except for medical purposes, of intoxicating drinks and of drugs, which are injurious to health. The various drug de-addiction programmes of Government of India have to be seen in this light. However, to provide effective and acceptable de-addiction services to about 3 million (about 0.3 % of the total population) estimated drug users (excluding alcohol dependents) of India is a Herculean task, which requires concerted efforts from several ends. The activities to reduce the drug use related problems in the country could broadly be divided into two arms supply reduction and demand reduction. The supply reduction activities which aim at reducing the availability of illicit drugs within the country came under the purview of the Ministry of Home Affairs with the Department of Revenue as the nodal agency and are executed by various enforcement agencies. The demand reduction activities focus upon awareness building, treatment and rehabilitation of drug using patients. These activities are run by agencies under the Ministry of Health and Family Welfare, and the Ministry of Social Justice and Empowerment.

8.5 Tobacco Control Legislation

A comprehensive tobacco control legislation titled "The Cigarettes And Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 was passed by the Parliament in April, 2003 and received the assent of the President of India on 18th May 2003. This was notified in the official gazette on 19th May 2003. The Act is applicable to whole of India and covers all types of tobacco products. The important provisions of the Act are as follows:

a) To prohibit direct and indirect advertisement of and provide for regulation of the trade and commerce in, production, supply and distribution of all tobacco products (implemented w.e.f. 1st May 2004).

b) No person shall engage in smoking in a public place (implemented w.e.f. 1st May 2004).

c) c) No person shall sale tobacco products to any person below the age of 18 years (implemented w.e.f. 1st May 2004).

d) There shall be a total ban on sponsoring of any sport / cultural events by cigarette and other tobacco product companies (implemented w.e.f. 1st May 2004).

e) Ban of sale of tobacco products within 100 years of educational institutions (implemented w.e.f. 1st December 2004).

f) No person shall trade in any tobacco products including imported products unless the specified warnings are indicated. (Rules have been notified and would come into effect on 1st December 2007).

g) The nicotine and tar contents and the maximum permissible limits will be indicated on the package as will be prescribed under the rules, which will be notified separately. (Rules are yet to be framed).

The State / UT Governments and other Central Government Organisations have been requested to implement the provisions of the Act in letter and spirit.

India has been a forerunner in the WHO Framework Convention on Tobacco Control (FCTC) negotiations in Geneva since its inception. India signed the said convention on 10th September 2003 and later on ratified on 5th February 2004.

India has already translated a number of provisions of the FCTC into domestic law by enactment of above legislation. Considering the public health of the citizens especially pregnant women and children from involuntary exposure to tobacco smoke, discourage the use of tobacco and impose progressive restrictions and taking effective action to eventually eliminate all direct and indirect advertising, the Central Government has notified rules regarding:

1. Ban on sale of tobacco products through vending machines by minors;
2. Restriction on display at the point of sale of advertisement and ban on visible stacking of tobacco products;
3. Ban on display of scenes in films / TV serials depicting tobacco products, with certain exemptions;
4. Comprehensive definition of 'indirect advertisement in order to prohibit advertisement through sports events, held in other countries; and
5. Constituted a 'Steering Committee' to look into surrogate advertisements of tobacco products.

India being one of the parties to FCTC, it has to establish administrative, legislative, mechanism for tobacco control, which includes setting up of effective Regulatory Mechanism. In order to have effective tobacco control measures and implementation of various provisions of the Act and at the same time creating awareness about ill effects of tobacco, a comprehensive National Tobacco Control Programme has been launched in 2007.

The proposed programme broadly envisages:-

- Setting up of a National Regulatory Authority (NRA, in 2007-08) for effective monitoring and enforcement of anti-tobacco laws; FCTC provisions. The NRA would also be providing for surveillance and lab testing facilities.
- The other important component is capacity building of the stake holders at the local (district) level. It is proposed to help the states set up State Tobacco Control Cells and District Level Monitoring / outreach. At the district level, it is proposed to –

    1. Train the health workers, school teachers, etc. on ill effects of tobacco;
    2. Engage NGOs, to carry out school health campaign in the Government Schools.
    3. There is also a strong IEC campaign, tailored to regional needs.

8.6 Nutrition

The Nutrition Cell in the Directorate General of Health Services provides technical advice on all matters related to policy making, programme implementation and evaluation, training modules for different levels of medical and para-medical workers. It took up technical scrutiny of standards and labels for foods, proposals, project evaluation, review of research projects, etc.

The cell has been working on creating awareness regarding prevention and control of micronutrient deficiency disorders, diet related chronic disorders and promotion of healthy life style through dissemination of various type of IEC materials. Expert committee meetings have been held to examine and finalize scripts with reference to production of video film on under-nutrition and promotion of healthy life styles.

Participated in the Health Mela at Lalganj Tehsil, Rai Barelli, where IEC material developed by this cell on Healthy Life Style (pamphlets) for different age groups; Iodine Deficiency Disorders, Vitamin 'A' Deficiency, Iron Deficiency, Anemia, Healthy Life Style, Diet Related Chronic Disorders (Posters) were distributed to create awareness among community. Testing of Iodine in salt demonstrated along with other health education activities.

Small committee meetings were held in connection with revision of the Publication "Guidelines for Standardized Hospital Diets'.

An expert group discussion on 'Infant and Young Child Nutrition (IYCF) Operational Guidelines' in order to prevent and control under-nutrition and micronutrient deficiency was convened.

Budgetary issues of the Pilot programme for Control of Micronutrient Deficiency and impact evaluation of the programmes by independent agency – Administrative Staff College of India, Hyderabad, budget release were coordinated.

A National Programme for Prevention and Control of Fluorosis has been formulated and will be launched during current financial year in five district of the country as Phase I.

8.7 Public Health Foundation of India

Background: The Public Health Foundation of India (PHFI) was conceptualized at a national multi-stakeholder consultation held in September 2004. The foundation was legally registered as a Society, in February 2006. It was formally launched on March 28, 2006, by the Honourable Prime Minister of India. Staff appointments commenced in June 2006, the President assumed office in August 2006 and a regular office was set up in November 2006.

The Charter of PHFI: PHFI has been mandated by its Board to:

(a) Establish 7 new institutes of public health over the next six years;

(b) Assist the growth of existing public health training institutions / departments and facilitating their evolution into major institutes of public health;

(c) Establish a strong national research network of public health and allied institutions which would undertake policy and programme relevant research that will advance public health goals in prioritized areas - with suitable international partnerships where useful and appropriate;

(d) Engage public health expertise to collectively undertake analytic work for generating policy recommendations related to public health action, in not only the health sector but also in all other sectors which impact upon health of the people, and developing a vigorous advocacy platform to effectively communicate these recommendations to policy makers and other relevant stake holder groups, (including civil society organisations which represent the interests of people's health); and

(e) Facilitate the establishment of an independent accreditation body for degrees in public health which are awarded by training institutions across India.

Part – II

Department of Ayurveda, Yoga-Naturopathy, Unani, Sidha and Homoeopahty (AYUSH)

1. *Overview*

1. A separate Department of Indian Systems of Medicine and Homeopathy (ISM&H) was set up in the Ministry of Health & Family Welfare in 1995 to ensure the optimal development and propagation of these systems of health care. The Department of ISM&H was re-named the Department of AYUSH (Ayurveda, Yoga and Natruopathy, Unani, Siddha, Homeopathy) in November 2003.

2. With an increase in lifestyle-related disorders there is a world wide resurgence of interest in holistic systems of health care, particularly with respect to the prevention and management of chronic lifestyle-related non-communicable and systemic diseases. It is increasingly understood that no single health care system can provide satisfactory answers to all the health needs of modern society. Evidently there is a need for a new inclusive and integrated health care regime that should guide health policies and programmes in future. India has an advantage in this global resurgence of interest in holistic therapies as it has a rich heritage of indigenous medical knowledge coupled with strong infrastructure and skilled manpower in modern medicine. Medical pluralism is here to stay and the AYUSH sector has a critical role to play in the new and emerging situation.

3. Bringing AYUSH into the mainstream health care delivery system of the country has long been a major policy objective of the Department. The latest step in the direction of the integration of health care services has been the provision of AYUSH systems in the field under the National Rural Health Mission (NRHM), so as to met the unmet health needs of the Indian population. Under the NRHM, AYUSH facilities are being set up in PHCs and CHCs and are being manned by qualified AYUSH physicians appointed on contract basis.

4. National Institute in the various AYUSH systems has been set up by the Central Government to set benchmarks for teaching, research and clinical practices. Upgrading these National Institutes into Centres of Excellence has been a constant endeavour of the Department. Another priority area is setting up of a state-of-the-art tertiary care Ayurveda hospital in the National capital which will specifically focus on research.

5. The Central Government's investments in the AYUSH sector since the first five-year plan have ranged from 1% to 3% of the National health budget. In the States too, a small proportion of the health budget is generally allocated to the AYUSH systems. The private sector investment in the AYUSH drug manufacturing industry (the annual turnover being Rs.8800.00 crores) and in

medical education is relatively large, while private sector investment in research and in the provision of public health and community health services are relatively small. There is a necessity for greater public investment in the AYUSH sector which needs to be supplemented by both private investment and public-private partnerships.

6. During the 10th Plan, the Department continued to lay emphasis on the upgradation of AYUSH educational standards, quality control and standardization of drugs, improving the availability of medicinal plant material, reseach and development and on awareness generation about the efficacy of the systems domestically and internationally. The plan expenditure of the department rose from Rs.33.04 crore in 1997-98 to Rs.290.96 crore in 2005-06. The expenditure in 2006-07 was Rs.316.69 crore. The increase in allocations and expenditure indicates that the greater level of activity has been achieved during the 10th plan. The original approved outlay of Rs.775.00 crore for the Department for the 10th plan was increased to Rs.1`214.00 crore. Year-wise allocation and corresponding expenditure substantially increased during the 10th plan, particularly from the year 2004-05 onwards. Apart from core areas for the AYUSH sector like education, research, industry and medicinal plants, four important dimensions have been added to AYUSH in 11th Plan, viz., (a) role of AYUSH in public health, (b) technology upgradation of AYUSH industry, (c) international cooperation and (d) revitalization of community based local health traditions of AYUSH. All these dimensions will serve to enhance the social and community outreach of AYUSH in the 11th Plan both domestically and globally.

7. Local health traditions which constitute the community-health dimension of AYUSH.

8. India has around a million village-based healers in the form of birth attendants, herbal healers and several million knowledgeable households who have useful knowledge of local grains, cereals, wild fruits and vegetables, and locally available medicinal plants. The local health traditions constitute the folk or "prakrit" roots of AYUSH. The village-based healers have been playing an important role in health education and primary health care. Pilot projects will be taken lup via NGOs and research institutes to document, assess and promote sound local health practices via community based associations of traditional health workers at the Taluka / Block level.

9. The strategy of partnerships adopted by AYUSH seeks to actively recognise and support partnership with universities, non-government and community based organisations involved in research and education, industry and government departments like the CSIR, ICMR, DST and Ministries of Environment and Forests, Agriculture and Commerce. This approach is

expected to (a) broaden perspectives; (b) bring in greater transparency and accountability; (c) enhance talent; and (d) pool resources.

10. Major capacity building initiatives have been institutionalized in order to orient AYUSH practitioners to contemporary public health problems. Reputed educational and research institutions in the AYUSH and modern medicine sector have been identified and supported to play, on a long-term basis, the capacity building role via well-designed short-term courses.

11. Continuing Medical Education (CME) and Reorientation and Training Programme (ROTP) were initiated with two sub-components – (a) reorientation programme for AYUSH personnel; and (b) short-term CME programme for AYUSH physicians / practitioners. Government / non-government / private institutions if AYUSH are eligible to take up this training programme.

12. There are a total of 467 government and non-government AYUSH educational institutions in India. The Under Graduate and Post Graduate Regulations 2006 of Central Council of Indian Medicine (CCIM) for Minimum Standards of Ayurveda, Siddha and Unani education have been approved. The teaching institutions provide the infrastructure specified in the regulations, which include building for the college, hostel, library, hospital with requisite bed strength, teaching and non-teaching staff, etc. The major challenge in the 11th Plan will be to initiate reforms in the UG and PG education that can make AYUSH education more contemporary and to provide generous support to centres of excellence.

13. Four different Pharmacopoeia Committees are working for preparing official formularies / pharmacopoeias to evolve uniform standards in preparation of drugs of Ayurveda, Siddha, Unani and Homeopathy and to prescribe working standards for single drugs as well as compound formulations. Standards for around 40 percent of the raw materials and around 15 per cent of the formulations have been published by these committees. A Drug Control Cell (AYUSH) is working in the Department of AYUSH to deal with the matters pertaining to licensing and regulation of Ayurveda, Siddha and Unani drugs. The challenge before AYUSH is to establish a modern pharmacopoeia Commission with adequate representation of stakeholders and to develop standards that are in line with internationally acceptable pharmacopoeia standards.

14. The Central Government has established research councils for Ayurveda & Siddha (CCRAS), Unani (CCRUM), Homeopathy (CCH), Yoga & Naturopathy (CCYN). These Councils have been responsible for the officially sponsored research activities. Other government departments like the ICMR, CSIR, DST,

DBT and ICAR also have research centres and focused programmes related to specific aspects of AYUSH.

15. The resource base of AYUSH is largely plants. Around 6000 species of medicinal plants are documented in medical and ethno-botanical literature. Wild populations of several hundreds of these species are under threat in their natural habitats. In the 10th Plan, a National Medicinal Plants Board (NMPB) was established for supporting conservation of gene pools and large scale cultivation of medicinal plants. The NMPB has also promoted the creation of State Medicinal Plants Boards (SMPB) in most of the States. In addition to plants, there are also around 300 species of medicinal fauna and around 70 different metals and minerals used by AYUSH. However, there have been no official efforts so far to conserve these resources. The key challenges in the 11th Plan will be to conserve gene pools of red listed species, support large-scale cultivation of species that are in high trade, involve forestry sector in plantation of medicinal tree species and establish modern processing zones for post-harvest management of medicinal plants.

16. India has an immense treasure of traditional knowledge of medicine, both codified and un-codified, in Sanskrit and other regional languages. The attempts to misappropriate the traditional knowledge and formulations of India at global level led to presenting such knowledge in an official data base and in international languages through Traditional Knowledge Digital Library (TKDL). The TKDL is a collaborative project of AYUSH and the CSIR. It is organized in a format that can be conveniently interpreted by international patent examiners. It will enable rejection of frivolous patent claims on products derived from AYUSH knowledge systems. Continuation of this work and digitizing medical manuscripts will be a priority in the 11th Plan.

17. There have been efforts for promotion and propagation of Indian Systems of Medicine abroad through conferences and trade fairs which have been utilized to sensitize the world community about the strengths and efficacy of these systems. One of the strategies in the 11th Plan will be to develop more comprehensive plan for international cooperation in such key areas as research, education, clinical services and industry.

18. The Department of AYUSH participated in the 11th Session of the World Intellectual Property Organisation's Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore in July 2007 in Geneva, Switzerland and highlighted India's concerns regarding misappropriation of traditional knowledge and the need for an internationally binding legal instrument for protection of traditional knowledge and genetic resources.

2. *Organisation*

2.1 The Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH) is headed by a Secretary to the Government of India. The Secretary is assisted by two Joint Secretaries and four Directors / Deputy Secretaries and a number of Advisers (at present three) and Deputy Advisors (at present six) of Ayurveda, Siddha, Unani and Homeopathy. The total sanctioned staff strength of the Department in Group A, B, C and D is 268, which include Secretariat and Technical posts.

2.2 The Department has, over the years, developed a broad institutional framework to carry out the activities in the field of AYUSH. The institutional framework consists of:

i. Statutory Regulatory Bodies]

- Central Council of Indian Medicine (CCIM) and
- Central Council of Homeopathy (CCH)

The duties of these bodies are –

- Laying down minimum standards of education;
- Recommending recognition of medical qualifications;
- Registering the practitioners and laying down of ethical codes.

ii. Apex Research Bodies

- Central Council for Research for Ayurveda and Siddha (CCRAS)
- Central Council for Research in Unani Medicine (CCRUM)
- Central Council for Research in Homeopathy (CCRH)
- Central Council for Research in Yoga and Naturopathy (CCRYN)

iii. Apex Educational Institutions

- National Institute of Ayurveda (NIA), Jaipur
- National Institute of Homeopathy (NIH), Kolkata
- National Institute of Naturopathy (NIN), Pune
- National Institute of Unani System of Medicine (NIUSM), Bangalore
- Morarji Desai National Institute of Yoga (MDNIY), New Delhi.
- Rashtriya Ayurveda Vidyapeeth

iv. Apex Laboratories

- Pharmacopoeial Laboratory for Indian Medicine (PLIM), Ghaziabad
- Homeopathic Phamacopoeial Laboratory (HPL), Ghaziabad

v. **Public Sector Undertakings**

- Indian Medicines Pharmaceutical Corporation Ltd. (IMPCL), manurfactures classical Ayurveda and Unani drugs.

vi. **National Medicinal Plants Board**

The National Medicinal Plants Board (NMPB) functions under the Department to coordinate activities relating to conservation, cultivation, marketing, export and policy making for the development of the medicinal plants sector. The Medicinal Plants Cell (MPC) working under the department for implementing the Central Scheme for development and cultivation of medicinal plants and developing agro-techniques has now been transferred to the National Medicinal Plants Board.

vii. **Pharmacopoeial Committees**

Pharmacopoeial Committees for Ayurveda, Unani, Homeopathy and Siddha.

viii. The Department also manages the CGHS Ayurveda Hospital, Lodhi Road, New Delhi.

2.3 A Drug Control Cell (AYUSH) is working in the department to deal with the matters pertaining to licensing, regulation and control of misbranded / adulterated drugs and the spurious manufacture of Ayurvedic, Unani and Siddha Drugs and other matters. The Drug Control Cell also deals with the Traditional Knowledge Digital Library (TKDL) and matters relating to Intellectual Property Rights (IPR) as also coordination with Government of India Ministries / Departments concerned with IPR.

2.4 An Information, Education and Communication (IEC) Cell and Facilitation Centre are also functioning in the department.

2.5 The department realizes the need to develop into a dynamic and flexible organisation in a rapidly changing and complex environment. The department also realizes the need for an appropriate human resource policy to maintain the motivation and cooperation of its employees to increase their efficiency.

3. *National Policy*

3.1 The National Health Policy, 1983 referred to our rich heritage of medicinal knowledge and suggested that it was necessary to initiate measures to enable India's rich medicinal heritage to develop in accordance with its genius. It took note of the fact that a vast infrastructure is available in Indian Systems of Medicine and Homeopathy and that it should be integrated at the appropriate level especially in regard to the preventive, promotive and public health objectives.

3.2 The Central Council for Health and Family Welfare in 1999 also recommended, inter alia, that at least one physician from the Indian Systems of Medicine and Homeopathy should be available in every Primary Health Centre and that vacancies caused by non-availability of allopathic personnel should be filled by ISM&H physicians. The Council also resolved that specialist ISM&H treatment centers should be introduced in rural hospitals and that a wing should be created in existing state and district level government hospitals for extending health care to the public.

3.3 The National Policy on Indian Systems of Medicine and Homeopathy, 2002 outlined the following basic objectives:

(a) To promote good health and expand the outreach of health care to our people, particularly those not provided with health cover, through preventive, promotive and curative interventions through ISM&H.

(b) To improve the quality of teachers and clinicians by revising curricula to contemporary relevance by creating model institutions and Centres of Excellence and assistance for creating infrastructural facilities.

(c) To ensure affordable ISM&H services and drugs which are safe and efficacious.

(d) To facilitate availability of raw drugs which are authentic and contain essential components as required under pharmacopoeial standards to help improve quality of drugs, for domestic consumption and export.

(e) To integrate ISM&H in the health care delivery system and National Programmes and ensure optimal use of the infrastructure of hospitals, dispensaries and physicians.

(f) To re-orient and prioritize research in ISM&H to gradually validate therapy and drugs to address in particular the chronic and new life style related emerging diseases.

(g) To create awareness about the strengths of these systems in India and abroad and sensitize other stakeholders and providers of health.

(h) To provide full opportunity for the growth and development of these systems and utilization of their potential, strength and revival of their glory.

3.4 The following strategies have been outlined in the National Policy on AYUSH, 2002:

(a) Legislative measures would be taken to check mushroom growth of substandard colleges.

(b) Course curricula would be reinforced to raise the standards of medical training and to equip trainees for utilization in national health programmes.

(c) Priority would be accorded to research covering clinical trials, pharmacology, toxicology, standardization and study of pharmaco-kinetics in respect of already identified areas of strength.

(d) The Medicinal Plants Board would address all issues connected with conservation and sustainable use of medicinal plants leading to remunerative farming, regulation of medicinal forms and conservation of bio-diversity.

(e) Medicinal Plants Board would acquire statutory status to be able to regulate registration of farmers and cooperative societies, transportation, marketing of medicinal plants and proper procurement and supply of pharmaceutical industry.

(f) Protection of India's traditional medicinal knowledge would be undertaken through a progressive creation of a Digital Library for each system and eventually for codified knowledge leading to innovation and good health outcomes.

(g) Efforts would be made to integrate and mainstream ISM&H in the health care delivery system and in National Programmes.

(h) A range of options for utilization of ISM&H manpower in the health care delivery system would be developed by assigning specific goal oriented roles and responsibilities to the ISM&H work force.

(i) Allopathic hospitals would be encouraged to set up AYUSH health facilities.

(j) Central Government would assist allopathic hospitals to establish Panchkarma and Ksharshutra facilities for the treatment of neurological disorders, musculo-skeletal problems as well as ambulatory treatment of fistula-in-ano, bronchial asthma and dermatological problems.

(k) States would be encouraged to consolidate the ISM&H infrastructure and health services.

(l) Pharmacopoeial work related to Ayurveda, Unani, Siddha and Homoeopathy drugs would be expedited.

(m) Industry would be encouraged to make use of quality certification and acquisition of GMP and ISO 9000 certification.

(n) Quality Control Centres would be set up on regional basis to standardize the in-process quality control of ISM products and to modernize traditional processes without changing the concepts of ISM.

(o) States would be advised and supported to augment facilities for drug manufacture and testing.

(p) Operational use of ISM in Reproductive and Child Health (RCH) would be encouraged in eleven identified areas, where the Indian systems of medicine would be useful for antenatal, intra-natal, post-natal and neo-natal care.

(q) North Eastern States, rich in flora and fauna, would be supported to develop infrastructure and awareness of ISM.

(r) Keeping in view the global interest in understanding ISM concepts and practices, modules will be formulated for introducing Ayurveda and Yoga to medical schools and institutions abroad and to expose medical graduates.

(s) Awareness programmes on the utility and effectiveness of ISM&H would be launched through the electronic and print media.

Part - III

Department of Health Research

Overview

A new Department of Health Research has been created in the Ministry by amending Allocation of Business Rules. The President of India had notified creation of Department of Health Research under the Ministry of Health & Family Welfare on 17.9.2007. The Department was formally inaugurated in a function held on 5.10.2007 at New Delhi. Allocations of work to the newly created Department of Health Research are as under:-

1. Promotion and co-ordination of basic, applied and clinical research including clinical trials and operational research in areas related to medical, health biomedical and medical profession and education through development of infrastructure, manpower and skills in cutting edge areas and management of related information thereto.

2. Promote and provide guidance on research governance issues, including ethical issues in medical and health research.

3. Inter-sectoral coordination and promotion of public private partnership in medical, biomedical and health research related areas.

4. Advanced training in research areas concerning medicine and health, including grant of fellowships for such training in India and abroad.

5. International co-operation in medical and health research, including work related to international conferences in related areas in India and abroad.

6. Technical support for dealing with epidemics and natural calamities.

7. Investigation of outbreaks due to new and exotic agents and development of tools for prevention.

8. Matters relating to scientific societies and associations, charitable and religious endowments in medicine and health research areas.

9. Coordination between organisations and institutes under the Central and State Governments in areas related to the subjects entrusted to the Department and for promotion of special studies in medicine and health.

10. Indian Council of Medical Research.

11. In view of the various important tasks assigned to the new Department relating to promotion and coordination of Health Research, inter-sectoral and international coordination, training, coordination between Central and State Government research institute and Indian Council of Medical Research, a detailed XI Plan document has been prepared for the new Department of Health Research wherein an amount of Rs.10,116 crores has been envisaged during XI Plan which includes an amount of Rs.4766 crores for ICMR.

Indian Council of Medical Research (ICMR)

The Indian Council of Medical Research (ICMR), the apex body for the planning, organisation, implementation and coordination of medical research in the country promotes biomedical research through a network of its 21 permanent Institutes and 6 Regional Medical Research Centres distributed throughout the country and also through grants-in-aid given to projects in non-ICMR Institutes.