सत्यमेव जयते

ANNUAL REPORT
2013-14

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

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

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INTRODUCTION

This Annual Report outlines the activities of the Department of Health & Family Welfare and of schemes implemented over the year 2013-14.

Under the VIIth Schedule of the Constitution of India, it is the responsibility of the State Governments to provide for health care; however, the Government of India plays a vital role in supporting State Governments in their efforts towards achieving the targets of National Health Policy, 2002.

The obligation of the Government to ensure the highest possible health status of India's population and to ensure that all people have access to quality health care has been recognized by a number of key policy documents. The policy directions of the "Health for All" declaration became the stated policy of Government of India with the adoption of the National Health Policy Statement of 1983. Driven by this declaration there was some expansion of primary health care in the eighties. Further, the National Health Policy of 2002 and the Report of the Macro-Economic Commission on Health and Development (2005) emphasized the need to increase the total public health expenditure from 2 to 3% of the GDP. They also stressed the need to strengthen the role of public sector in social protection against the rising costs of health care and the need to provide a comprehensive package of services without reducing the prioritization given to women and children's health.

India's health challenges are diverse. Communicable diseases, notably Tuberculosis and Malaria, continue to constitute a major part of the country's disease burden. At the same time the threat of Non-communicable Disease (NCD) including diabetes, hypertension, cancer and mental illness is clearly perceived. It is also crucially relevant that maternal and infant mortality continue to remain unacceptably high in several parts of the country.

The Ministry of Health & Family Welfare is implementing various schemes, programmes and national initiatives to provide universal access to quality healthcare. The approach is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. As part of the plan process, many different programmes have been brought together under the overarching umbrella of the National Health Mission (NHM) with National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) as its two Sub-Missions. The major programmes being implemented are Routine Immunization (RI), National Vector Borne Disease Control Programme (NVBDCP), Revised National TB Control Programme (RNTCP), Integrated Diseases Surveillance Programme (IDSP), National Programme for Control of Blindness (NPCB), National Mental Health Programme (NMHP), National Programme for Health Care of the Elderly (NPHCE) and National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes (NPCDCS). Besides, central assistance is also being provided to strengthen the medical, disaster management, redevelopment of hospitals and dispensaries etc.

By the end of the 12th Plan (i.e. 2017) the National Health Mission endeavors to reduce Maternal Mortality Ratio (MMR) from 1.78 to 1 per 1000 live births, Infant Mortality Rate (IMR) from 42 to 25 per 1000 live births, Total Fertility Rate (TFR) from 2.4 to 2.1, prevent and reduce incidence of anaemia in women aged 15-49 years, prevent and reduce mortality & morbidity from communicable, non-communicable, injuries and emerging diseases and reduce household out-of pocket expenditure on total health care. India's public spending on core health as a proportion of GDP is approximately 1.04% and the 12th Plan goal is to increase it to 1.87% by the end of the Twelfth Plan.

NATIONAL HEALTH MISSION

The National Health Mission (NHM) with its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) was approved by the Cabinet in May, 2013. The NHM envisages universal access to equitable, affordable & quality healthcare services that are accountable and

responsive to people's needs. The main programmatic components include Health System Strengthening in rural and urban areas, Reproductive- Maternal- Newborn-Child and Adolescent Health (RMNCH+A) and control of Communicable and Non-Communicable Diseases. The framework for Implementation of National Health Mission was approved in December, 2013. Under NHM, substantial achievements have been made, the details of which are available in the report. The 7th Common Review Mission (CRM) under NHM was conducted from November 2013 in 14 States / UTs namely Bihar, Jharkhand, Odisha, Uttar Pradesh, Jammu & Kashmir, Himachal Pradesh, Arunachal Pradesh, Meghalaya, Nagaland, Andhra Pradesh, Haryana, Karnataka, Maharashtra, and Gujarat. The CRM observed increased child survival, population stabilization and utilization of health services, though the progress across States was not analogous. The Infant Mortality Rate (IMR), the deaths of children before age 1 per 1000 live-births, has fallen steadily every year, with an all India average of 42. While this is short of the 12th Plan target of 25, some States have made remarkable progress with Goa having an IMR of 10, Kerala 12, Nagaland 18, Manipur 10 and Tamil Nadu 21. The Maternal Mortality Ratio (MMR), which measures the number of women of reproductive age (15 to 49) dying due to maternal causes per 1,00,000 live-births, has come down to 178, though this is far short of the 12th Plan target of 100. Some States have registered significant reduction in MMR with Kerala at 66, Maharashtra at 87 and Tamil Nadu at 90.

There has been a significant improvement in creation of new facilities and infrastructure, though adequate staffing of these facilities by qualified health personnel remains a problem. Availability of drugs has improved at all levels and the robust logistic arrangements for procurement and storage of these drugs are being put in place. An important achievement of NHM has been a considerable reduction in out of pocket expenses from 72% to 60%.

Recently, new initiatives have been launched under NHM. Rashtriya Bal Swasthya Karyakram (RBSK) was launched to provide comprehensive healthcare and improve the quality of life of children through early detection of birth defects, diseases, deficiencies, and development delays including disability. Another initiative, viz. Rashtriya Kishor Swasthya Karyakram (RKSK) was launched to comprehensively address the health needs of the 253 million adolescents, who account for over 21% of the country's population, by bringing in several new dimensions like mental health, nutrition, substance misuse, injuries and violence and non-communicable diseases. The programme has introduced community based interventions through peer educators and is underpinned by collaborations with other Ministries and State Governments and knowledge partners, coupled with operational research. In addition to these initiatives, the Weekly Iron Folic Acid Supplementation Programme (WIFS) was launched to address adolescent anaemia whereunder supervised Iron-Folic Acid (IFA) tablets are given to adolescent population between 10-19 years of age in both rural and urban areas throughout the country. NUHM, a sub-mission under the NHM, caters to the healthcare needs of the urban population with the focus on urban poor and is aimed at reducing out of pocket expenses for treatment. NHM is a step towards realizing the objective of Universal Health Coverage in the country.

Maternal Health is an important aspect for the development of any country in terms of increasing equity and reducing poverty. The survival and well being of mothers are not only important in their own right but also central to solving broader, economic, social and developmental challenges. Janani Suraksha Yojna (JSY) has resulted in a steep rise in demand for services in public health institutions with the institutional deliveries registering a substantial increase since its inception in 2005. The number of JSY beneficiaries has risen from 7.3 lakhs in 2005-06 to about 105.48 lakhs in 2013-14. Capitalizing on the surge in institutional deliveries brought about by JSY to provide service guarantees at health facilities, Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new- borns on drugs, diet, diagnostics, user charges, referral transport, etc. This has now been expanded to cover the complications during ANC, PNC and also sick infants.

In a remarkable turn of events, India reported only one case of the crippling disease of polio in January 2011 and after that not a single case of polio was reported

over the years. The World Health Organization (WHO) has taken India off its polio endemic list and declared the whole South-East Asia Region including India free of polio on 27 March, 2014, a major milestone. Hib containing pentavalent vaccine has been introduced in 8 States in 2012-13 and country wide expansion is planned in 11 States from October 2014 and remaining 16 States/ UTs from April 2015. Elimination of Maternal and Neonatal Tetanus is validated in 18 States (2005-2013) and there is a plan to validate 9 States by 2014 and the entire country by 2015.

FAMILY PLANNING

The Family Planning programme has been repositioned as a critical intervention to reduce maternal and child mortality and not just as a strategy for population stabilization. At present the emphasis is being placed on spacing between births along with terminal methods. Strengthening community based service delivery is another key focus area; where ASHAs are delivering contraceptives at the doorstep of beneficiaries and are counseling them for maintaining spacing.

HEALTH POLICY

The Five Year Plans outline the strategy for implementing the policy, bearing in mind the dynamics of a developing economy. Accordingly, the Twelfth Five Year Plan for the health sector envisages transformation of the National Rural Health Mission into a National Health Mission covering both rural and urban areas. It envisages providing public sector primary care facilities in selected low income urban areas, expansion of teaching and training programmes for health care professionals particularly in the public sector institutions giving greater attention to public health, strengthening the drug and food regulatory mechanism, regulation of medical practice, human resource development, promoting information technology in health and building an appropriate architecture for Universal Health Care. The Twelfth Plan strategy is to strengthen initiatives taken in the Eleventh Plan to expand the reach of health care with focus on vulnerable and marginalized sections of population and therefore, envisages substantial expansion and strengthening of the public health systems and provision of robust primary health care.

MEDICAL EDUCATION (ME)

This year the Cabinet Committee on Economic Affairs (CCEA) has approved Centrally Sponsored Schemes for *Establishment of new medical colleges attached with existing district/referral hospitals and Centrally Sponsored Schemes for Strengthening & Up-gradation of State Government/Central Government medical colleges for increasing the number of MBBS seats in the country*. The objective is to utilize the existing infrastructure of district hospitals for increasing undergraduate seats in a cost effective manner by attachment of new medical college with existing district/ referral hospitals and to mitigate the shortage of doctors by increasing the number of undergraduate seats in the country for equitable health care across the country and to achieve the desired doctor population ratio respectively.

At present, there are 387 medical colleges in the country out of which 181 are in the public and 206 in the private sector with annual admission capacity of about 51,979 MBBS and 24,196 Postgraduate students per year. 25 new medical colleges have been granted permission for the academic year 2013-14 and a total of 6350 MBBS seats and 1081 PG seats have been increased for the year.

There are two Centrally Sponsored Schemes for the Financial Year 2013-14 regarding Paramedical Education. These are "Establishment of National Institute of Allied Health Sciences (NIAHS) and Eight Regional Institute of Allied Health Sciences (RIAHS) and supporting the State Govt. Medical Colleges for conducting paramedical courses through one time grant" and "Setting up of State institutions of paramedical sciences in States and setting up of college of paramedical education".

Further, two Centrally Sponsored Schemes regarding Pharmacy Education are "*Strengthening/Up-gradation of Pharmacy Institutions*" and "*Setting up of College of Pharmacy in Government Medical Colleges*".

The National Florence Nightingale Award was given on 12.5.2013 by the Hon'ble President of India to 35 nursing personnel as a mark of the highest recognition for meritorious services in the nursing profession in the country.

The National Nursing Portal, designed and developed by National Informatics Centre was launched on 14th February, 2013. It is an online resource centre for nurses, students, nursing institutions, national and State nursing councils and boards and the Ministry of Health & Family Welfare.

PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) envisaged the establishment of six AIIMS-like institutions and upgradation of the existing 13 medical college institutions in the first phase. It provided for the establishment of two AIIMS like institutions in Uttar Pradesh & West Bengal and upgradation of 6 more medical college institutions in the second phase, with the objective of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services and to also augment facilities for quality medical education in the country. The PMSSY up-gradation programme broadly envisages improving health infrastructure through construction of Super Speciality Blocks/Trauma centres etc. and procurement of medical equipments for existing as well as new facilities.

Out of 13 medical college institutions taken up for up-gradation in the first phase of PMSSY, upgradation work at 8 medical colleges has been completed. Out of 6 medical college institutions being upgraded in second phase, five institutions involve civil work. The civil work at Dr. Rajendra Prasad Government Medical College, Tanda has been completed. The civil work at the other four institutions, namely Aligarh Medical College, PGIMS-Rohtak, Amritsar Medical College and Madurai Medical College is in progress. At one institution where up-gradation programme involves only procurement of equipments, the procurement process has already been initiated. In addition, the Central Government has approved up-gradation of additional 39 medical colleges under the third phase of PMSSY upgradation.

COMMUNICABLE DISEASES

The incidence of vector borne diseases viz. Malaria, Filaria, Kala-azar, Acute Encephalitis Syndrome (AES) including Japanese Encephalitis (JE), Dengue and Chikungunya is linked with economic and social development of the community. Among all the vector borne diseases, malaria is still a major problem in the country though the reported figures from the States have shown a decline. Various initiatives have been taken for prevention and control of malaria such as upscaling of rapid diagnostic tests, use of effective drugs i.e. Artemisinin Combination Therapy (ACT), use of Long Lasting Insecticidal Nets (LLINs) and providing additional manpower. In the North-Eastern States early signs of resistance to currently used SP-ACT has been noticed and to tackle that an effective combination of Artemether-Lumefantrine (ACT-AL) has been recommended for the treatment of Pf cases in the North Eastern States. To intensify the malaria control activities in high malarious endemic districts, additional inputs are also provided in projects under the aegis of World Bank and Global Fund.

The cases of viral diseases such as J.E., Dengue and Chikungunya are managed symptomatically. However, the surveillance and diagnosis have been strengthened to detect more cases and provide early case management by the States/UTs. Kala-azar has been targeted for elimination by 2015 as per tripartite agreement between India, Nepal and Bangladesh. Lymphatic Filariasis has been targeted for elimination by 2015 as per NHP - 2002, however, the global elimination target is 2020. Efforts have been initiated to achieve the target for elimination of these diseases. In filaria elimination, 186 out of 250 districts have achieved a microfilaria prevalence less than 1%. The validation process has been initiated in a phased manner and 5 districts have successfully completed the transmission assessment survey indicating that transmission has been interrupted. The process is on in another 50 districts which is likely to be completed in 2013-14.

National Leprosy Eradication Programme was introduced in 1983. Since then, remarkable progress has been achieved in reducing the disease burden. India achieved the goal set by the National Health Policy, 2002 of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population, at the National level in December 2005. Still around 1.30 lakh new cases are detected & put on treatment every year. The budgetary outlay has been increased to Rs. 500 crore in the 12th Plan from Rs. 221 Crore in the 11th Plan.

Tuberculosis continues to be a major public health problem, with an estimated 3 million people in India suffering from the disease. 2 million cases are estimated to be added every year of which 7% are children and around 3 lakh people still die from this disease every year, despite availability of an effective treatment strategy. The Revised National Tuberculosis Control Programme (RNTCP) is working on strategies to provide Universal Access to quality TB Diagnosis and treatment for all TB cases, finding unreached TB cases before they can transmit infection, treating all of them more effectively and preventing the emergence of Drug Resistant TB. The Government has approved the Standards of TB Care in India, which will be instrumental in addressing diagnosis and treatment practices in the country along with many non-medical aspects that impact the care of TB patients. The programme is actively involving Information Communication Technology (ICT) which gives unprecedented opportunities to ensure that TB cases are promptly diagnosed and optimally treated. Nikshay, a case-based, web enabled system for recording and reporting of TB cases, developed by NIC in collaboration with the RNTCP, will enable better surveillance and tracking of all TB cases, including those in the private sector.

NON-COMMUNICABLE DISEASES (NCDS)

The Government of India has launched the *"National Programme for Health Care of the Elderly" (NPHCE)* to address health related problems of elderly people with the basic aim to provide separate, specialized and comprehensive health care to senior citizens at various levels of the State health care delivery system including outreach services, in 100 identified districts of 21 States during the 11th Plan period. Eight Regional Geriatric Centres as referal units have also been developed in different regions of the country under the programme. It is expected to cover 225 more districts during the 12th Five Year Plan in a phased manner. 12 more Regional Geriatric Centres in selected Medical Colleges of the country are also expected to be developed under the programme.

In the 12th Five Year Plan, the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Strokes (NPCDCS) is being implemented in 35 States/UTs from 2013-14. NPCDCS has now been brought under the umbrella of NHM in PIP mode. Interventions upto District level and below have been integrated under the Mission and funds provided through NCD Flexipool.

The National Programme for Control of Blindness (NPCB) is an ongoing centrally sponsored scheme since 1976 with the goal of reducing the prevalence of blindness to 0.3% by 2020. The Plan of Action to implement NPCB has been prepared in line with the Global Initiative: "Vision 2020: the Right to Sight". The programme continues to focus on development of comprehensive eye care services targeting common blinding disorders including Cataract, Refractive Errors, Glaucoma, Diabetic Retinopathy, Childhood Blindness, Corneal Blindness etc. during the 12th Five Year Plan to combat blindness.

Nutritional Iodine Deficiency can result in abortions, stillbirth, mental retardation, dwarfism, deafness, mutism, squint, goiter, neuromotor defects, loss of IQ, compromised school performance etc. A centrally sponsored programme namely National Iodine Deficiency Disorders Control Programme (NIDDCP) formerly known as the National Goiter Control Programme (NGCP) is being implemented in the entire country with focus on provision of iodated salt, district IDD survey/resurvey, laboratory monitoring of iodated salt and urinary iodine excretion, community awareness and monitoring of household salt by ASHAs, health education and publicity.

INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Information, Education and Communication (IEC) is now rightfully recognized as an integral part of policy making procedure. Over the years, the thrust of the Department has been to place IEC as an intervention tool to generate demand for the range of services under the National Rural Health Mission and various other schemes implemented by this Department. The communication strategy aims to facilitate awareness and disseminate information regarding availability and access to quality health care within the Government run public health system.

The sustained IEC campaign on Polio and hard work of health functionaries over several years had unprecedented success as no incident of Polio has been reported since 13th January, 2011, thus paving the way for a Polio free India. It was without doubt the result of a focused and well-coordinated IEC campaign for Polio free India. The World Health Organization has given official certification to India for its 'Polio Free' status on 27th March, 2014.

The health magazine programme "Swasth Bharat" has been produced & telecast and broadcast through 30 Regional Kendras of Doordarshan and 29 stations of All India Radio covering 27 States to reach out to a wider spectrum of population with information on health related issues. Among the important print materials published for IEC campaign during the year were 20 folders on various National Health Programmes/schemes, NRHM newsletter and Hamara Ghar (Hindi journal) and leaflets on different health issues. These print materials were distributed across the country for dissemination, information and generation of awareness of people on health issues. The annual exhibition at Health Pavilion was organized at Pragati Maidan during the India International Trade Fair 2013 with the theme 'Health with Equity' and was awarded a silver medal among the pavilions of "Ministry" category.

ASSISTANCE TO PATIENTS

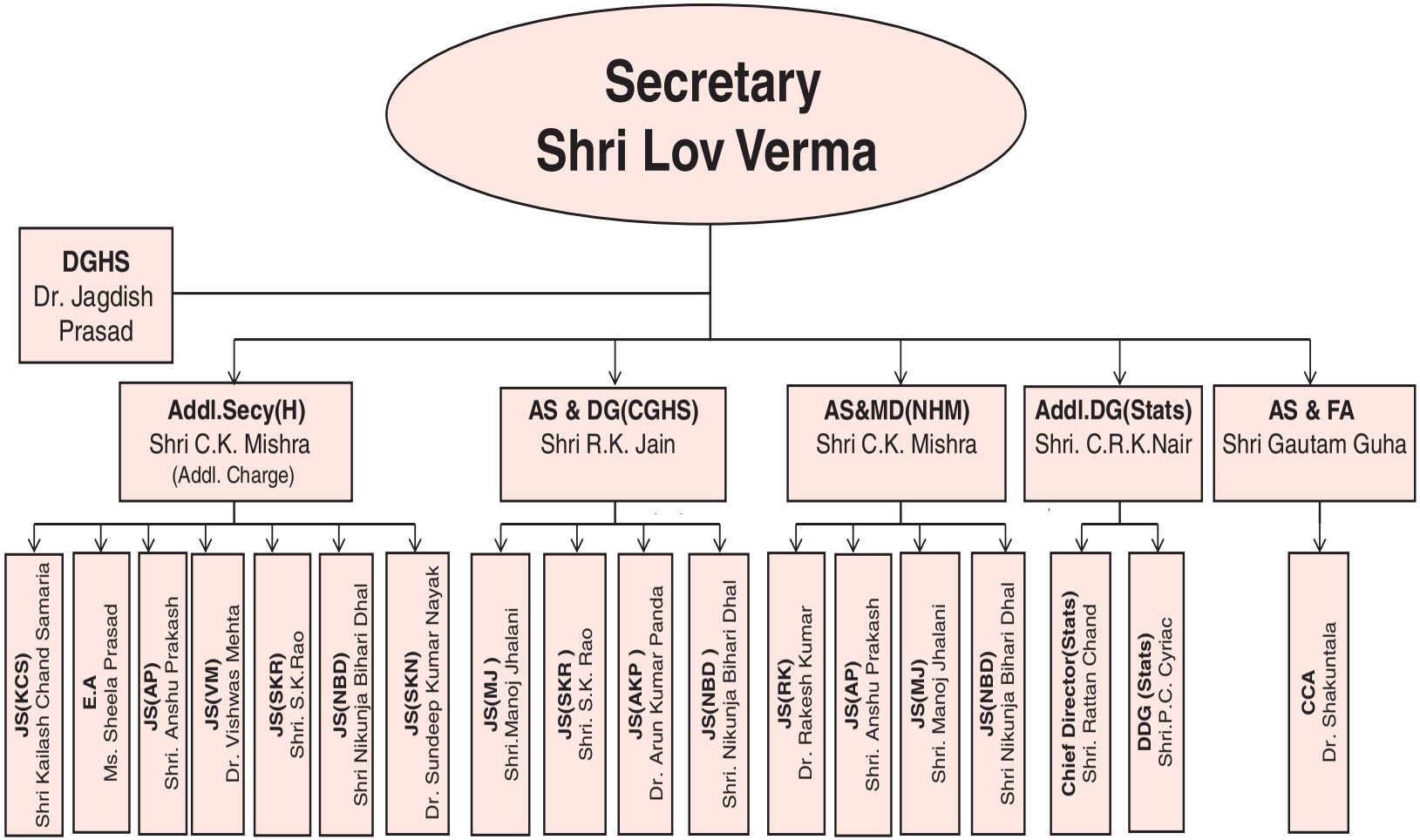
Health Minister's Cancer Patient Fund (HMCPF) within the Rashtriya Arogya Nidhi (RAN) has also been set up in 2009. In order to utilize the HMCPF, the revolving fund as under RAN, has been established in the various Regional Cancer Centres (RCCs). Such steps would ensure and speed up financial assistance to needy cancer patients and would help to fulfill the objective of HMCPF. The financial assistance to the cancer patient up to Rs.1.00 lakh would be processed by the concerned Institutes/Hospitals at whose disposal, the revolving fund has been placed. Individual cases which require assistance of more than Rs.1.00 lakh but not exceeding Rs.1.50 lakh are to be sent to the concerned State Illness Assistance Fund of the State/UT to which the applicant belongs or to this Ministry in case no such scheme is in existence in the respective State or the amount is more than Rs.1.50 lakh. Initially 27 Regional Cancer Centres (RCCs) were proposed at whose disposal revolving fund of Rs. 10.00 lakh was placed. An amount of Rs. 440 lakh was released to 16 Institutes during the year 2013-14.

FUTURE COMMITMENTS

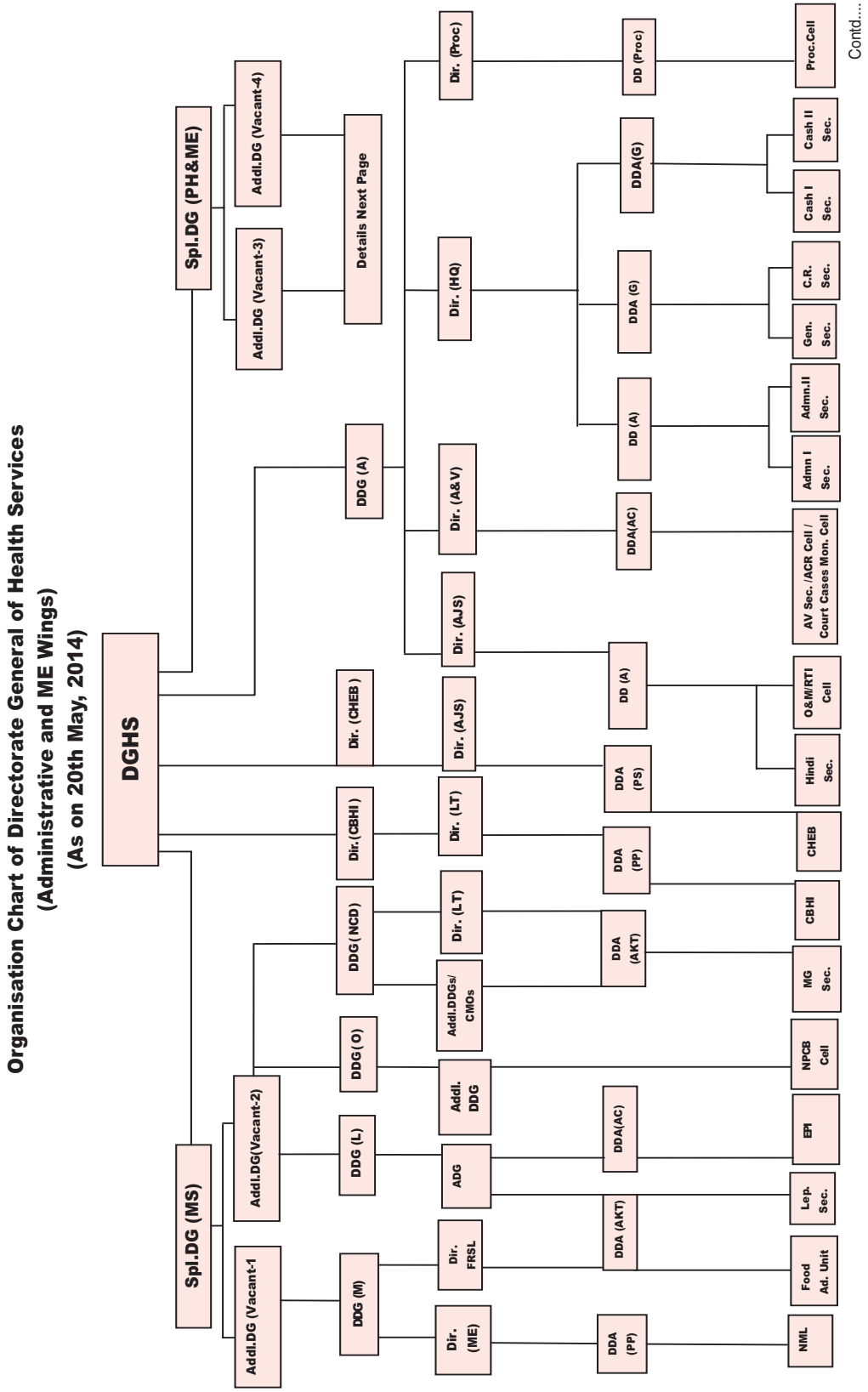
The National Urban Health Mission (NUHM), launched as a Sub-Mission of National Health Mission (NHM), has been identified as an area of priority attention for scaling up effective roll out during 2014-15. Important legislative measures like amendments to the Mental Health Care Bill and the Indian Medical Council, 1956 (Amendment) Bill have to be pursued vigorously to achieve the desired objectives in Mental Health Care and Medical Education. Further expansion of the project of setting up of AIIMS in remaining States under Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) and taking effective steps for introducing Injectable Polio Vaccine (IPV) as a part of Global Polio Endgame Strategy are other areas of priority for this Ministry to deliver acceptable standards of good health amongst the general population in the country.

(Lov Verma)
Secretary
Department of Health & Family Welfare

ORGANIZATION CHART
OF
DEPARTMENT OF HEALTH
&
FAMILY WELFARE


Secretary
Shri Lov Verma
DGHS
Dr. Jagdish Prasad
Addl.Secy(H)
Shri C.K. Mishra
(Addl. Charge)
AS & DG(CGHS)
Shri R.K. Jain
AS&MD(NHM)
Shri C.K. Mishra
Addl.DG(Stats)
Shri. C.R.K.Nair
AS & FA
Shri Gautam Guha
JS(KCS) Shri Kailash Chand Samaria
E.A Ms. Sheela Prasad
JS(AP) Shri. Anshu Prakash
JS(VM) Dr. Vishwas Mehta
JS(SKR) Shri. S.K.Rao
JS(NBD) Shri Nikunja Bihari Dhal
JS(SKN) Dr. Sundeep Kumar Nayak
JS(MJ) Shri.Manoj Jhalani
JS(SKR) Shri. S.K. Rao
JS(AKP) Dr. Arun Kumar Panda
JS(NBD) Shri. Nikunja Bihari Dhal
JS(RK) Dr. Rakesh Kumar
JS(AP) Shri. Anshu Prakash
JS(MJ) Shri. Manoj Jhalani
JS(NBD) Shri Nikunja Bihari Dhal
Chief Director(Stats) Shri. Rattan Chand
DDG (Stats) Shri.P.C. Cyriac
CCA Dr. Shakuntala

Organisation Chart of Directorate General of Health Services
(Administrative and ME Wings)
(As on 20th May, 2014)



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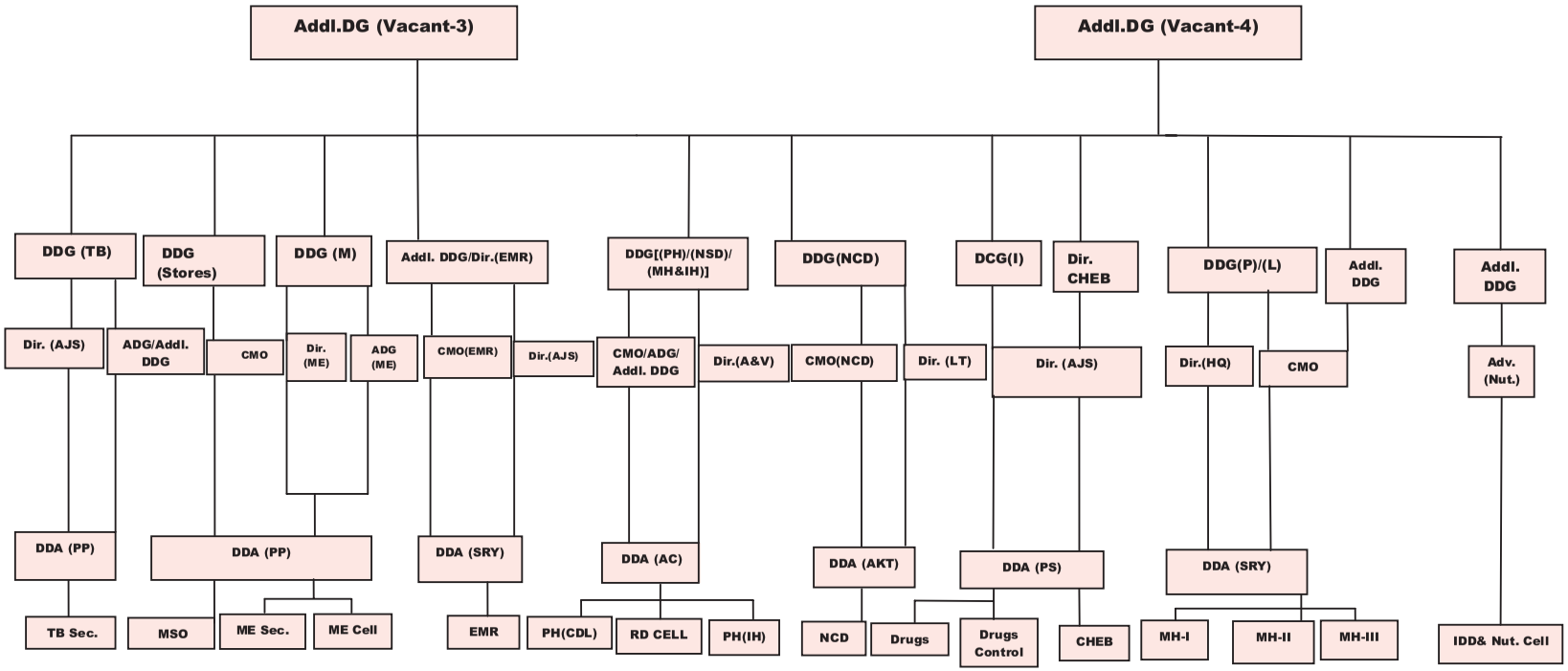
Organisation Chart of Directorate General of Health Services



SUMMARY OF IMPORTANT AUDIT OBSERVATIONS

The summary of important audit observations, appearing in the following most recent Audit reports of the year ended March 2012 are given below in the table:

1. Report No. 19 of 2013 Union Government (Civil)

Ministry of Health and Family Welfare	
Pradhan Mantri Swasthya Suraksha Yojana	An audit of the process of selection and payments made to consultants and contractors for different stages of construction of the six AIIMS like institutions was conducted. Audit noted deficiencies in selection of project consultants and payment processes to consultants and contractors. Cases of irregular release of mobilization advances were also noticed. **(paragraph 6.2)**
Procurement of Allopathic drugs in CGHS	Audit noted that 71 per cent of the drugs procured consisted of drugs outside the formulary despite the fact that prices of drugs in the formulary are comparatively lower. CGHS resorted to procurement of higher priced branded despite availability of low cost brands. Branded drugs continue to be preferred over generic drugs despite adverse remarks of the Parliamentary committee. This caused significant additional financial burden on the exchequer. The money value included in this report relates to only test checked cases which constitutes only a small percentage of actual procurement. Therefore, the monetary impact of such irregular practice would be much higher if the entire procurement were to be reckoned. **(paragraph 6.3)**
Loss due to expiry of anti-TB drugs	Improper planning in procurement of anti-TB drugs by the Central Tuberculosis Division the Ministry resulted in losses due to the expiry of drugs valuing 5.06 crore. **(paragraph 6.4)**

SUMMARY OF IMPORTANT AUDIT OBSERVATIONS

1. Report No. 23 of 2013 Union Government (Civil)

Department of Health & Family Welfare, Ministry of Health & Family Welfare	
All India Institute of Medical Sciences	Un-authorised expenditure on learning resource allowance All India Institute of Medical Sciences reimbursed learning resource allowance to its faculty members and Group A officers in violation of instructions of the Ministry. **(paragraph 4.1)**
All India Institute of Medical Sciences	Excess payments on procurement of surgical items Delay in initiating tendering process resulted procurement of surgical items at higher prices resulting inviolable payment of 51.53 lakh. **(paragraph 4.2)**

Chapter 1

ORGANIZATION & INFRASTRUCTURE

1.1 INTRODUCTION

In view of the federal nature of the Constitution, areas of operation have been divided between Union Government and State Governments. Seventh Schedule of Constitution describes three exhaustive lists of items, namely, Union list, State list and Concurrent list. Though some items like public health, hospitals, sanitation etc. fall in the State list, the items having wider ramification at the national level like Family Welfare and Population Control, Medical Education, Prevention of Food Adulteration, Quality Control in manufacture of Drugs etc. have been included in the Concurrent list.

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

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

Dr. Harsh Vardhan
Union Minister of Health & Family Welfare

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

i. Department of Health & Family Welfare
ii. Department of AYUSH
iii. Department of Health Research
iv. Department of AIDS Control

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

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

1.2 MINISTER IN CHARGE

The Ministry of Health & Family Welfare is headed by Union Minister of Health & Family Welfare Dr. Harsh Vardhan since 27th May 2014.

1.3 ADMINISTRATION

The Department has taken new initiatives and steps to implement Government programmes and policies in an efficient and time-bound manner as part of Government's commitment for better health care for all its citizens.

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

File Tracking System has been operational since December 2011, e-governance initiative has been strengthened further by introduction of e-office system in a phased manner. Biometric attendance system has also been introduced in the Department.

1.4 CENTRAL HEALTH SERVICE (CHS)

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

i.	General Duty Medical Officer Sub-cadre	-	2152
ii.	Teaching Specialists Sub-cadre	-	987
iii.	Non-Teaching Specialists Sub-cadre	-	647
iv.	Public Health Specialists Sub-cadre	-	104

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

1.5 RECRUITMENT & PROMOTIONS

1.5.1 Recruitment in GDMOs:- On the basis of Combined Medical Services Examination- 2012, dossiers of 672 candidates have been received from UPSC and they have been allocated to different cadres viz: Ministry of Defence, Ministry of Railways, MCD, NDMC besides Central Health Services on the basis of their Rank, preference and availability of vacancies. Further from the reserve list of CMSE-2012, dossiers of 41 candidates also have been received which have also been distributed to participating cadres based on the demand. Offer of appointment have been issued to 110 candidates under CHS cadre. 14 Assistant Professors have joined CHS on recruitment. Appointment of 36 GDMO Officers has been notified in the Gazette of India.

1.5.2 Promotions: During the year, the following number of promotions took effect in various sub-cadres of the Central Health Service:

Sub-cadre	Sr. No.	Designation of posts	No.
	1.	Promotion to the post of Special DGHS in Dte. General of Health Service	01
GDMO	1.	Senior Medical Officer (Grade Pay Rs. 6600/- in PB-3) to Chief Medical Officer (Grade Pay Rs. 7600/- in PB-3)	1
	2.	Chief Medical Officer (Grade Pay Rs. 7600/- in PB-3) to Chief Medical Officer (NFSG) (Grade Pay Rs. 8700/- in PB-4)	47
	3.	Chief Medical Officer (NFSG) (Grade Pay Rs. 8700/- in PB-4) to Senior Administrative Grade (Grade Pay of Rs. 10000/- in PB-4)	138
TEACHING	1.	Assistant Professor (Grade Pay Rs. 6600/- in PB-3) to Associate Professor (Grade Pay Rs. 7600/- in PB-3).	03
	2.	Associate Professor (Grade Pay Rs. 7600/- in PB-3) to Professor (Grade Pay of Rs. 8700/- in PB-4).	32
NON TEACHING	1.	Specialist Grade-II (Jr. Scale) (Grade Pay Rs. 6600/- in PB-3) to Special Grade-II (Sr. Scale) (Grade Pay Rs. 7600/- in PB-3).	09
	2.	Specialist Grade-II (Sr. Scale) (Grade Pay Rs. 7600/- in PB-3) to Special Grade-I (Grade Pay Rs. 8700/- in PB-4).	15
PUBLIC HEALTH	1.	Specialist Grade-II (Jr. Scale) (Grade Pay Rs. 6600/- in PB-3) to Special Grade-II (Sr. Scale) (Grade Pay Rs. 7600/- in PB-3).	05
	2.	Specialist Grade-I Officers (Grade Pay Rs. 8700/- in PB-4) to the post of SAG (Grade Pay Rs. 10000/- in PB-4)	04

1.5.3 Confirmation of CHS Officers: Confirmation orders in respect of 19 GDMO officers and 70 Assistant/ Associate Professors have been issued.

1.5.4 CHS-Rules, 2014: Recruitment Rules, 2014 for Central Health Service has been finalized & notified by Ministry of Health & Family Welfare.

1.5.5 Other Service related matters:

(i) RTI: The number of RTI cases received in this Division is 279.

(ii) Court Cases: There were 81 Court cases pending in the Hon'ble CAT, the High Courts and the Supreme Court in the beginning of financial year 2013-14. However, vigorous efforts are taken by CHS Division to get disposal of the cases in the courts.

(iii) Study Leave: 06 officers of GDMO Sub-cadre were granted study leave during the period

1.5.6 Considering the representations of CHS Officers for Upgradation of below bench Mark grading in the ACRs: Consequent to the instructions contained in Department of Personnel and Training's O.M. No. 21011/1/2010-Estt.A dated 13.4.2010 and also under Annual Performance Appraisal Report (APAR) guidelines, the representations of 16 CHS officers for upgradation/retention of the below bench mark grading in their ACRs/APARs were considered by the Competent Authority.

1.5.7 Non-Medical Scientists 2012-13: A proposal is under process for holding the DAB (DPC) to consider the cases of Non-Medical Scientists from S-IV level for In-situ promotion against the 06 vacant posts (floating) for the post of S-V level working under Ministry of Health and Family Welfare/Directorate General of Health Services (DGHS).

1.5.8 Dental Doctors 2013-14: 03 posts of Assistant Professor of Dentistry in the Department of Dentistry, LHMC, New Delhi under Ministry of Health and Family Welfare had been filled. Orders for promotion of 02 officers from Jr. Staff Surgeon (Dental) to the post of Staff Surgeon (Dental) for which DPCs were held in 2012-13, have been issued. DPC was held for promotion under DACP Scheme for 05 officers from Dental Surgeon to the post of Jr. Staff Surgeon during the current year and the orders for the promotion have also been issued. The process has also been initiated to amend the Dental Posts Recruitment Rules-1997.

1.6 e-GOVERNANCE INITIATIVES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE

Health Informatics Division of National Informatics Centre (NIC) provides MIS and Information & Communication Technology (ICT) support to Ministry of Health & Family Welfare. More than 1800 PCs of the Ministry are connected to the Local Area Network (LAN) at Nirman Bhawan, which in turn, are connected to NICNET through RF Link and leased line circuits. Salient features of important projects handled by NIC are as follows:

i) Website of the Ministry of Health & Family Welfare & of various bodies under Ministry

The redesigned website of the Ministry of Health & Family Welfare http://mohfw.nic.in with new additional URL (http://mohfw.gov.in) is under process for restructuring and making it content-rich, user-friendly. At present, the old website is operational for public and new one is likely to be made available to public soon. Various other websites under the ministry are updated on a regular basis, as and when the information is provided by the users. Critical information such as notifications of the CGHS, tenders and advertisements under the Ministry, Sanction. Details of the Principal Accounts Office & Public Expenditure Management, etc are uploaded in the website on regular basis. In addition a no. of websites under the MoHFW are being maintained by the respective users on their own using Content Management System.

Many new websites have been designed, developed and hosted on NIC servers while many others are being re-designed to incorporate recent technologies viz. website of Sports Injury Centre, Safdarjung Hospital, website of LRS Institute of TB & Respiratory Diseases, website of National Rural Health Mission, to name a few.

ii) ICT Infrastructure Support

NIC provides new LAN connections; network based Anti-virus solution in addition to maintaining existing

network users. At present over 1800 LAN nodes have been provided in the Department of Health & Family Welfare, Directorate General of Health Services and over 300 LAN nodes at Department of AYUSH. NICNET Support is also provided at Department of Health Research (ICMR) and Department of AIDS Control (DAC). A number of organizations under MoHFW are under NICNET domain. An NKN node has also been provided in each Government Medical College across Country. The email and internet usage has grown significantly and officials prefer email communication over other means. The network maintenance and desktops require constant updation from the operating system service providers and hence the un-authorized access is controlled effectively. The migration to the new ipv6 from ipv4 is underway.

iii) e-Office / FTS implementation in MoHFW

The File Tracking System (FTS) has been implemented successfully in the Department of Health & Family Welfare with over 1200 users. Now all the files and receipts are being diarized online and essentially move using online system, ensuring an easy mechanism for all the users to track the files and receipts anywhere in the network. The e-Office system of NIC is under implementation in Department of Health and Family Welfare. The Knowledge Management System (KMS) and e-leave module have been implemented in Department of Health and Family Welfare and Dte. GHS. The e-File has been started in NRHM and Administration Divisions on a selective basis. The File Tracking System (FTS) has been in continued usage in Department of AYUSH and Dte. GHS.

iv) e-Tendering implementation in MoHFW

The Department of Expenditure, Ministry of Finance has vide office memorandum dated 30th Nov. 2011, made e-publishing of all tenders mandatory, following which e-Procurement has also been made mandatory. For this purpose a Central Procurement Portal has been designed (http://eprocure.gov.in). The Director Procurement has been designated as Nodal Officer. NIC-HID has assisted him and also various sub-ordinate bodies under the Ministry of Health & Family Welfare to successfully implement e-publishing and e-Tendering has also been implemented in certain Departments. MSO, CGHS, to name a few have completed live e-tenders with the help of NIC. NIC-HID has co-ordinated with the CPP Team at HQ to conduct various sensitization workshops for awareness of the users. Recently a new Autonomous Body under Ministry of Health and Family Welfare named Central Medical Services Society is being roped in for usage of e-Procurement in a large scale for the Ministry of Health and Family Welfare. While most of the organizations have started e-Publishing, the entire process of e-tendering is being taken up by various organizations in phased manner.

v) Mother & Child Tracking System (MCTS)

Mother and Child Tracking System (MCTS) facilitate to create the work plan, its execution and monitoring towards Anti Natal Care and Post Natal Care of mother and child. It includes registrations; SMS based verification of health facilities in English/Hindi or preferred language, validation, the work plans for services through SMS to ANMs, ASHAs. Unstructured Supplementary Service Data (USSD) based service for MCTS Data updating has been made operational in Haryana State. Direct Benefit Scheme for Janani Suraksha Yojna (JSY) has been made operational through CPSMS. MCTS have been integrated with Maternal Death Review (MDR) software. 5 crores women and 4 crores children are being tracked using MCTS software. The URL is http://nrhm-mcts.nic.in/ .

vi) NIKSHAY - Web based Tracking of TB Patients

NIKSHAY facilitates tracking of Normal TB Patients, Multi-Drug Resistant (MDR) TB patients and TB patients being treated by the private sector under Notification from Government of India. SMS is sent to the Central TB Division (CTD) Officers, State and District TB Officers for monitoring purposes. SMS is sent to TB Patient on registration. More than 20 lakhs patients are monitored using NIKSHAY. This application has been implemented across India in all states. The URL is http://nikshay.gov.in.

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

The computerized system is aimed at computerizing all functions of the dispensary such as Registration, Doctor's prescription, Pharmacy Counter, Stores, Laboratory &

Indent etc. The system has been successfully implemented for the last 5 years in all the 24 cities of CGHS including NCR Delhi covering 270 allopathic Wellness Centers (WCs). On an average 50,000 patients are registered in CGHS WCs daily in all locations. The CGHS wing of Dr. Ram Manohar Lohia Hospital, New Delhi is already computerized, while of Safdarjung Hospital, New Delhi is under progress. The merged P&T dispensaries have been also computerized.

The plastic card for every individual CGHS beneficiary has been provided in NCR Delhi. The implementation for outside delhi has also been initiated. The provision has been made for uploading of individual beneficiary photo while applying for plastic card online. The preventive Health Check-up for 40+ aged CGHS beneficiaries is being implemented in 8 CGHS Wellness Centers in 4 Zones at NCR Delhi. The Rate Contract Medicines (Most Consumable Medicines, which are indented) are procured locally from supplier for instant availability to the beneficiaries. Permission and Claim module for pensioners are started online in NCR Delhi. For outside Delhi it has been implemented in 9 cities.

The computerization of AYUSH CGHS WCs has been successfully implemented in NCR Delhi. The store of homeopathic has been made online also. There are total 38 units in Delhi/NCR which include Homeopathic, Ayurvedic, Unani and Sidha WCs & their Stores. The SMS facility is also integrated for increased transparency to the beneficiaries. The beneficiary now can see their prescribed medicine history online.

To improve the network performance the alternate connectivity of 4mbps optical fiber leased line has been implemented in 12 CGHS WC initially in Delhi. Proposal for rest of the WC is under progress.

viii) National Programme for Control of Blindness (NPCB) MIS

Ministry of Health & Family Welfare had launched a website and online application in 2009 for their National Programme for Control of Blindness in India. This is a national level project wherein following stake holders are involved:

The NGOs enter the details of the patients operated upon for cataract surgeries, get paid from Ministry for various activities done under the programme and this system isable to generate the actual funds that need to be provided to NGOs. Currently 2311 NGOs and 497 District Hospitals and District Programme Managers (DPMs) are using NPCB MIS.

The system also has the provision for information exchange between Districts, States and Ministry pertaining to work execution and expenditure details and through this system the state and district users can give their annual PIP (Programme Implementation Plan) and utilization of funds allocated by Ministry. The system is also able to provide eye disease wise MIS reports. The URL of the site is http://npcb.nic.in

ix) MIS for CHS (Central Health Services)

CHS (Central Health Services) was constituted with a view to manage various medical posts for Doctors under the Central Government, Union Territories and certain other organizations. Presently, it caters to the needs of various participating units like Directorate General of Health Services including the organizations under its control, Central Government Health Scheme, Govt. of NCT of Delhi, Ministry of Labour, Ministry of Finance, Department of Posts etc. There is a web based application for information management about all Doctors online with assigned roles to update the records of the doctors. Currently 75 Organizations where CHS Doctors are posted, use online CHS MIS. The URL of the MIS is http://chsmohfw.nic.in/

x) e-Hospital@NIC - A Hospital Management System from NIC

The e - Hospital is a workflow based ICT solution for Hospitals specifically meant for the hospitals in Government Sector. This is generic software which covers major functional areas like patient care, laboratory services, workflow based document/ information exchange, human resource and medical records management of a Hospital. It is a patient-centric system rather than a series of add-ons to a financial system. e-Hospital Product is being implemented in more than 25 Hospitals of the country including All India Institute of Medical Sciences (AIIMS), New Delhi, NIMHANS, Bengaluru, Gas Rahat Hospitals in Bhopal.

xi) All India Quota Counseling for Medical and Dental Seats

In order to reduce the time span for counseling and facilitate students to take part in the counseling process from their homes or nearest internet access point, online system has been designed for allotment of All-India Quota of Medical/Dental Seats from 2012. This web based application (http://mcc.nic.in) facilitates end-to-end support towards streamlining the admission processes in all phases like Counseling and post counseling operations in Medical Institutions.

xii) National Eligibility cum Entrance Test (NEET) - UG

In order to conduct NEET for Medical aspirants, a web based solution http://cbseneet.nic.in was developed by NIC, which facilitates applying online by candidates, printing of Bank e-Challan for depositing fee in Banks across India, Pay the examination fee through Electronic Payment Gateway using Credit/Debit cards, Post Office e-Challan for depositing fee in Post Offices across India, application status, online correction in particulars, download admit card. Apart from this, information on various notices, facilitation centres, information at a glance, RTI, useful links and contact information has been provided on the website. The result of the NEET will be published on the http://results.nic.in website with a link on the NEET website. The website has provided information about latest news, important dates download and help.

xiii) MIS for National Organ and Tissue Transplant Organization (NOTTO)

The Transplantation of Human Organs (Amendment) Act (THOA), 2011 is an Act, to provide the regulation of removal, storage and transplantation of human organs and tissues for therapeutic purposes and for prevention of commercial dealings in human organs. Hence, Ministry of Health and Family Welfare has decided to set up an organization named as National Organ and Tissue Transplant Organization (NOTTO) which will linked with Regional Organ and Tissue Transplant Organization (ROTTO) and State Organs and Tissue Transplant Organization (SOTTO). This National Organ and Tissue Transplant Organization has been set up on the 4th and 5th Floor of Indian Institute of Pathology (IoP) Building, inside Safdarjung Hospital, New Delhi.

A web based application has also been designed and hosted to facilitate the Donors who are willing to Donate their Organs or Tissue after his/her death so that their organs may be used for saving the life of those who are in need of Organ or Tissue. A Donor can pledge for donation of their organs through this web based application system. A Donor pledge card is also being issued to him so that their Family Members or near relatives may also aware that he/she has pledged for Donation of Organ or Tissue. Through this web based application, hospitals who are actively involved in Organ Retrieval and Transplantation activity or going to start this activity, would be authorized to do Retrieval and Transplantation of Organ or Tissue after registering through this web based system and finally approved by the Ministry of Health and Family Welfare (MoHFW).

xiv) MIS for Health Accounting Scheme (ICMR)

A web based application named as http://healthaccountsscheme.nic.in has been hosted as a pilot project by Indian Council of Medical Research, Govt. of India, for online updation of Health Record on monthly basis of individuals. Under this scheme a person get Health Diary with carbon page. Original copy of the Health Diary remains with the user and carbon copy is used for feeding information of individual health account through this web based system. The information of health of individuals remains confidential so that no one, other than concerned person, may know about health data. A health account number is allotted to individual person and based on that number further analysis and reports are prepared for study and providing health services as per need of your area.

xv) Medicinal Plants database for National Medicinal Plant Board (NMPB)

The National Medicinal Plants Board (NMPB) and Central Council for Research in Ayurvedic Science (CCRAS), under Department of AYUSH, Government of India, proposed the idea of developing a database in which, all the available published information on selected medicinal plants, covering every subject area can be accessed at one place.

xvi) MIS for online Clinical Establishment Registration and Regulation

The Clinical Establishments (Registration and Regulation) Act, 2010 has been enacted by the Central Government to provide for registration and regulation of all clinical establishments in the country with a view to prescribing the minimum standards of facilities and services provided by them. The Act has taken effect in the four states namely, Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, and all Union Territories since 1st March, 2012 vide Gazette notification dated 28th February, 2012. The States of Uttar Pradesh, Rajasthan and Jharkhand have adopted the Act under clause (1) of article 252 of the Constitution.

The Ministry has notified the National Council for Clinical Establishments and the Clinical Establishments (Central Government) Rules, 2012 under this Act vide Gazette notifications dated 19th March, 2012 and 23rd May 2012 respectively.

The Act is applicable to all kinds of clinical establishments from the public and private sectors, of all recognized systems of medicine including single doctor clinics. The only exception will be establishments run by the Armed forces.

The web based system http://clinical establishments.nic.in/ provides easy mechanism for any clinical establishment to register for provisional certification online and get the same after the approval by the District Registering Authority. Presently Himachal, Jharkhand and Daman and Diu started Online Registration process.

xvii) MIS for Medical Stores Organization (MSO)

The procurement, storage and distribution of medicines, surgical items and other hospital consumables by Medical Stores Organizations (MSO) and/or its subordinate organizations/Warehouse under Director General of Health Services (DGHS), Ministry of Health & Family Welfare (MoHFW). There was a need of computerization of this application to create the transparency and quick response. Hence a web based application (http://msotranparent.nic.in) has been designed which is running since 2007. All the GMSDs have been linked with this website.

Now this application has been upgraded having following features:

- Dynamic and CMS based.
- Multi-users features at difference levels having different roles.
- User can upload Tenders related to MSO through this website.
- User can upload Photos in Photo gallery as per their requirements.

Presently total 16 users at MSO level, 27 users at GMSD level, 1513 Indentors, 199 Suppliers and 35 Labs are using this online application.

1.7 ACCOUNTING ORGANIZATION

General Accounting set up

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

The Secretary of each Ministry/Department is the Chief Accounting Authority. This responsibility is to be discharged by him through and with the help of the Chief Controller of Accounts (CCA) and on the advice of the Financial Advisor of the Ministry. The Secretary is responsible for certification of Appropriation Accounts

and is answerable to Public Accounts Committee and Standing Parliamentary Committee on any observations of the accounts.

Accounting set up in the Ministry

The Ministry of Health & Family Welfare has four Departments viz. Department of Health & Family Welfare, Department of AYUSH (Ayurveda, Yoga, Unani, Sidha & Homeopathy), Department of Health Research & Department of AIDS Control (NACO). There is a common Accounting Wing for all the Departments. The Accounting Wing is functioning under the supervision of a Chief Controller of Accounts supported by a Controller of Accounts (CA), Dy. CA and eleven Pay & Accounts Officers (PAOs) (Seven PAOs in Delhi & One each at Chennai, Mumbai, Kolkata & Puducherry). The CCA is also entrusted with the responsibility of Budget Division of the Ministry.

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

Accounting functions in the Ministry

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

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

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

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

Internal Audit Wing

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

The CCA is submitting internal audit observations and matter related to financial discipline to the Secretary in respect of each Department and its subordinate organizations. The Annual Review Report of the Internal Audit is also subject to scrutiny by the CGA and Ministry of Finance. The role of Internal Audit is growing and shifting from Compliance audit confined to examining the transaction with reference to Government rules and regulations to complex auditing techniques of examining the performance and risk factors of an entity. In 2012-13, 811 audit paras have been raised which include observations to the tune of Rs. 5686.73 crores. A total No. of 293 paras have been settled during 2012-13. Besides this in 2012-13 Internal Audit Wing had conducted Performance/Special Audit of following schemes and Institutions implemented/working under Ministry of Health & Family Welfare:

1. Engagement of Security Personnel in All India Institute of Medical Science, Delhi.
2. Procurement of Medicines and Consumables in All India Institute of Medical Sciences, Delhi.

3. Govt. Medical Supply Depot, Chennai.
4. Govt. Medical Supply Depot, Hyderabad.
5. Govt. Medical Supply Depot, Kolkata.
6. Govt. Medical Supply Depot, Guwahati.
7. Govt. Medical Supply Depot, Mumbai.
8. Govt. Medical Supply Depot, Delhi.

1.8 IMPLEMENTATION OF THE RTI ACT, 2005

Under the Right to Information Act, 2005, 55 Central Public Information Officers (CPIOs) and 30 Appellate Authorities (A/As) have been appointed in the Ministry of Health & Family Welfare (Department of Health & Family Welfare).

In the light of directions of DOP&T, Shri S. K. Rao, Joint Secretary (CDN) has been nominated as Nodal Officer for ensuring the compliance with the proactive disclosure guidelines within the Department of Health & Family Welfare and also for the formations.

Department of Health & Family Welfare has placed all obligatory information pertaining to their office, under Section 4(1) (b) of the RTI Act, 2005 on the Website of this Ministry.

The facility of filing Application and 1st Appeal under RTI Act, 2005 online through RTI online Web Portal developed by DOP&T has been introduced in Department of Health & Family Welfare w.e.f. 3rd June 2013 and the general public is sending their RTI query(ies) through this facility in a large number. Besides, the Applications and Appeals under the RTI Act, received physically through post or by hand, are also accepted by Receipt & Issue (R&I) Section and RTI Cell, Room No.216, D Wing, Nirman Bhawan, New Delhi.

During 2013-14, 5432 RTI applications received through R&I and Online in the RTI web portal and 385 RTI appeals (RTI appeals received physically and online through RTI web portal) have been received till dated i.e. 29.10.13 and handled efficiently & timely.

1.9 VIGILANCE

Vigilance Wing of the Department of Health and Family Welfare is under the control of an officer of the rank of Joint Secretary to the Government of India who also works as part time Chief Vigilance Officer (CVO). The CVO is assisted by a part time Director (Vig.), an Under Secretary and staff of Vigilance Section. During the period, Dr. Vishwas Mehta, IAS has been looking after the charge of Chief Vigilance Officer (CVO).

The Vigilance Division of the Ministry deals with vigilance and disciplinary cases having vigilance angle against the officers of Dte. GHS and CGHS of the Department of Health and Family Welfare. The Vigilance Wing also monitors vigilance enquires, disciplinary proceedings having vigilance angle, in respect of doctors and non-medical/technical personnel borne on the Central Health Service (CHS) Dte. GHS/PNT Dispensaries and other institutions like Medical Stores Organization, Port Health Organization, Labour Organization etc.

In year 2013-14 (ending December, 2013) following action/cases have been taken/dealt with by Vigilance Division:-

Sl. No.	Item	Number
1.	Charges Sheet issued under Rule 14 of CCS (CCA) Rules	3
2.	Instances of sanction for prosecution accorded	3
3.	Finalization of Disciplinary cases	8
4.	Instances of appointment of IOs/POs	17
5.	Instances of permission accorded to CBI for registration of case against senior level Officers	1
6.	Instances of suspension/revocation/extension	7
7.	No. of Disciplinary cases live at the end of the period	24
8.	No. of complaints received form CVC for appropriate action and which are under examination/processed	76
9.	Misc. complaints received from CBI for appropriate action	60
10.	Complaints received from other sources	97
11.	Cases sent to CVC for advice	13
12.	Cases sent to UPSE for advice	7
13.	Matter referred to DOPT for advice	1

14.	Cases referred to Ministry of Law and Justice for advice	1
15.	RTI application received and disposed	29
16.	No. of Court cases processed during the period	3
17.	Vigilance clearance granted during the period	7020
18.	VIP/PMO reference received/processed	4

1.10 PUBLIC GRIEVANCE CELL

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

Sh. S. K. Rao, Joint Secretary in the Department of Health & Family Welfare has been designated as Nodal Officer for Public Grievances relating to the Department. Shri Mahendra Singh, Deputy Secretary in the Department of Health & Family Welfare is functioning as Public Grievance Officer. Similarly other organizations under the Ministry have also senior level officials functioning as Public Grievances Officers.

Pursuant to the instructions of the Govt. for creation of Sevottam Compliant System to redress and monitor pubic grievances under Results Framework Documents for 2012-13 and implementation of Centralized Public Grievances Redress and Monitoring System (CPGRAMS) in the Ministries/Departments. CPGRAMS has been implemented in the Department, Attached Office i.e. Directorate General of Health Services (Dte.GHS), Central Govt. Health Scheme and extended to Autonomous Bodies/PSUs. It is being extended to other Subordinate Offices of Dte.GHS. It is a web based portal and a citizen can lodge grievance through this system directly with the concerned Departments. A link of CPGRAMS has also been provided on the website of the Ministry i.e. www.mohfw.nic.in.

The number of written Grievance petitions received/ disposed of and pending during 2012 & 2013 are as follows:

Year	Opening Balance	Grievance petitions received during the year	Grievance petitions disposed of during the year	Pending
2012	90	175	210	55
2013	55	154	179	30

The position in regard to grievance received through CPGRAMS is as under:-

No. of Grievances Received	Disposal	Pendency
9268 (As on 19.12.2013)	8704	564

1.11 INFORMATION & FACILITATION CENTRE

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

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

1.12 RURAL HEALTH INFRASTRUCTURE

The Health and Family Welfare programme in the country is being implemented through primary health care system. In rural areas, primary health care services are being provided through a network of 148366 Sub-centres, 24049 Primary Health Centres and 4833 Community Health Centres as on March 2012 based on the following norms of population. The population norms for SC/PHC/CHC are as follows:

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

The Ministry has recently decided to provide a sub-Health Centre within 30 minutes of walk of habitation in certain districts of hill states.

Sub-Centre

Sub-centre is the first peripheral contact point between Primary Health Care system and the community. It is manned by at least one Female (Auxiliary Nurse Midwife) and also one Male Health Worker, One Lady Health Visitor (LHV) is provided for six such Sub-Centres. Sub-centres are assigned task relating to Maternal and Child Health, Family Welfare, Nutrition, Immunization, Diarrohea and Pneumonia Control and control of Communicable Diseases. ANMs and also provided drugs for minor ailments and for essential material and child health care. ANMs also provide Family Planning counseling and supplies.

Government of India bears the salary of ANM and LHV while the salary of the Male Health Worker is borne by the State Governments.

Under NRHM Sub-centers are being strengthened by provision of untied funds of Rs.10,000/- per year which is operated by the ANM and the Sarpanch, supply of allopathic and indigenous medicines and provision of an additional ANM. Annual maintenance grant of Rs. 10,000/- is also made available to every Sub-centre to undertake and supervise improvement and maintenance of the facility. Up gradation of existing Sub-centres, including building for Sub-centers functioning in rented premises and establishing new one based on population and time to care norms to being undertaken.

Primary Health Centre (PHC)

PHC is the first contact point between village community and the Medical Officer. It is manned by a Medical Officer and other support staff. It acts as a referral Unit for 6 Sub-Centres and many PHCs as 4-6 beds for patients. It provides curative, preventive, promotive and Family Welfare services.

The PHCs are being strengthened under NRHM to provide a package of essential public health services, and support for outreach services including for regular supplies of essential drugs and equipment, upgrading single doctor PHC to 2 doctors PHC by posting AYUSH practitioners at PHC level, provision of 3 Staff Nurses in a phased manner based on patient load and delivery load. The States/UTs have to incorporate their proposals and requirement of funds in their Programme Implementation Plans under NRHM. Untied Grant of Rs. 25,000/- per PHC for local health action and Annual Maintenance Grant of Rs. 50,000/- per PHC and Rs. One Lakh to Rogi Kalyan Samiti (RKS) to undertake and supervise improvement and maintenance of physical infrastructure is provided.

Community Health Centre(CHC)

CHC is established and maintained by the State Governments and as per standards it is supposed to be manned by four Medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It normally has 30 in-door beds with one OT, X-ray, and Labour room and Laboratory facilities and serves as a referral centre for 4 PHCs. It provides facilities for emergency obstetrics care and specialist consultations. Indian Public Health standards lays down that this CHC should be manned

by 6 Medical Specialists including an Anaesthetics and Gynecologist supported by 24 paramedical and other staff with inclusion of two nurse midwives in the present system of seven nurse midwives.

Funds are being provided every year as requested by the States in their Programme Implementation Plan under NRHM to strengthen CHCs as per IPHS standards and make them First Referral Unit. Untied Grant of Rs. 50,000/- AMG of Rs. One lakh and RKS coupon Grant of Rs. One lakh is also provided under NRHM to all CHCs.

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

Strengthening of sub-divisional /sub-district and district hospitals is also an approved activity under NRHM. The states propose their requirement in their PIPs, which are approved by the NPCC and approvals are generated in light of the appraisal. Funds and release to carry out approved activities.

Indian Public Health Standards (IPHS)

Indian Public Health Standards (IPHS), detail the specifications of standards to which institutions of primary health care should be raised to so that the citizen is confident of getting public health services in the hospital that can be measured to be of acceptable standards. Indian Public Health Standards (IPHS) for Sub-centres, PHCs, CHCs, Sub-divisional/Sub-district Hospitals and District Hospitals lay down Standards not only for personnel and physical infrastructure, but also for delivery of services, and management.

Each hospital as part of IPHS, is required to set up a Rogi Kalyan Samittee (RKS)/Hospital Management Committee (HMC). This brings in community control into the management of public hospitals. The objective is to provide sustainable quality care with accountability, people's participation and total transparency.

Mobile Medical Units/Health Camps

With the objective of taking health care to the door step of the public in the rural areas, especially in under-served areas, Mobile Medical Units (MMUs), have been provided, upto 5 MMUs can be provided in a district.

The States are required to involve District Health Society/Rogi Kalyan Samiti/NGOs in deciding the appropriate modality for operationalization of the MMUs. The MMUs can generally operated with the help of NGOs.

Tackling the problem of lack of manpower in Rural Areas

The Government is seized of the problem of lack of skilled manpower in rural areas. Augmentation of human resources is one of the thrust areas under the National Rural Health Mission [NRHM]. Financial support is provided under NRHM for engagement of staff on contractual basis. Multi-skilling of doctors to overcome the shortage of specialists, provision of incentives to serve in rural areas, improved accommodation arrangements, measure to set up more medical colleges and increase seats in existing medial colleges, measures to open new GNM/ANM Schools to produce more doctors and nurses are also measures to bridge the gap in human resources. Overall 1.55 lakh additional human resources have been provided to the states under NRHM.

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

Under Secretary (Vig.) being of the member of the complaints committee is not aware of any sexual harassment complaint received during 2013-2014. Further on the nomination of US (Vig.) as one of the members, clarification has been sought from Establishment Division, in terms of Gazette Notification prescribing the constitution of complaints committee. As Joint Secretary & Chief Vigilance Officer (CVO) does not handles, complaints of sexual harassment, the nil information for 2013-2014 is being furnished by Under Secretary (Vig.) as per available information.

1.14 CENTRAL MEDICAL SERVICES SOCIETY (CMSS)

To streamline drug procurement and distribution system of Department of Health and Family Welfare and to eliminate existing deficiencies, Central Medical Services Society (CMSS) has been established and registered as

a society on 22 March, 2012 under the Societies Registration Act of 1860.

The CMSS will function as a professional and autonomous agency for purchasing medicines, vaccines, contraceptives and medical equipments for all disease control, family welfare & immunization programme of the Union Health Ministry. It will also procure various commodities for the National Aids Control Programme (NACP) of Department of Aids Control (DAC). The CMSS is also responsible for distribution of above mentioned health sector goods to the state and UT Governments by setting up IT enabled State level warehouses at different locations spread across the country.

An action plan to make the CMSS operational has been prepared. As per the action plan, regular requirement of the year 2015-16 shall be supplied to States/UTs by the CMSS from its own network of IT enables warehouses.

Standard Tender documents have been prepared. Quality policy has also been prepared. At present, action to acquire warehouses, IT software and empanelment of laboratories is in hand.

1.15 EMPOWERED PROCUREMENT WING

Procurement Division deals with the procurement of drugs and commodities supply under the National Vector Borne Disease Control Programme (NVBDCP), Revised National Tuberculosis Control Programme (RNTCP), Reproductive Child Health (RCH), Immunisation Programmes.

In addition, operationalisation of Central Medical Services Society (CMSS), autonomous body of Ministry of Health and Family Welfare (MoHFW) is also handled in the Procurement Division. CMSS is likely to be operationalised by the end of the current financial year.

MoHFW has appointed M/s RITES as Procurement Agent to assist the Ministry for procurement of drugs and commodities under various diseases control programme viz- RNTCP, NVBDCP, RCH, Immunization during the year 2012-13. The following drugs/ commodities were procured by EPW and supplied to the State Government during 2012-13:-

S.No.	**Drugs/Commodities**	**Value** (Rs. in crores)
1	Anti Malarial Drugs	146
2	Anti TB Drugs	112
3	RCH supplies	42
4	Polio supplies	100
	Total	**400**

Chapter 2

NHM, HEALTH & POPULATION POLICIES

2.1 THE NATIONAL HEALTH MISSION (NHM)

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the newly launched National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening in rural and urban areas- Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs.

National Rural Health Mission (NRHM): NRHM seeks to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

National Urban Health Mission (NUHM): NUHM seeks to improve the health status of the urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary health care. NUHM would cover all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will be covered under NRHM.

Major initiatives under NRHM:

2.1.1 ASHA: More than 8.94 lakh community health volunteers called Accredited Social Health Activists (ASHAs) have been engaged under the mission to work as a link between the community and the public health system. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHA Programme is expanding across States and has particularly been successful in bringing people back to Public Health System and increase in the utilization of their out-patient services, diagnostic facilities, institutional deliveries and in-patient care.

2.1.2 Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society is a simple yet effective management structure. This committee is a registered society whose members act as trustees to manage the affairs of the hospital and is responsible for upkeep of the facilities and ensure provision of better facilities to the patients in the hospital. Financial assistance is provided to these Committees through untied fund to undertake activities for patient welfare. 31,109 Rogi Kalyan Samitis (RKS) have been set up involving the community members in almost all District Hospitals (DHs), Sub-District Hospitals (SDHs), Community Health Centres (CHCs) and Primary Health Centres (PHCs) till date.

2.1.3 The Untied Grants to Sub-Centres (SCs) has given a new confidence to our ANMs in the field. The SCs are far better equipped now with Blood Pressure measuring equipment, Hemoglobin (Hb) measuring equipment, stethoscope, weighing machine etc. This has facilitated provision of quality antenatal care and other health care services.

2.1.4 The Village Health Sanitation and Nutrition Committee (VHSNC) is an important tool of community empowerment and participation at the grassroots level. The VHSNC reflects the aspirations of the local

community, especially the poor households and children. Untied grants of Rs. 10,000 are provided annually to each VHSNC under NRHM, which are utilized through involvement of Panchayati Raj representatives and other community members in many states. Till date, 5.12 lakh VHSNCs have been set up across the country. In many states, capacity building of the VHSNC members with regards to their roles and responsibilities for maintaining the health status of the village is being done.

2.1.5 Health care service delivery requires intensive human resource inputs. There has been an enormous shortage of human resources in the public health care sector in the country. NRHM has attempted to fill the gaps in human resources by providing nearly 1.69 lakh additional health human resources to states including 7,659 GDMOs, 2,973 Specialists, 71,946 ANMs, 38,339 Staff Nurses etc. on contractual basis. Apart from providing support for health human resource, NRHM has also focused on multi skilling of doctors at strategically located facilities identified by the states e.g. MBBS doctors are trained in Emergency Obstetric Care (EmOC), Life Saving Anaesthesia Skills (LSAS) and Laparoscopic Surgery. Similarly, due importance is given to capacity building of nursing staff and auxiliary workers such as ANMs. NRHM also supports co-location of AYUSH services in health facilities such as PHCs, CHCs and DHs. A total of 12,357 AYUSH doctors have been deployed in the states with NRHM funding support.

2.1.6 Janani Suraksha Yojana (JSY) aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a government health facility. Since the inception of NRHM, 7.04 crore women have benefited under this scheme.

2.1.7 Janani Shishu Suraksha Karyakarm (JSSK): Launched on 1st June, 2011, JSSK entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. This marks a shift to an entitlement based approach. The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home and exemption from all kinds of user charges. Similar entitlements are available for all sick infants (up to 1 year of age) accessing public health institutions. All the 35 States and Union Territories are implementing this scheme. In 2012-13, Rs. 2107 crore was provided to states under JSSK and in 2013-14 more than Rs. 2000 crore has been approved for implementing the free entitlements under JSSK.

2.1.8 National Mobile Medical Units (NMMUs): Support has been provided in 418 out of 640 districts for 2127 MMUs under NRHM in the country. To increase visibility, awareness and accountability, all Mobile Medical Units have been repositioned as "National Mobile Medical Unit Service" with universal colour and design.

2.1.9 National Ambulance Services: NRHM has supported free ambulance services to provide patients transport in every nook and corner of the country connected with a toll free number. Over 16,000 basic and emergency patient transport vehicles have been provided under NRHM. Besides these, over 4,769 vehicles have been empanelled to transport patients, particularly pregnant women and sick infants from home to public health facilities and back. 28 states have set up a call centre for effective patient transport system.

2.1.10 Upto 33% of NRHM funds in High Focus States can be used for infrastructure development. Details of new construction and renovation/upgradation works undertaken across the country under NRHM are as follows:

Facility	New Construction		Renovation/ Upgradation	
	Sanctioned	Completed	Sanctioned	Completed
SC	23492	13150	17146	12053
PHC	1797	993	8802	4504
CHC	683	324	3117	1701
SDH	88	40	612	378
DH	94	41	811	510
Other*	709	160	849	654
Total	**26863**	**14708**	**31337**	**19800**

** These facilities are above SCs but below block level.*

2.1.11 In order to ensure that enhanced fund allocations to States/UTs and other institutions under the NRHM are fully coordinated, managed and utilized, Financial Management Group for NRHM (FMG-NRHM) has been set up.

2.1.12 Mainstreaming of AYUSH: Mainstreaming of AYUSH has been taken up by allocating AYUSH facilities in 8425 PHCs, 2374 CHCs, 324 DHs, 3715 health facilities above SC but below block level and 512 health facilities other than CHC at or above block level but below district level.

2.1.13 Mother and Child Tracking System: It is a name based tracking system, launched by the Government of India as an innovative application of information technology directed towards improving the health care service delivery system and strengthening the monitoring mechanism. MCTS is designed to capture information on and track all pregnant women and children (0-5 Years) so that they receive 'full' maternal and child health services and thereby contributes to the reduction in maternal, infant and child morbidity and mortality which is one of the goals of National Rural Health Mission.

MCTS relies heavily on information technology tools and techniques and promotes its usage by grass roots level health service providers and even by the beneficiaries at large. MCTS is a centralized web based application, which facilitates in real time entry of the information related to pregnant women and children and subsequent health care services provided to them. This tool also facilitates in generation of work plan for the field level health care service providers, to ensure timely and full range of services to them. MCTS employs mobile based SMS technology to alert health service providers and beneficiaries about the service delivery and for providing the due services on time. The system also facilitates with status note and actionable messages to policy makers, health managers and health administrators at different tiers of health care delivery system for necessary action on time.

A total of 2,06,77,184 pregnant women were registered in MCTS during 2013-14 as on 31st March, 2014, which indicates a registration of 69.43 % as against estimated number of pregnant women in 2013-14. A total of 1,64,10,571 children have been registered in MCTS during 2013-14 as on 31st March, 2014, which indicates a registration of 60.61% as against estimated number of infants in 2013-14.

2.2 NEW INITIATIVES

i. **Rashtriya Bal Swasthya Karyakram (RBSK):** This initiative was launched in February 2013 and provides for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability. In 2013-14, an allocation of over Rs. 1100 crore under NRHM for 11839 RBSK Mobile Health Teams and 225 Districts Early Intervention Centre have been approved.

ii. **Rashtriya Kishor Swasthya Karyakram (RKSK):** This is a new initiative, launched in January 2014 to reach out to 253 million adolescents in the country in their own spaces and introduces peer-led interventions at the community level, supported by augmentation of facility based services. This initiative broadens the focus of the adolescent health programme beyond reproductive and sexual health and brings in focus on life skills, nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse.

iii. **Mother and Child Health Wings (MCH Wings):** 100/50/30 bedded Maternal and Child Health (MCH) Wings have been sanctioned in public health facilities with high bed occupancy to cater to the increased demand for services. More than 28,000 additional beds have been sanctioned across 470 health facilities across 18 states.

iv. **Free Drugs and Free Diagnostic Service:** Extremely high out of pocket expenditure on health care due to high cost of drugs and diagnostics have proved to be a deterrent in provision of accessible and affordable healthcare for all. To address this, Ministry introduced an incentive to the extent of 5% of the state's Resource Envelope under NRHM for those states that implemented free essential drugs scheme for

all patients accessing public health facilities. Under the National Health Mission - Free Drug Service Initiative and Free Diagnostics Service Initiative, substantial funding is being provided to state that implement these initiatives. States notifying policy for provision of free essential drugs and/or diagnostics to all patients accessing public health facilities, creates a robust procurement, logistics & supply chain system that is IT backed, has differential facility wise Essential Drug List/Diagnostic List depending on the nature of the facility, has sound drug regulatory and quality assurance system, Standard Treatment Guidelines and provides for prescription audits to ensure rational use of drugs.

In 2012-13, Rs. 1540 crore was provided under NHM to states to support free drugs alone. In 2013-14, this support is about Rs. 2000 crore.

v. **National Iron+ Initiative** is another new initiative to prevent and control iron deficiency Anaemia, a grave public health challenge in India. Besides pregnant women and lactating mothers, it aims to provide IFA supplementation for children, adolescents and women in reproductive age group. Weekly Iron and Folic Acid Supplementation (WIFS) for adolescents is an important strategy under this initiative. The operational guidelines for the same were unveiled in February 2013. WIFS (10-19 years) has already been rolled out in 32 States and UTs under the National Iron Plus Initiative. WIFS covered around 3 crore beneficiaries in December 2013.

vi. **Reproductive, Maternal, Newborn, Child and Adolescent Health Services (RMNCH+A):** A continuum of care approach has now been adopted under NRHM with the articulation of strategic approach to Reproductive Maternal, Newborn, Child and Adolescent health (RMNCH+A) in India. This approach brings focus on adolescents as a critical life stage and linkages between child survival, maternal health and family planning efforts. It aims to strengthen the referral linkages between community and facility based health services and between the various levels of health system itself.

vii. **Delivery Points (DPs):** Health facilities that have a high demand for services and performance above a certain benchmark have been identified as "Delivery Points" with the objective of providing comprehensive reproductive, maternal, newborn, child and adolescent health services (RMNCH+A) services at these facilities. Funds have been allocated to strengthen these DPs in terms of infrastructure, human resource, drugs, equipments etc. Around 17,000 health facilities have been identified as "Delivery Points" for focused support under NRHM.

viii. **Universal Health Coverage (UHC):** Moving towards Universal Health Coverage (UHC) is a key goal of the 12th Plan. The National Health Mission is the primary vehicle to move towards UHC. India has charted a path that depends largely on provision of affordable, quality health care by the public health system as its main form of social protection, with supplementation from the private sector to close gaps. UHC pilot projects would be supported in at least one district of each state. Guidelines of the same have been issued to the states along with essential service package. The pilots are expected to demonstrate how access to care and social protection against the costs of care can be meaningfully expanded in the most cost effective manner, while at the same time reducing health inequity.

ix. **Mother and Child Tracking Facilitation Centre (MCTFC):** MCTFC has been operationalized from National Institute of Health and Family Welfare (NIHFW). It is being operated by 80 Helpdesk Agents (HAs). It will validate the data entered in MCTS in addition to guiding and helping both the beneficiaries and service providers with up to date information on Mother and Child Care services through phone calls and Interactive Voice Response System (IVRS) on a regular basis. MCTFC will create awareness about Government mother and child health related programmes and seek feedback on services being provided.

In addition, a module has been provided in the Mother and Child Tracking System (MCTS) portal

so that States / UTs may utilise it to make calls for validation of MCTS data, getting feedback and raising awareness.

x. **Quality Assurance (QA):** The present strategy is shift in focus from fragmented approach of different quality systems to one comprehensive approach of Quality Assurance. Based on best practices of existing quality system such as NABH, ISO, JCI and other scientific literature, comprehensive operational guidelines on Quality Assurance has been launched wherein National Quality Assurance standards have been published. The road map for QA envisages development of a robust institutional mechanism within the states to make States self- sufficient and to have more sustainable system than existing systems. A total of 8 major areas of concerns- Service provision, Patient right, Inputs, Support Services, Clinical Services, Infection Control, Quality Management and Outcome have been identified. Standards have been developed for each area of concern and detailed checklist has been laid down to ensure conformance to these standards. All Public Health Facilities would be assessed, and Quality scored in a phased manner. Besides clinical care, due weightage has been given to issues of patients' right, confidentiality, privacy, compliance to National Health Programme Guidelines, cleanliness at health facilities, etc. The facilities having a credible system of quality assurance (verified through district & state assessment) would be assessed for National Level Certification. On successful attainment of the National certification, facilities would be given incentives and QA certification.

xi. **ASHA Certification:** A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment has been approved recently. The certification of ASHAs would be done by National Institute of Open Schooling (NIOS). The following components of the programme, namely, the Training curriculum, State Training Sites/District Training Sites, Trainers and ASHAs and ASHA Facilitators would be taken up for accreditation/certification. The Certification of ASHAs and accreditation of associated agencies involved in ASHA Training is intended to enhance competency and professional credibility of ASHAs, improve the quality of training and ensure desired programme outcomes, provide an assurance to the community on the quality of services being provided by the ASHA besides promoting a sense of self recognition and worth for ASHAs.

xii. **NGO Guidelines:** Guidelines for NGO involvement under NHM during Twelfth Five Year Plan have been issued recently. The new guidelines envisage greater state ownership for NGO led programmes and are intended to provide a broad framework to the States to partner with NGOs and facilitate their participation in capacity building, support for community processes service delivery, develop innovations through research and documentation, advocacy, and for supplementing capacities in key areas of the public health system to improve health care service delivery.

2.2.1 Progress under National Rural Health Mission (NRHM)(Status as on 30.06.2013)

ASHAs

- 8.89 lakh Accredited Social Health Activists (ASHAs) have been selected in the country, of which over 8.25 lakh received training upto 1st Module, 7.96 lakh upto Module II, 7.92 lakh upto Module III, 7.84 lakh upto Module IV, 7.63 lakh up to Module V, 5.12 lakh in round 1 & 3.34 lakh in round 2 & 1.41 lakh in round 3 & 1.06 lakh in round 4 of VI & VII Module.
- Over 8.06 lakh ASHAs have been positioned after training and have been provided with drug kits.

Infrastructure

- 63 District Hospitals (DHs), 451 Community Health Centers (CHCs), 1594 Primary Health Centers (PHCs), and 21,524 Health Sub-Centers have been taken up for new construction.

Construction work of 35 DHs, 287 CHCs, 936 PHCs and 12,068 SCs has been completed.

- 471 District Hospitals, 2,394 Community Health Centers (CHCs), 4,649 Primary Health Centers and 16,454 Health Sub-Centers have been taken up for upgradation/renovation, out of which upgradation/renovation of 264 DHs, 1,289 CHCs, 3,125 PHCs and 11,451 SCs has been completed.
- 8,236 PHCs are made functional round the clock (24X7) and 2,641 facilities were operationalized as First Referral Units (FRUs).
- All 1.48 lakh Sub Centers (RHS 2012) in the country have been strengthened with untied funds of Rs. 10,000 and AMG of Rs. 10,000 each.

Manpower

- 8,129 Doctors, 11,925 AYUSH Doctors, 2,007 Specialist, 70,608 ANMs, 34,605 Staff Nurses, 13,725 Paramedics and 4,785 AYUSH Paramedics have been appointed on contract by States to fill in critical gaps under NRHM.

Management Support

- District Programme Management Unit has been established in 654 districts, 589 District Programme Manager and 610 District Accountant are in position.
- Nearly, 5,352 Block Programme Management Unit has been established with 3,526 Block Managers in position to support the health system at blocks and below levels.

Mobile Medical Units

- 2,028 Mobile Medical Units (MMUs) are operational in different States, providing services in the interior areas covering 427 districts.

Institutional Delivery

- Janani Suraksha Yojna (JSY) is operationalized in all the States, 7.38 lakh women are benefited in the year 2005-06 and 106.57 lakh in the year 2012-13. 19.57 lakh women received benefits in the year 2013-14 upto June 2013.

Convergence

- Over 64.7 lakh VHNDs were organized in 2012-13 and 12.9 lakh VHNDs were organized in 2013-14 in the villages across the country.
- The States have constituted 5,11,670 Villages Health Sanitation & Nutrition Committees that facilitate convergence with ICDS/Drinking Water/ Sanitation and PRIs. They are also being involved in dealing with disease outbreak.
- Rogi Kalyan Samitis (RKSs) have been registered in 31,358 Health facilities (722 District Hospitals, 4,922 CHCs, 1,048 facilities other than CHCs above block level, 18,685 PHCs and 5,981 facilities above SC and below block level).

Training

- Training in critical areas including Life Saving Anesthesia Skills (LSAS), BEmoC (Basic Emergency Obstetric Care), FBNC, F-IMNCI and NRC and No Scalpel Vasectomy (NSV) etc has been taken up for MOs. Skill Development Training including training on SBA, IMNCI and NSSK has been taken up for ANMs. Similarly, IMNCI, F-IMNCI, NSSK, FBNC etc. have been taken up for the Staff Nurses. Professional Development Programme for CMOs is also on full swing.
- Upgradation of ANM Schools is being supported.

Health Resource Centers

- National Health System Resource Center (NHSRC) has been set up at the National level.
- A Regional Resource Center has been set up in Guwahati for NE.
- State Resource Centre is being set up in many states.

Monitoring and Evaluation

- *Annual Common Review Mission-:* So far 6 Common Review Missions have been undertaken.
- *Joint Review Mission (JRM)-:* So far 8 JRM were held focusing on maternal and child health.

- *Financial & Physical Monitoring System-:* A Quarterly Financial & Physical Monitoring System has been instituted at national level to monitor the implementation of the Mission.
- *Concurrent Evaluation-:* A Concurrent evaluation study was done by International Institute for Population Studies (IIPS) on NRHM.
- *District Level Vigilance & Monitoring Committee (DLVMC) -:* States have been asked to constitute these committees at district level to monitor the implementation of the Mission.

Free Drugs Service

- Extremely high out of pocket expenditure on health care due to high cost of drugs and diagnostics have proved to be a deterrent in provision of accessible and affordable healthcare for all. To address this, Ministry introduced an incentive last year to the extent of 5 % of the State's Resource Envelope if the state implemented free essential drugs scheme for all patients coming to public health facilities. 28 States/UTs have so far notified Free Drugs policy.
- Further, it has also been decided to provide substantial support for implementing the Free Drugs initiative under the "NHM-National Free Drugs Service" provided the State meets the following requirements:

  a. It notifies or has a clearly notified policy of providing free essential drugs to all patients coming to public health facilities, at least upto district hospital level.

  b. It creates a robust procurement, logistics & supply chain system that is IT backed.

  c. It has a differential facility wise Essential Drug List/ Diagnostic List depending on the nature of the facility.

  d. It has a sound drug regulatory and quality assurance system.

  e. It sets up prescription audit system.

2.3 NATIONAL URBAN HEALTH MISSION (NUHM) (NEW SCHEME)

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

NUHM would endeavour to achieve its goal through:-

- Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.
- Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.
- Availability of resources for providing essential primary health care to urban poor.
- Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers.

The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim

and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10. The Programme Implementation Plan (PIPs) sent by the states are appraised and approved by the Ministry.

In the 12th Plan an allocation of Rs. 15,143 crores has been made for National Urban Health Mission.

2.4 HEALTH POLICY

The National Health Policy (NHP) of 2002 guides the strategy adopted by the Government for the health sector. The NHP 2002 evolved from the National Health Policy of 1983. Guidance was provided by the Bhore Committee Report (1946) wherein the main underlying principles for future health development of the country inter-alia included that "No individual should fail to secure adequate medical care because of inability to pay for it. In view of the complexity of modern medical practice, the health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment." Policy directions of the 'Health for All Declaration' at Alma Ata in 1978 became the stated policy of Government of India with adoption of the National Health Policy Statement of 1983. The Report of the Macro Economic Commission on Health and Development 2005 contributed further to the policy direction and roadmap of the Government.

Some of the salient aspects of the NHP 2002, inter-alia, include: making good the deficiencies in availability of health facilities, narrowing the gap between various states as also the gap across the rural urban divide in attainment of health goals and reducing the uneven access to and benefits from the public health system between the better endowed and the more vulnerable sections of society. Accordingly consistent with the primacy given to equity a marked emphasis has been provided for expanding and improving the primary health facilities. Emphasis has been laid on the implementation of public health programmes through local self-Governments. The need to ensure improved standard of medical education, alleviate the shortage of specialists in Public Health and Family Medicine, need for an improvement in the ratio of nurse vis-à-vis doctors/beds, the need for basing treatment regimens on a limited number of essential drugs of a generic nature and progressively strengthening the food and drugs administration are among the various aspects emphasized in the policy.

The Five Year Plans outline the strategy for implementing the policy, bearing in mind the dynamics of a developing economy. Accordingly, the Twelfth Five Year Plan for the health sector envisages transformation of the National Rural Health Mission into a National Health Mission covering both rural and urban areas. It envisages providing public sector primary care facilities in selected low income urban areas, expansion of teaching and training programmes for health care professionals particularly in the public sector institutions giving greater attention to public health, strengthening the drug and food regulatory mechanism, regulation of medical practice, human resource development, promoting information technology in health and building an appropriate architecture for Universal Health Care. The Twelfth Plan strategy is to strengthen initiatives taken in the Eleventh Plan to further expand the reach of health care with focus on vulnerable and marginalized sections of population and therefore, envisages substantial expansion and strengthening of the public health systems and provision of robust primary health care.

2.5 NATIONAL COMMISSION ON POPULATION

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

The first meeting of the Commission was held on 23.07.2000 and the then Hon'ble Prime Minister had announced the formation of an Empowered Action Group within the Ministry of Health and Family Welfare

for paying focused attention to States with deficient national socio-demographic indices and establishment of National Population Stabilization Fund [Jansankhya Sthirata Kosh] to provide a window for canalizing monies from national voluntary sources to specifically aid projects designed to contribute to population stabilization.

2.5.1 Annual Health Survey (AHS)

The first round of Annual Health survey (AHS) was got conducted by the Ministry of Health & Family Welfare through the Office of Registrar General of India, during 2010-11 in 284 districts of 8 Empowered Action Group (EAG) States namely Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Odisha and Assam.

Key results on some of the AHS indicators have been released in the form of State wise Bulletins by the Office of RGI on 10-08-2011, which contain district level data on Crude Birth Rate, Crude Death Rate, Infant Mortality Rate, Neo-Natal and Post Neo-Natal Mortality Rate, Under 5 Mortality Rate, Sex Ratio at birth, Sex Ratio (0-4 years) and overall sex Ratio. In addition, the Maternal Mortality Ratio has also been released for a group of districts in each of the State.

The Survey was conducted during 2010-11; the reference period for the data is 2007-09.

2.5.2 Expert Groups

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

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

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

The second meeting of the Commission was held on 21st October 2010 adopted the following resolution with broad consensus recommending the key points for the stakeholders as follows:

➢ **According Priority**

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

➢ **Programmatic Interventions**

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

➢ **Inter - sectoral Co-ordination**

- Ministries of HRD, WCD and Panchayati Raj

should be actively involved in population stabilization programmes.

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

➢ **Other Interventions**

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

2.6 JANSANKHYA STHIRATA KOSH (JSK)

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

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

PRERNA Strategy:

In order to help push up the age of marriage of girls and space the birth of children in the interest of health of young mothers and infants, Jansankhya Sthirata Kosh (National Population Stabilization Fund)has launched PRERNA, a *Responsible Parenthood Strategy* in seven focus states namely Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha, and Rajasthan.

The strategy recognizes and awards couples who have broken the stereotype of early marriage, early childbirth and repeated child birth and have helped change the mindsets of the community.

In order to become eligible for award under the scheme, the girl should have been married after 19 years of age and given birth to the first child after at least 2 years of marriage. The couple will get an award of Rs.10,000/- if it is a Boy child or Rs.12,000/- if it is a Girl child. If birth of the second child takes place after at least 3 years of the birth of first child and either parent voluntarily accept permanent method of family planning within one year of the birth of the second child, the couple will get an additional award of Rs.5,000/- (Boy child) / Rs.7,000/- (Girl child). The amount of award is given in the form of National Saving Certificate (NSC). The scheme is meant only for BPL families.

The strategy has been identified and awarded 244 couples till September, 2013 from districts of Bihar, MP and Chhattisgarh. Many more awaiting for award in the financial year 2013-14.

SANTUSHTI Strategy:

Santushti is a strategy of Jansankhya Sthirata Kosh (JSK) for high populated States of India viz Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh & Odisha. Under this strategy, Jansankhya Sthirata Kosh, invites private sector gynecologists and vasectomy surgeons to conduct operations in Public Private Partnership mode.

According to this Scheme, an accredited private Nursing Home/Hospital can sign a tripartite (State Health Society as 1st party, accredited private health facility 2nd party

while JSK is third party) MoU with JSK. Upon signing the MoU Pvt. Hospitals/Nursing Home shall be entitled for incentive, whenever it conducts 10 or more Tubectomy/Vasectomy cases in a month.

Requisites for the strategy:

- Accredited Private Hospitals/Nursing Homes, who conduct 10 or more Tubectomy (Female Sterilization) and Vasectomy (Male Sterilization) operations in a month, are eligible for payment under Santushti Strategy.
- Private facilities conforming to the aforesaid criteria are entitled to claim Rs.1500/- per case from NRHM funds while an additional amount of Rs. 500/- per case will be paid by JSK.
- JSK will also pay wage compensation to the clients undergoing sterilisation operation equal to the sum paid to them in the public facility. i.e. Rs.600/-for Tubectomy and Rs 1100/- for Vasectomy clients.

Type of Service	Type of facility	Incentive to the Providers by JSK (Rs.)	Wage compensation to the beneficiaries provided by JSK (Rs.)	Amount from NRHM Fund (Rs.)
Tubectomy	Private	500/-	600/-	1500/- (includes Motivation money)
Vasectomy	Private	500/-	1100/-	1500/- (includes Motivation money)

- All the reputed NGOs working in the state are eligible to participate in the Scheme if they full-fill the requisite criteria for quality assurance.
- NGOs are also permitted to utilize infrastructure of PHCs, CHCs for related activities as many of these facilities have good infrastructure but are not optimally utilized due to lack of manpower.

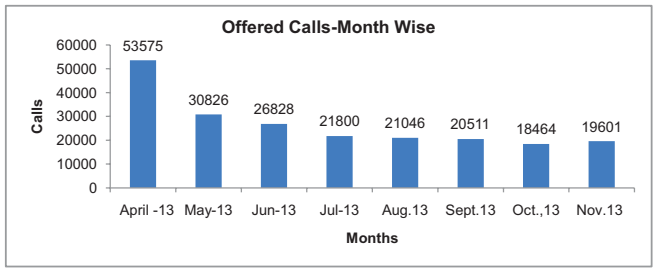
Total no. of 7757 cases has been sterilized till November, 2013 from Rajasthan under the strategy.

2.6.1 National Helpline- Toll Free (1800-11-6555)

Jansankhya Sthirata Kosh initiated a first of its kind National Helpline in India on Reproductive, Sexual Health, Family Planning and Infant and Child Health etc.

The aim of National Helpline is to provide reliable information on reproductive health, sexual health, contraception, pregnancy, child health and related issues. It is specifically for adolescents, newly married and about to be married persons from the high focus States of Bihar, U.P. Rajasthan, Madhya Pradesh, Jharkhand and Chhattisgarh.

Till 30 November, 2013 approximately 2,12,612 calls have been offered from entire country. The maximum numbers of queries being received are on issues related to contraception, pregnancy, sexual health and infertility. Month-wise break-up of these calls are as under:



2.6.2 World Population Day 2013

As part of its awareness and advocacy efforts on population issues, Jansankhya Sthirata Kosh (JSK) organized a series of advocacy events on the occasion of the World Population Day on 11th July, 2013. Walk towards Population Stabilization which was flagged off by Hon'ble Union Minister of Health and Family Welfare. Over 2000 youth from various schools of Delhi, students from Medical Colleges and several other organisations were in the walk to endorse their support for the cause of population stabilisation. The "Walk" was an effort to build momentum and raise awareness around issues like low female literacy, early age at marriage and early child besides among a host of other challenges to be dealt with to address the issue of population stabilisation. Carrying placards with slogans supporting the cause of population stabilisation, everyone joined to advocate for the cause.

2.6.3 Geographical Information System (GIS)Mapping

As part of this initiative, JSK mapped 450 districts in India through a unique amalgamation of Geographical Information System (GIS) maps and Census data in 2006. The mapping gives a picture of each district, its sub-divisions and the population of every village along with the distance to the health facility. The maps highlight inequities in coverage down to the village to enable resources to be targeted where they are needed the most. These maps are being revised as per 2011 census.

2.6.4 Virtual Resource Centre

JSK has established a Virtual Resource Centre with regular updating which provides access to resource material like films, posters, photos on subjects like gender, maternal and infant mortality, declining sex ratio, adolescent health, spacing and other related issues. The material is hosted on JSK's website and is a useful resource for NGOs, schools, students, government bodies, medical colleges, Institutes of Public Health, universities, researchers and the media.

2.7 FAMILY PLANNING INDEMNITY SCHEME

As per the Hon'ble Supreme Court of India in its order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai v/s Union of India), the Family Planning Insurance Scheme (FPIS) was introduced w.e.f. 29th November, 2005 with Oriental Insurance Company to take care of the cases of failure of sterilization, medical complications or death resulting from sterilization, and also provide Indemnity Cover to the doctors/health facilities performing sterilization procedure.

With effect from 1st April,2013 it has been decided that States/UTs would process and make payment of claims to acceptors of sterilization in the event of death/ failures/complications /indemnity cover to doctors/health facilities. It is envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective State/UT Programme Implementation Plans (PIPs) under the National Rural Health Mission (NRHM) and the scheme may be renamed **"Family Planning Indemnity Scheme"**. The scheme is uniformly applicable for all States/UTs. A letter to that effect has already been sent to all States/ UTs vide No N.23011/68/2011-FW(Ply) dated 27th December, 2012.

The States/UTs may plan for the payment of compensation to sterilization acceptors as per the scheme, under Budget Head A.3.5.4 -Other Strategies/activities Sub-Head A.3.5.4.1.

Current Scheme (Part of State Programme Implementation Plans (PIPs) w.e.f. 1st April, 2013):

The available benefits under the Family Planning Indemnity Scheme are as under:

Section	Coverage	Limits
I A	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
I B	Death following sterilization within 8 - 30 days from the date of discharge from the hospital	Rs. 50,000/-
I C	Failure of sterilization	Rs 30,000/-
I D	Cost of treatment ***in hospital and*** **upto 60 days** arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge Actual not exceeding	Rs. 25,000/-
II	Indemnity per Doctor/ Health Facilities but not more than 4 in a year	Upto Rs. 2 Lakh per claim

A Comprehensive Manual for "Family Planning Indemnity Scheme" was launched in the "National Family Planning Summit" held on 3rd October, 2013 in New Delhi. The soft copy of the manual would soon be made available on the Ministry's website: www.mohfw.nic.in click www.nrhm.gov.in and then click http://nrhm.gov.in/nrhm-components/rmnch-a/family-planning/schemes.html

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

2.8.1 Adverse Child Sex-Ratio in India

The Child Sex Ratio (CSR) for the age group of 0-6 years as per the 2011 census (provisional) has dipped further to 919 girls as against 927 per thousand boys recorded in 2001 Census. This negative trend reaffirms the fact that the girl child is more at risk than ever before. Except for the States/ UTs viz.Puducherry (967), Tamil Nadu (943), Karnataka (948), Delhi (871), Goa (942), Kerala (964), Mizoram (970), Gujarat (890), Arunachal Pradesh (972), Andaman & Nicobar Islands (968), Himachal Pradesh (909), Haryana (834), Chandigarh (880) and Punjab (846), the CSR has shown a declining trend in 18 States and 3 UTs. The steepest fall of 79 points is in J&K and the largest increase of 48 points is in Punjab. (Appendix-I)

Jammu and Kashmir, Maharashtra and Haryana have had the worst 30 years decline in child sex ratios. Among the larger States, Chhattisgarh has the highest Child Sex Ratio (CSR) of 969 followed by Kerala with 964. Haryana (834) is at the bottom followed by Punjab (846). This census saw a declining trend even in North Eastern States expect Mizoram and Arunachal Pradesh. Half of the districts in the country showed decline in the CSR greater than national average. The number of districts with Child Sex Ratio of 950 and above has been reduced from 259 to 182.

2.8.2 Reasons for adverse Sex Ratio

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

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

2.8.3 Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

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

The technique of pre-conception sex selection has been brought within the ambit of this Act so as to preempt the use of such technologies, which significantly contribute to the declining sex ratio. Use of ultrasound machines has also been brought within the purview of this Act more explicitly so as to curb their misuse for detection and disclosure of sex of the foetus, lest it should lead to female foeticide. The Central Supervisory Board (CSB) constituted under the Chairmanship of Minister for Health and Family Welfare has been further empowered for monitoring the implementation of the Act. State level Supervisory Boards in the line of the CSB constituted at the Centre, has been introduced for monitoring and reviewing the implementation of the Act in States/UTs. The State/UT level Appropriate Authority has been made a multi member body for better implementation and monitoring of the Act in the States. More stringent punishments are prescribed under the Act so as to serve as a deterrent against violations of the Act. Appropriate

Authorities are empowered with the powers of Civil Court for search, seizure and sealing the machines, equipments and records of the violators of law including sealing of premises and commissioning of witnesses. It has been made mandatory to maintain proper records in respect of the use of ultrasound machines and other equipments capable of detection of sex of foetus and also in respect of tests and procedures that may lead to pre-conception selection of sex. The sale of ultrasound machines has been regulated through laying down the condition of sale only to the bodies registered under the Act.

2.8.4 Punishment under the Act

- Imprisonment up to 3 years and fine up to Rs. 10,000
- For any subsequent offences, he/she may be imprisoned up to 5 years and fine up to Rs. 50,000 / 1,00,000
- The name of the registered medical practitioner is reported by the Appropriate Authority to the State Medical Council concerned for taking necessary action including suspension of the registration if the charges are framed by the court and till the case is disposed of and on conviction, for removal of his name for a period of 5 years for the first offence and permanently for the subsequent offence.

2.8.5 Implementation of PC & PNDT Act in States/UTs

As per the Quality Progress Reports (QPRs) submitted by States/UTs 49998 bodies have been registered under the PC & PNDT Act. So far a total of 1682 machines have been sealed and seized for violations of the law. A total of 1945 ongoing court cases and 201 convictions have been secured under PC & PNDT Act and following the conviction the medical licenses of 97 doctors have been suspended/cancelled. (Appendix-II)

As a result of intensification of the drive against illegal sex determination, 288 cases has been filed in 2012-13, 279 in 2011-12 as compared to 157 in 2010-11.

PROGRESS CARD

	Cases	Convictions	Sealing	License cancellation/ suspensions
May 2011	869	55	409	-
Jan. 2012	1040	85	869	16
June 2012	1212	111	866	33
Jan. 2013	1327	111	989	33
July 2013	1521	116	1180	53
Sept. 2013	1833	143	1242	65

2.8.6 Recent steps taken by the Government of India

New Amendment to the 'Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996:

Government of India has recently notified several important amendments in Rules under the Act as mentioned below:

- Rule 11(2) has been amended to provide for confiscation of unregistered machines and punishment against unregistered clinics/facilities. Earlier the guilty could escape by paying penalty equal to five times of the registration fee.
- Rule 3B has been inserted with regard to the Regulation of portable ultrasound machines and Regulation of services to be offered by Mobile Genetic Clinic.
- Rule 3(3)(3) has been inserted restricting the registration of medical practitioners qualified under the Act to conduct ultrasonography in maximum of two ultrasound facilities within a district. Number of hours during which the Registered Medical Practitioner would be present in each clinic would be specified clearly.
- Rule 5(1) has been amended to enhance the Registration fee for bodies under Rule 5 of the PNDT Rules 1996 from the existing Rs. 3000/- to Rs. 25000/- for Genetic Counselling Centre,

Genetic Laboratory, Genetic Clinic, Ultrasound Clinic or Imaging Centre, and from Rs. 4000/- to Rs. 35000/- for an institute, hospital, nursing home, or any place providing jointly the service of a Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic, Ultrasound Clinic or Imaging Centre.

- Rule 13 has been amended mandating every Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre intimation every change of employee, place, address and equipment installed, to the Appropriate Authority 30 days in advance of the expected date of such change, and seek issuance of a new certificate with the changes duly incorporated.

The above two (3 & 5) recent amendents to PC & PNDT Rules have been challenged in various High Courts and the Supreme Court and the matter is sub-judice.

- Rules for six months training in Ultrasound for the MBBS Doctors have been notified vide GSR.14 E dated 10 January, 2014. The Rules include the training curriculum, criteria for accreditation of institutions and procedure for competency based evaluation test.
- Revised form F has been notified vide GSR 77 (E) dated 31st January 2014. The received format is more simplified as the invasive and non-invasive portions have been separated.
- Rules for Code of conduct for Appropriate Authorities has been notified vide GSR 119 (E) dated 24th February, 2014. Legal, monitoring, administrative and financial procedure have been explicitly laid down to facilitate appropriate authorities in the course of effective implementation of the PC & PNDT Act.

2.8.7 Monitoring and review of the implementation scaled up

i. Central Supervisory Board (CSB) under the PNDT Act has been reconstituted. The 18th, 19th, 20th and 21st meetings of CSB have been held at an interval of six months on 14th January, 2012, 20th July 2012, 16th January 2013 and 23rd July 2013. Important amendments to the PNDT Rules have been approved and notified.

ii. 14 states with the most skewed child sex ratio have been identified for concerted attention. A meeting of Health Secretaries of these States was convened on 20th April 2011. As the primary responsibility for implementing the Act rests with the states, they have been asked to take the following steps:

- Constitute State Supervisory Board, conduct its regular meetings and send quarterly progress report to the Central Supervisory Board as per the Act
- Notify District Collectors as District Appropriate Authority
- Constitute State Inspection and Monitoring Committees (SIMC)
- Identify districts with skewed Child Sex Ratio and focus on them
- Conduct regular surveys, update registrations and renewals to avoid multiple registrations
- Ensure analysis and scrutiny of Form -F (which provides detailed information on the pregnant woman and copy of which has to be sent to the District Appropriate Authority every month under the Act)
- Obtain regular information from ultrasound manufacturers regarding the sale of machines which is also mandatory as per the Act.
- Conduct workshops and training for judiciary and public prosecutors.
- Give training to appropriate authorities for building strong cases against offenders
- Strengthen inter-state coordination for regulating ultrasound clinics across borders.

iii. Directions given vide Order dated 04.03.2013 by the Hon'ble Supreme Court in the matter of WP (C) 349/2006 were communicated to the States/ UTs at the level of Health Minister to Chief Ministers and Chief Secretaries to ensure immediate compliance.

iv. Inspections by the National Inspection and Monitoring Committee (NIMC) have been scaled

up. Inspections have been carried out in 34 districts of 16 states including Gujarat, Uttar Pradesh, Rajasthan, Maharashtra, Madhya Pradesh, Delhi, Bihar, Odisha, Haryana, Punjab, Andhra Pradesh, Chhattisgarh, Uttarakhand, Himachal Pradesh, Karnataka, Jammu & Kashmir and Jharkhand. A total of 114 clinics were inspected and 45 clinics were sealed from August 2011 Sept. 2013. 23 cases have already been filed in court.

v. The intensification of the drive against sex determination through effective implementation of the Act is being reviewed regularly in State meetings. Five regional review workshops for North, West, Central, North-East and Southern regions have been organized to evaluate and review the progress of implementation of PC & PNDT Act in the country.

vi. Hon'ble Prime Minister of India has urged Chief Ministers of all states to provide personal leadership to reserve the declining trend in child sex ratio and address the neglect of the girl child through focus on education and empowerment.

vii. Considering that almost all states have shown declining trend in child sex ratio Minister of Health and Family Welfare has written to all states on 30th May, 2011, emphasizing the need to strengthen implementation of the Act and take timely steps to stop misuse of medical technology for illegal sex determination.

viii. Union Health Secretary has addressed all Chief Secretaries to take effective measures and regularly monitor implementation of the PNDT Act.

ix. A Ministerial meeting was held under the Chairpersonship of Minister of Health & Family Welfare with Health Ministers of States on 28th September, 2011 at New Delhi to strengthen effective implementation of the PC & PNDT Act.

x. Status of Implementation of PC & PNDT Act was included in the TORs of the Joint Review Mission (JRM), Common Review Mission (CRM) and Integrated Monitoring Visits for the current year so that teams can assess the situation on the ground.

2.8.8 Capacity building programme for all stake holders

- State level capacity building programme on enforcement of the Act has also been organized for district PNDT officers in the States of Rajasthan, Gujarat, West Bengal, Haryana, Kerala, Maharashtra, Uttar Pradesh and Bihar.
- Capacity building programmes for Judicial Officers and public prosecutors have been conducted in Chandigarh, Maharashtra, Uttar Pradesh, West Bengal, Andhra Pradesh, Gujarat and Rajasthan.
- The National workshop for State Appropriate Authorities and State Nodal Officers of PNDT was organized 27th & 29th Feb. 2012 by Ministry of Health & Family Welfare in collaboration with UNFPA. The 2nd National workshop was held 28th & 29th November, 2013 in Pune.

2.8.9 Other initiatives taken by MoHFW

- Four expert committees have been constituted under the chairmanship of Joint Secretary on the recommendation of Central Supervisory Board to look into the amendments to the PC & PNDT Act, simplification of Form-F, lay down code of conduct and to evolve regulatory mechanisms on sale & operations of USG machines.
- Medical Council of India has accepted the proposal to include a chapter on the issue of declining of Child Sex Ratio in the MBBS curriculum for the sensitizations of MBBS doctors.
- Medical Council of India has been directed to cancel registration of doctors convicted under the Act.
- PNDT has been Included under NRHM and states have been asked to take advantage of funding available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the Act. Rs. 2935.79 lakh and Rs.1731.56 lakh have been allocated under NRHM during 2012-13 and 2013-14 respectively.

- In addition to the Ministry's website, (www.mohfw.nic.in), an independent website, 'pndt.gov.in' for PNDT Division has been launched by the Minister for Health & Family Welfare. This website contains all the relevant information relating to the Act and the Rules.
- Minister for Health & Family Welfare launched the Toll Free Telephone (1800 110 500) to facilitate the public to lodge complaint anonymously, if so desired, against any violation of the provisions of the Act by any authority or individual and to seek PNDT related general information.

Appendix-I

Trend of child sex ratio in last three Censuses

S.No.	State/UT	1991	2001	Absolute Difference (1991-2001)	2001	2011	Absolute Difference (2001-2011)
1	Jammu & Kashmir	NA	941	NA	941	862	-79
2	Dadra & Nagar Haveli	1013	979	-34	979	926	-53
3	Lakshadweep	941	959	18	959	911	-48
4	Daman & Diu	958	926	-32	926	904	-22
5	Andhra Pradesh	975	961	-14	961	939	-22
6	Rajasthan	916	909	-7	909	888	-21
7	Nagaland	993	964	-29	964	943	-21
8	Manipur	974	957	-17	957	936	-21
9	Maharashtra	946	913	-33	913	894	-19
10	Uttaranchal	948	908	-40	908	890	-18
11	Jharkhand	979	965	-14	965	948	-17
12	Uttar Pradesh	927	916	-11	916	902	-14
13	Madhya Pradesh	941	932	-9	932	918	-14
14	Odisha	967	953	-14	953	941	-12
15	Tripura	967	966	-1	966	957	-9
16	Bihar	953	942	-11	942	935	-7
17	Sikkim	965	963	-2	963	957	-6
18	Chhattisgarh	974	975	1	975	969	-6
19	West Bengal	967	960	-7	960	956	-4
20	Meghalaya	986	973	-13	973	970	-3
21	Assam	975	965	-10	965	962	-3
22	Puducherry	963	967	4	967	967	0
23	Tamil Nadu	948	942	-6	942	943	1
24	Karnataka	960	946	-14	946	948	2
25	Delhi	915	868	-47	868	871	3
26	Goa	964	938	-26	938	942	4

27	Kerala	958	960	2	960	964	4
28	Mizoram	969	964	-5	964	970	6
29	Gujarat	928	883	-45	883	890	7
30	Arunachal Pradesh	982	964	-18	964	972	8
31	Andaman & Nicobar Islands	973	957	-16	957	968	11
32	Himachal Pradesh	951	896	-55	896	909	13
33	Haryana	879	819	-60	819	834	15
34	Chandigarh	899	845	-54	845	880	35
35	Punjab	875	798	-77	798	846	48
	INDIA	**945**	**927**	**-18**	**927**	**919**	**8**

Note: (-) shows negative sign

Appendix-II

Status of registration, cases and convictions under PC & PNDT Act (up to March, 2014)

S.No.	States/ UTs	No. of bodies registered	No. of on-going Court/ Cases	Machines Seized / Sealed	Convictions	No. of suspension/ cancellation of medical license
1	Andhra Pradesh	5003	52	132	0	0
2	Arunachal Pradesh	35	0	0	0	0
3	Assam	692	5	2	0	0
4	Bihar	1418	6	6	11	0
5	Chhattisgarh	656	7	0	0	0
6	Goa	155	18	1	0	0
7	Gujarat	4318	127	3	6	1
8	Haryana	1573	97	241	49	8
9	Himachal Pradesh	253	0	0	1	0
10	Jammu & Kashmir	300	6	72	1	0
11	Jharkhand	695	19	0	0	0
12	Karnataka	2878	45	0	0	0
13	Kerala	1548	0	0	0	0
14	Madhya Pradesh	1404	18	2	2	2
15	Maharashtra	9002	481	709	61	59

16	Manipur	77	0	0	0	0
17	Meghalaya	38	0	0	0	0
18	Mizoram	47	0	0	0	0
19	Nagaland	45	0	0	0	0
20	Odisha	685	24	6	3	0
21	Punjab	1400	127	0	28	4
22	Rajasthan	2199	578	384	37	21
23	Sikkim	24	0	0	0	0
24	Tamil Nadu	5494	77	72	0	0
25	Tripura	66	0	0	0	0
26	Uttarakhand	531	22	4	0	0
27	Uttar Pradesh	5248	154	34	1	0
28	West Bengal	2185	18	14	0	0
29	A & N. Island	10	0	0	0	0
30	Chandigarh	104	2	0	0	0
31	D. & N. Haveli	13	0	0	0	0
32	Daman & Diu	12	0	0	0	0
33	Delhi	1794	62	0	1	2
34	Lakshadweep	18	0	0	0	0
35	Puducherry	78	0	0	0	0
	TOTAL	**49998**	**1945**	**1682**	**201**	**97**

2.9 IMPROVEMENT IN THE QUALITY OF HEALTH CARE

The improvement in the status of health care over the years in respect of some of the basic demographic indicators is given in Table 1. The Crude Birth Rate (CBR) has declined from 40.8 in 1951 to 29.5 in 1991 and further to 21.6 in 2012. Similarly there was a sharp decline in Crude Death Rate (CDR) which has decreased from 25.1 in 1951 to 9.8 in 1991 and further to 7.0 in 2012. Also, the Total Fertility Rate (average number of children likely to be born to a woman aged 15-49 years) has decreased from 6.0 in 1951 to 2.4 in the year 2012 as per the estimates from the Sample Registration System (SRS) of Registrar General & Census Commissioner, India, Ministry of Home Affairs.

The Maternal Mortality Rate has also declined from 437 per one lakh live births in 1992 - 93 to 178 in 2010-12 according to the SRS Report brought out by RGI. Infant Mortality Rate, which was 110 in 1981, has declined to 42 per 1000 live births in 2012. Child Mortality Rate has also decreased from 57.3 in 1972 to 11.5 in 2012.

Table 1 : Achievements of Health & Family Welfare Programme

Sl. No.	Parameter	1951	1981	1991	2001	2012 (Latest available)
1	Crude Birth Rate (Per 1000 Population)	40.8	33.9	29.5	25.4	21.6
2	Crude Death Rate (Per 1000 Population)	25.1	12.5	9.8	8.4	7.0
3	Total Fertility Rate (Per women)	6.0	4.5	3.6	3.1	2.4
4	Maternal Mortality Rate (Per 100,000 live births)	NA	NA	437 (1992-93) NFHS	301 (2001-03) S.R.S.	178 (2010-12) S.R.S.
5	Infant Mortality Rate (Per 1000 live births)	146 (1951-61)	110	80	66	42
6	Child (0-4 years) Mortality Rate per 1000 children	57.3 (1972)	41.2	26.5	19.3	11.5

Source: Office of Registrar General & Census Commissioner, India, Ministry of Home Affairs.

Family Planning Methods

The total number of acceptors of different Family Planning methods enrolled in the country during 2013-14 was 26.88 million. **Table 2** below summarizes the position in regard to Family Planning achievements during 2013-14 and 2012-13 (April to March) at All India Level.

Table 2: Family Planning Acceptors by methods-All India

(Figures in millions)

Sl. No.	Methods	Achievement*	
		2013-14 (April 2013-March 2014)	2012-13 (April 2012-March 2013)
1.	Sterilisation	03.94	04.58
2.	IUD Insertions	05.00	05.41
3.	**Condom Users (Eq.)** i. Under Free Distribution Scheme (Equivalent) ii. Under Commercial Distribution scheme (Equivalent)	12.49$ 04.51 07.99	13.96$ 05.30 08.67
4.	**Oral Pill Users** i. Under Free Distribution Scheme ((Equivalent)) ii. Under Commercial Distribution Scheme (Equivalent)	05.44 03.02 02.42	06.24 03.09 03.15
	Total Acceptors	**26.88$**	**30.19**

Note: Data during the year 2013-14, decreased as compared to last year after Districts shifted to facility level reporting.
Source: HMIS Portal (Status as on 25th April, 2014)
**: Provisional figures*
Eq -Equivalent
$:-Total does not match due to round off.

Immunisation Performance for the year 2013-14 vis-à-vis 2012-13 is given in **Table 3**.

Table 3:Assessed Need of Immunisation and Achievement during 2013-14 vis-a-vis Achievement during 2012-13 under RCH Programme (All India)

(Figures in 000's)

Sl. No.	Activity	Assessed Need for 2013-14	Achievement*		% Achvt. of Assessed Need 2013-14
			2013-14	2012-13	
1	2	3	4	5	6
A.	**Immunisation**				
	i. Tetanus Immunisation for Expectant mothers	29576	23256	22739	78.6
	ii. DPT Immunisation for Children	25760	19072#	21383	74.0
	iii. Polio	25760	22802	22278	88.5
	iv. B.C.G.	25760	23626	23657	91.7
	v. Measles	25760	22505	22725	87.4
	vi. DT Immunisation for Children	23503	10854	10171	46.2
	Vii T.T. (10 Years)	24398	14326	14123	58.7
	viii T.T. (16 Years)	25573	13760	13559	53.8
B.	**Prophylaxis against nutritional anaemia among women**	29576	23331	21317	78.9
C.	**Prophylaxis against Blindness due to Vit. 'A' deficiency $**				
	i. 1st dose	25760	18292	17229	71.0
	ii. 5th dose	23883	15199	11723	63.6
	iii 9th dose	23520	13279	10151	56.5

** Provisional figures*
 # Decline due to introduction of Pentavalent vaccine
Source: HMIS Portal (Status as on 25th April, 2014)

2.10 HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Health Management Information System (HMIS) is a web-based Monitoring system that has been put in place by Ministry of Health and Family Welfare (MoHFW) to monitor its health programmes and provide key inputs for policy formulation and interventions.

It was launched in October 2008 and States / UTs were initially reporting district wise data on HMIS portal. To make HMIS more robust, effective and to facilitate local level monitoring, all States/UTs were requested to shift to "facility based reporting" from April, 2011. At present, 602 districts (out of 659) are reporting facility wise data while rest are uploading District Consolidated figure on the HMIS web portal. The data is being made available to various stakeholders in the form of standard & customized reports, factsheets, score-cards etc. HMIS data is widely used by the Central / State Government officials for monitoring and supervision purposes.

MoHFW is also conducting periodic review meetings, workshops, training etc. to discuss data quality,

conceptual issues and the latest developments including new reports, features available on the portal. To enhance the analytical capabilities of National and State level users, they have been provided SAS WRS and SAS-VDD software. The process to make the HMIS as GIS enabled is in progress.

2.10.1 National Health Portal (NHP)

In pursuance of recommendations of National Knowledge Commission (NKC), Ministry of Health and Family Welfare (MoHFW) has decided to set up and operationalize National Health Portal (NHP) which will provide easy access to health related information for various stake holders like common man, health professionals, academicians, Government Departments, etc. in Hindi, English and other major regional languages. The project is being implemented as a pilot project initially for a period of two years after which a decision on its continuation / ups-scaling will be taken by the Ministry. A Steering Committee for NHP (SCNHP) has been constituted to direct, advice and manages the NHP. Centre for Health Informatics (CHI) of the National Health Portal (NHP), one of the main entities under NHP, has been set up. Creation of other entities mentioned in the Detailed Project Report (DPR) is in process. Layout of NHP has been designed, some content has been created and the portal has been made live for beta testing since 15th November, 2013.

2.11 SURVEYS AND EVALUATION ACTIVITIES

2.11.1 Large Scale Surveys: The Ministry has been conducting large scale surveys periodically to assess the level and impact of health interventions. These surveys include National Family Health Survey (NFHS), District Level Household Survey (DLHS), Annual Health Survey (AHS) etc. The main aim of these surveys is to assess the impact of the health programmes and to generate various health related indicators at the District, State and National level.

2.11.2 District Level Household Survey: The District Level Household and Facility Surveys (DLHS) were initiated with a view to assess the utilization of services provided by health facilities and people's perception about the quality of services. DLHS -3 (2007-08), the third in the series of the district surveys was preceded by DLHS-1 in 1998-99 and DLHS 2 in 2002-04. DLHS is designed to provide district level estimates on important indicators on maternal and child health, family planning and other reproductive health services and important interventions of National Rural Health Mission (NRHM).

The fourth round of DLHS has been taken up with the objective of estimating reliable indicators of population, maternal & child health and family planning at District and State Level. As part of the Survey, a number of Clinical Anthropometric and Biochemical (CAB) tests are carried out to produce district level estimates for nutritional status and prevalence of certain life style disorders. The major constituents of the CAB component are height, weight and blood pressure, estimation of hemoglobin (Hb), blood sugar and test for iodine content in the salt used by households. The key survey results are expected to be available in May, 2014.

2.11.3 Annual Health Survey (AHS): Three rounds of Annual Health Survey (AHS) were approved for providing district level estimates on major programme indicators, besides estimates of impact indicators like Total Fertility Rate (TFR), Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR), Maternal Mortality Ratio (MMR), etc. Office of RGI is the nodal organisation for conducting AHS. Under the AHS, 284 districts in the nine States, i.e., Assam, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Odisha, Uttar Pradesh and Uttarakhand were covered. The AHS was conducted during 2010-11, 2011-12 and 2012-13 and the results are now available. Further, under the AHS, a separate component on Clinical, Anthropometric and Bio-chemical (CAB) tests has been introduced to collect data on height & weight measurement, blood test for anaemia and sugar, blood pressure measurement and testing of iodine in the salt used by households. Fieldwork of CAB component is under progress.

2.11.4 National Family Health Survey (NFHS): Three rounds of National Family Health Surveys were carried out in 1992-93 (NFHS-1), 1998-99 (NFHS-2) and 2005-06 (NFHS-3) under the stewardship of the

Ministry of Health and Family Welfare, Government of India, with the International Institute for Population Sciences (IIPS), Mumbai, serving as the nodal agency for conducting the survey. The Ministry has decided to integrate all surveys and to conduct one survey (i.e. National Family Health Survey) to provide district level data with a periodicity of three years. Accordingly, fourth round of the Survey (NFHS-4) will be conducted during 2014-15 to provide essential data up to district level on Health and Family Welfare. Three Committees have been constituted namely Steering Committee, Technical Advisory Committee (TAC) and Administrative & Financial Management Committee to facilitate decisions regarding policies, planning and procedure of the survey. The sampling design and questionnaire of this survey have been finalized and the selection of agencies for conducting field work is under progress.

2.11.5 Regional Evaluation Teams: There are 7 Regional Evaluation Teams (RETs) located in the Regional Offices of the Ministry which undertake evaluation of the NRHM activities including Reproductive and Child Health Programme (RCH) on a sample basis by visiting the selected Districts and interviewing the beneficiaries. These teams generally visit two adjoining districts in a state every month and see the functioning of health facilities and carry out sample check of the beneficiaries to ascertain whether they have actually received the services. Reports of the RETs are sent to the States/UTs for taking corrective measures on issues highlighted in the reports. During 2013-14, 86 districts were visited by the RETs.

2.12 POPULATION RESEARCH CENTRES (PRCS)

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

Annual Report of 18 PRCs along with the audited statement of accounts is laid on the table of both the Houses of Parliament.

2.13 NATIONAL HEALTH SYSTEMS RESOURCE CENTRE (NHSRC)

The National Health Systems Resource Centre (NHSRC) was set up in 2007, as a technical support and knowledge management agency for the National Rural Health Mission (NRHM), Ministry of Health and Family Welfare (MoHFW). NHSRC is committed to lead as a professionally managed technical support organization to strengthen public health systems and facilitate creative and innovative solutions to address the challenges that this task faces. The Regional Resource Center, North East (RRC-NE) a branch of the NHSRC serves as the technical support organization for the states of the North East.

Chapter 3

FUNDING FOR THE PROGRAMME

The stated aim of the National Health Policy in India is to provide universal access to quality health care and to achieve an acceptable standard of good health amongst the general population in the country. The approach is to increase access to the decentralized public health system by establishing new infrastructure in deficient areas and by upgrading the infrastructure in the existing institutions. The strategy focus is on increasing the aggregate public health investment enabled through a substantially increased contribution by the Central Government. In consonance with this objective, the 12th Plan has drawn a roadmap, to seamlessly integrate the primary, secondary and tertiary sectors in the Health system. As a part of the plan process, many different programmes were consolidated under the broad National Health Mission, which **inter-alia** consists of two sub missions, viz. National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). Funding pattern is through flexible pools, viz., NRHM-RCH Flexible Pool, NUHM Flexible Pool, Flexible pool for Communicable Diseases, Flexible Pool for Non-communicable Diseases, Injury and Trauma and Infrastructure maintenance schemes. The creation of these Pool Funds is envisaged to provide greater financial flexibility and distribute more efficiently the funds for the delivery of better health outcomes in the community.

In furthering the pursuit of better health outcomes in terms of reduction in the IMR, MMR and improvements in the life expectancy rate, etc., through improved efficiency, equity of access and quality of health services, the Five Year Plans have increased the allocations over the years in the health sector. The allocation for this sector has been substantially enhanced from Rs. 1,40,135.00 crores in the 11th Five Year Plan to Rs. 3,00,018.00 crores during the 12th Five Year Plan. The table below details the financial outlays and expenditure of Department of Health & Family Welfare for the 12th Five Year Plan (2012-17) and Plan Outlay for 2013-14.

Plan Period/ Year	Approved Plan Outlay (BE) (Rs. in crores)						Plan Expenditure (Rs. in crores)		
	Health	NRHM/ NHM	Health Research	AIDS Control	AYUSH	Total	Health	NRHM	Total
12th Plan (2012-17)	75145.29	193405.71	10029.00	11394.00	10044.00	300018.00	…	…	…
2012-13	6585.00	20542.00	660.00	1700.00	990.00	30477.00	8111.21	16970.50	25081.51
2013-14	8166.00	20999	726.00	1785.00	1069.00	32745.00	8609.72	18295.17	26904.89

Expenditure Figures reported for 2012-13 are provisional.

The scheme-wise break up of Plan and Non-Plan expenditure during 2012-13 and Budget Outlays 2013-14 for the Department of Health and Family Welfare is at Statement-I.

Statement-1

DEPARTMENT OF HEALTH AND FAMILY WELFARE
Scheme-wise Breakup of Actual Expenditure during 2012-13, Outlay for 2013-14 & Actual Expenditure during 2013-14

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
	HEALTH										
1	Directorate General of Health Services	CS	2.07	35.25	37.32	3.00	41.60	44.60	1.47	34.59	36.06
2	Directorate General of CGHS	CS	...	...	...	...	1.50	1.50	0.00	0.67	0.67
3	National Medical Library	CS	1.04	2.00	3.04	27.75	4.25	32.00	16.82	2.63	19.45
4	Central Government Health Scheme	CS	73.89	752.23	826.12	89.92	689.00	778.92	77.58	753.01	830.59
	Hospitals & Dispensaries										
5	Safdarjung Hospital, New Delhi	CS	225.54	209.31	434.85	330.00	235.64	565.64	293.00	242.68	535.68
6	Dr. Ram Manohar Lohia Hospital, New Delhi	CS	168.34	143.63	311.97	240.55	162.50	403.05	155.51	173.32	328.83
7	Central Institute of Psychiatry, Ranchi	CS	25.32	30.59	55.91	50.00	31.00	81.00	21.76	28.72	50.48
8	All India Institute of Physical Medicine and Rehabilitation, Mumbai	CS	4.76	9.79	14.55	16.00	10.50	26.50	4.74	11.54	16.28
9	Kalawati Saran Children's Hospital, New Delhi	CS	24.31	27.89	52.20	38.50	33.50	72.00	29.95	29.98	59.93
10	Medical Treatment of CGHS Pensioners	CS	0.00	865.87	865.87	...	725.00	725.00	0.00	972.35	972.35
	Total- Hospitals & Dispensaries		***448.27***	***1287.08***	***1735.35***	***675.05***	***1198.14***	***1873.19***	***504.96***	***1458.59***	***1963.55***
	Medical Education Training & Research										
11	Vallabh Bhai Patel Chest Institute, Delhi University	CS	7.58	22.12	29.70	16.90	25.60	42.50	13.75	25.90	39.65

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
12	Cancer Research & Tobacco Control	CSS	13.99	10.20	24.19	100.00	17.00	117.00	52.15	15.86	68.01
	(a) Chittaranjan National Cancer Institute, Kolkata	CSS	4.75	10.20	14.95	50.00	17.00	67.00	27.94	15.86	43.80
	(b) Tobacco Control	CSS	9.24	0.00	9.24	50.00	…	50.00	24.21	0.00	24.21
13	Lady Hardinge Medical College & Smt. Sucheta Kripalani Hospital, New Delhi	CS	74.85	123.54	198.39	195.00	134.50	329.50	74.40	144.37	218.77
14	All India Institute of Medical Sciences (AIIMS), New Delhi	CS	470.00	788.70	1258.70	550.00	790.00	1340.00	485.00	870.00	1355.00
15	National Institute of Mental Health & Neuro-Sciences, Bengaluru	CS	109.00	86.41	195.41	132.80	100.00	232.80	132.80	104.98	237.78
16	All India Institute of Speech & Hearing, Mysore	CS	18.78	10.14	28.92	81.14	13.50	94.64	41.51	12.41	53.92
17	Post Graduate Institute of Medical Education & Research, Chandigarh	CS	118.23	415.00	533.23	200.00	435.00	635.00	150.00	484.50	634.50
18	Jawaharlal Institute of Post Graduate Medical Education & Research, Puducherry	CS	118.11	130.99	249.10	160.00	185.00	345.00	151.83	188.50	340.33
19	Kasturba Health Society, Wardha	CS	43.50	0.00	43.50	50.00	...	50.00	50.00	0.00	50.00
20	Vardhman Mahaveer Medical College, New Delhi	CS	8.86	0.00	8.86	9.50	...	9.50	10.25	0.00	10.25
21	Dr. Ram Manohar Lohia PG Institute of Medical Education & Research, New Delhi	CS	11.53	0.00	11.53	30.00	...	30.00	13.60	0.00	13.60
22	Establishment of AIIMS Type Super Speciality Hospitals-cum-Teaching Institutions and Upgrading of State Govt. Hospitals(PMSSY)	CS	989.04	0.00	989.04	1975.00	...	1975.00	1268.75	0.00	1268.75

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
23	Other Educational Institutions	CS	2.16	8.42	10.58	43.65	10.60	54.25	2.58	8.86	11.44
	(i) Rajkumari Amrit Kaur (RAK) College of Nursing , New Delhi	CS	0.80	6.08	6.88	10.00	6.50	16.50	0.93	6.28	7.21
	(ii) Grants to Medical Council of India	CS	0.00	0.00	0.00	1.10	0.30	1.40	0.50	0.00	0.50
	(iii) Lady Reading Health School and RC Lohia Infant Welfare Centre	CS	0.48	1.61	2.09	1.05	2.70	3.75	0.52	1.62	2.14
	(iv) Grants to National Academy of Medical Sciences, New Delhi	CS	0.63	0.50	1.13	1.10	0.55	1.65	0.63	0.56	1.19
	(v) Grants to National Board of Examinations	CS	0.25	0.00	0.25	30.00	0.00	30.00	0.00	0.00	0.00
	(vi) Grants to Dental Council of India	CS	0.00	0.10	0.10	0.00	0.20	0.20	0.00	0.20	0.20
	(vii) Grants to Pharmacy Council of India	CS	0.00	0.13	0.13	0.00	0.20	0.20	0.00	0.20	0.20
	(viii) Grants to Indian Nursing Council	CS	0.00	0.00	0.00	0.40	0.15	0.55	0.00	0.00	0.00
24	Human Resources for Health		398.28	0.00	398.28	1023.30	0.00	1023.30	42.67	0.00	42.67
	(i) Upgradation/Strengthening of Nursing Services	CSS	192.04	0.00	192.04	177.70	...	177.70	11.75	0.00	11.75
	(ii) Strengthening/Upgradation of Pharmacy Schools/ Colleges	CSS	...	...	...	4.45	...	4.45	…	…	…
	(iii) Strengthening/Creation of Paramedical Institutions(RIPS/NIPS)	CSS	21.22	0.00	21.22	177.71	...	177.71	0.00	0.00	0.00
	(iv) District Hospitals - Upgradation of State Govt. Medical Colleges (PG Seats)	CSS	185.02	0.00	185.02	231.02	...	231.02	30.92	0.00	30.92
	(v) Strengthening of Govt. Medical Colleges(UG Seats) and Central Govt. Health Institutions	CSS	...	...	...	266.57	...	266.57	0.00	0.00	0.00

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
	(vi) Establishing New Medical Colleges (Upgradation of District Hospitals)	CSS	...	...	...	124.40	...	124.40	0.00	0.00	0.00
	(vii) Setting up of State Institutions of Paramedical Sciences in States and setting up of College of Paramedical Education	CSS	...	...	...	17.77	...	17.77	0.00	0.00	0.00
	(viii) Setting up of College of Pharmacy in Govt. Medical Colleges	CSS	...	...	...	23.68	...	23.68	0.00	0.00	0.00
	Total-Medical Education Training & Research		***2383.91***	***1595.52***	***3979.43***	***4567.29***	***1711.20***	***6278.49***	***2489.29***	***1855.38***	***4344.67***
	Public Health										
25	Port/Airport Health Organisations/ Establishments (including De-ratisation of Ships)	CS	0.90	18.19	19.09	21.00	24.00	45.00	1.17	18.41	19.58
26	TB/Leprosy Training Institutes	CS	6.31	21.10	27.41	9.60	25.05	34.65	6.53	22.17	28.70
	(i) National Tuberculosis Institute, Bengaluru		2.26	7.06	9.32	2.65	7.95	10.60	1.28	8.05	9.33
	(ii) Central Leprosy Training & Research Institute Chengalpattu (Tamil Nadu)	CS	0.72	8.78	9.50	2.25	9.90	12.15	1.05	9.27	10.32
	(iii) Regional Leprosy Training and Research Institute, Aska(Odisha)	CS	0.05	2.25	2.30	0.30	3.00	3.30	0.07	2.11	2.18
	(iv) Regional Leprosy Training and Research Institute, Raipur (Chhattisgarh)	CS	0.34	3.01	3.35	0.70	4.20	4.90	0.58	2.74	3.32
	(v) Regional Leprosy Training and Research Institute, Gouripur (West Bengal)	CS	2.94	0.00	2.94	3.70	…	3.70	3.55	0.00	3.55

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
27	Development of Nursing Services	CS	7.91	0.00	7.91	20.00	...	20.00	4.68	0.00	4.68
28	National Institute of Communicable Diseases (National Centre for Disease Control), New Delhi	CS	10.62	21.27	31.89	18.00	27.00	45.00	11.27	23.46	34.73
29	National Mental Health Programme	CSS	51.91	0.00	51.91	133.28	...	133.28	6.32	0.00	6.32
30	Prevention of Food Adulteration (including Project of Feasibility Testing Scheme of Vitamins and Mineral Fortification of Staple Food)	CS	42.46	0.11	42.57	133.87	0.35	134.22	67.71	1.49	69.20
31	Central Drugs Standard Control Organisation (a) Indian Pharmacopeia Commission (b) National Pharmacovigilance Programme (c) Strengthening of State Drug Regulatory Authority	CS/CSS	27.63	17.37	45.00	239.86	22.50	262.36	54.70	19.09	73.79
32	Manufacture of Sera & Vaccine (a) Pasteur Institute of India, Coonoor (b) Integrated Vaccine Complex, Chengalpattu & Medi Park (c) B.C.G. Vaccine Laboratory, Guindy, Chennai	CS	184.31	6.53	190.84	187.86	10.00	197.86	70.78	6.58	77.36
33	Public Health Laboratories (a) Central Research Institute, Kasauli (b) Institute of Serology, Kolkata (c) National Institute of Biologicals, Noida (U.P.)	CS	20.82	32.55	53.37	45.85	40.50	86.35	29.44	31.25	60.69
34	Public Health Education	CS	8.05	32.64	40.69	17.60	34.20	51.80	4.97	33.86	38.83

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
35	Health Sector Disaster Preparedness & Management including Emergency Medical Relief	CS	0.13	0.00	0.13	68.50	...	68.50	1.74	0.00	1.74
36	Lala Ram Swarup Institute of T.B. and Allied Diseases, New Delhi	CS	27.72	12.93	40.65	35.00	14.00	49.00	34.38	15.12	49.50
37	Procurement of Meningitis Vaccine for Inoculation of Haj Pilgrims	CS	0.00	0.00	0.00	...	6.00	6.00	0.00	5.94	5.94
38	Assistance for Capacity Building for Trauma Centres	CSS	25.43	0.00	25.43	79.09	...	79.09	23.72	0.00	23.72
39	Rashtriya Arogya Nidhi	CS	0.00	20.48	20.48	...	25.50	25.50	0.00	16.95	16.95
	Other Health Schemes										
40	Oversight Committee	CS	306.74	0.00	306.74	350.00	...	350.00	150.38	0.00	150.38
41	Institute of Public Health (PHFI)	CS	0.00	0.00	0.00	0.30	...	0.30	0.00	0.00	0.00
42	Telemedicine	CSS	0.00	0.00	0.00	5.00	...	5.00	0.15	0.00	0.15
43	National Programme for Deafness	CSS	4.00	0.00	4.00	5.00	...	5.00	0.00	0.00	0.00
44	National Programme for Health Care of the Elderly	CSS	68.84	0.00	68.84	88.86	0.00	88.86	0.00	0.00	0.00
45	National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke	CSS	86.33	0.00	86.33	324.32	...	324.32	3.31	0.00	3.31
46	National Programme for Control of Blindness	CSS	0.00	0.00	0.00	60.00	...	60.00	12.45	0.00	12.45
47	New Initiatives of which	CSS/CS	17.63	0.00	17.63	148.23	0.00	148.23	91.62	0.00	91.62
	(i) Leptospirosis Control Programme	CSS	0.00	0.00	0.00	0.50	...	0.50	0.00	0.00	0.00
	(ii) National Organ Transplant Programme	CSS	0.95	0.00	0.95	12.50	...	12.50	0.58	0.00	0.58

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
	(iii) Oral Health	CSS	0.00	0.00	0.00	5.73	...	5.73	0.00	0.00	0.00
	(iv) National Programme for Prevention and Control of Fluorosis	CSS	4.17	0.00	4.17	10.00	...	10.00	1.82	0.00	1.82
	(v) Pilot Project on Prevention and Control of Human Rabies	CSS	0.00	0.00	0.00	2.00	...	2.00	0.70	0.00	0.70
	(vi) Medical Rehabilitation	CSS	0.11	0.00	0.11	5.00	...	5.00	0.48	0.00	0.48
	(vii) National Programme for Sports Injury	CSS	10.63	0.00	10.63	10.00	...	10.00	12.50	0.00	12.50
	(viii) National Centre for Disease Control	CS	1.77	0.00	1.77	100.00	...	100.00	75.30	0.00	75.30
	(ix) National Advisory Board of Standards	CS	0.00	0.00	0.00	2.50	...	2.50	0.24	0.00	0.24
	(x) Other Schemes	CS	1.18	4.54	5.72	2.71	5.42	8.13	0.91	6.03	6.94
	(a) Central Health Education Bureau	CS	0.22	2.22	2.44	1.00	2.50	3.50	0.11	2.39	2.50
	(b) Institute for Human Behaviour & Allied Sciences, Shahdara, Delhi	CS	0.00	0.00	0.00	0.01	2.40	2.41	0.00	0.00	0.00
	(c) Strengthening of HMIS	CS	0.96	0.00	0.96	1.70	0.00	1.70	0.80	0.00	0.80
	(d) Others	CS	0.00	2.32	2.32	...	0.52	0.52	0.00	3.64	3.64
	(xi) New Schemes	CS	50.00	0.00	50.00	102.21	...	102.21	0.00	0.00	0.00
	(a) Strengthening of existing branches & establishment of 27 branches of NCDC	CS	...	...	...	32.00	...	32.00	...	...	...
	(b) Strengthening intersectoral coordination of prevention and control of zoonotic diseases	CS	...	...	...	2.00	...	2.00	...	...	...
	(c) Viral Hepatitis	CS	...	...	...	2.00	...	2.00	...	...	...
	(d) Anti-Micro Resistance	CS	...	...	...	2.00	...	2.00	...	...	...
	(e) Health Insurance(CGEIPS)	CS	...	...	...	50.00	...	50.00	...	...	...
	(f) Emergency Medical Services	CS	...	...	...	14.20	...	14.20	...	...	...
	(g) Central Procurement Agency	CS	50.00	0.00	50.00	0.01	...	0.01	0.00	0.00	0.00

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
48	Medical Stores Organisation	CS	0.00	40.40	40.40	0.00	45.00	45.00	0.00	42.40	42.40
	Total-Public Health		948.92	228.11	1177.03	2096.14	279.52	2375.66	576.23	242.75	818.98
	Total- Health{excluding provision for projects/ schemes of North Eastern Areas & Sikkim(item 58)}		***3858.10***	***3900.19***	***7758.29***	***7459.15***	***3925.21***	***11384.36***	***3666.35***	***4347.62***	***8013.97***
	NATIONAL HEALTH MISSION										
49	NRHM -RCH Flexible Pool	CSS	...	...	...	11353.60	0.00	11353.60	10998.41	0.00	10998.41
	(i) RCH Flexible Pool		4030.72	0.00	4030.72	4711.12	...	4711.12	4652.16	0.00	4652.16
	(ii) Mission Flexible Pool		4553.03	0.00	4553.03	5071.64	...	5071.64	5006.66	0.00	5006.66
	(iii) Routine Immunisation		478.54	0.00	478.54	760.84	...	760.84	521.12	0.00	521.12
	(iv) Pulse Polio Immunisation		844.56	0.00	844.56	763.79	...	763.79	789.75	0.00	789.75
	(v) Iodine Deficiency Disorder Control Programme (I.D.D)		13.29	0.00	13.29	44.43	...	44.43	28.72	0.00	28.72
	(vi) Strengthening of District Hospitals for providing advanced secondary care		...	...	...	0.89	...	0.89	0.00	0.00	0.00
	(vii) Providing free generic medicines in all public health institutions in thecountry		...	...	...	0.89	...	0.89	0.00	0.00	0.00
50	NUHM Flexible Pool	CSS	...	...	...	0.89	...	0.89	662.22	0.00	662.22
51	Flexible Pool for Communicable Diseases	CSS	...	...	...	1180.56	8.41	1188.97	918.64	8.76	927.40
	(i) National Vector Borne Disease Control Programme (NVBDCP)		303.80	8.70	312.50	448.25	8.41	...	308.73	8.76	317.49
	(ii) National T.B. Control Programme (NTBCP)		459.27	0.00	459.27	631.01	...	...	513.70	0.00	513.70
	(iii) National Leprosy Control Programme		33.86	0.00	33.86	45.32	...	...	46.33	0.00	46.33
	(iv) National Integrated Disease Surveillance Programme		32.60	0.00	32.60	55.98	...	...	49.88	0.00	49.88

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
52	Flexible Pool for Non-Communicable Diseases, Injury & Trauma	CSS	…	…	…	764.17	0.00	764.17	260.84	15.81	276.65
	(i) National Trachoma & Blindness Control Programme		209.47	0.00	209.47	…	…	…	…	…	…
	(ii) National Mental Health Programme		…	…	…	…	…	…	…	…	…
	(iii) National Programme for Health Care of Elderly		…	…	…	…	…	…	…	…	…
	(iv) National Programme for Prevention and Control of Deafness		…	…	…	…	…	…	…	…	…
	(v) National Tobacco Control Programme		…	…	…	…	…	…	…	…	…
	(vi) National Oral Health Programme		…	…	…	…	…	…	…	…	…
	(vii) National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)		…	…	…	…	…	…	…	…	…
	(viii) Other New Initiatives under Non-Communicable Diseases		…	…	…	…	…	…	…	…	…
53	Infrastructure Maintenance		5168.92	0.00	5168.92	4556.79	17.88	4574.67	4702.54	0.00	4702.54
	Family Welfare- Central Sector		650.74	74.97	725.71	919.34	78.71	998.05	657.37	70.58	727.95
54	Supply of Contraceptives	CSS	165.03	0.00	165.03	231.05	0.00	231.05	159.33	0.00	159.33
55	Other Services	CSS	485.71	74.97	560.68	688.29	78.71	767.00	498.04	70.58	568.62
	(i) Funding to Institutions	CS	26.98	49.43	76.41	72.57	61.59	134.16	29.34	56.23	85.57
	(a) Population Research Centres	CS	12.55	0.00	12.55	13.50	0.00	13.50	14.16	0.00	14.16
	(b) Central Drug Research Institute, Lucknow	CS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	(c) National Institute of Health and Family Welfare, New Delhi	CS	8.35	27.09	35.44	18.00	30.50	48.50	9.65	28.11	37.76
	(d) International Institute for Population Sciences (IIPS), Mumbai	CS	4.92	8.03	12.95	27.00	15.58	42.58	5.00	12.58	17.58

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
	(e) National Commission on Population	CS	0.66	0.00	0.66	4.60	0.00	4.60	0.39	0.00	0.39
	(f) Funding to Training Institutions	CS	0.50	14.31	14.81	9.47	15.51	24.98	0.14	15.54	15.68
	(f.1) Family Welfare Training and Research Centre, Mumbai		0.50	2.42	2.92	8.30	3.63	11.93	0.14	2.79	2.93
	(f.2) Rural Health Training Centre, Najafgarh		0.00	11.89	11.89	0.02	11.88	11.90	0.00	12.75	12.75
	(f.3) Travel of Experts/Conf. Meetings etc. (Melas)		0.00	0.00	0.00	1.15	0.00	1.15	0.00	0.00	0.00
	(ii) Family Welfare Linked Health Insurance Plan	CS	8.58	0.00	8.58	3.00	0.00	3.00	1.22	0.00	1.22
	(iii) Procurement of Supplies & Materials (RCH Supplies)	CSS	29.65	0.00	29.65	56.81	0.00	56.81	0.00	0.00	0.00
	(iv) Information Education and Communication(IEC)	CS	261.76	6.51	268.27	230.00	7.85	237.85	241.75	6.71	248.46
	(v) Area Projects	CS	22.86	0.00	22.86	10.02	0.00	10.02	5.45	0.00	5.45
	(vi) Strengthening National Programme Management of the NRHM	CSS	0.00	0.00	0.00	100.00	0.00	100.00	35.14	0.00	35.14
	(vii) National Drug De-Addiction Control Programme	CSS	15.50	0.00	15.50	22.80	0.00	22.80	29.57	0.00	29.57
	(viii) Other CS activities		116.67	19.03	135.70	190.09	9.27	199.36	151.85	7.64	159.49
	(A) Other Family Welfare Activities	CS	2.97	0.00	2.97	5.20	0.00	5.20	2.95	0.00	2.95
	(a) Role of Men in Planned Parenthood		0.63	0.00	0.63	1.00	0.00	1.00	0.57	0.00	0.57
	(b) Training in Recanalisation		0.39	0.00	0.39	1.00	0.00	1.00	0.05	0.00	0.05
	(c) Testing Facilities for IUD & Fallopian		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	(d) FW Programme in Other Ministries		0.35	0.00	0.35	1.50	0.00	1.50	0.63	0.00	0.63
	(e) Technology in Family Welfare		1.60	0.00	1.60	1.70	0.00	1.70	1.70	0.00	1.70

(Rs. in crores)

Sl. No.	Name of the Schemes	Central Sector Scheme (CS)/ Centrally Sponsored Scheme (CSS)	Plan & Non-Plan 2012-13 Actual Expenditure (Provisional)#			Plan & Non-Plan Outlay 2013-14(BE)			Plan & Non-Plan 2013-14 Actual Expenditure (Provisional)#		
			Plan	Non Plan	Total	Plan	Non Plan	Total	Plan	Non Plan	Total
1	2	3	4	5	6	7	8	9	10	11	12
	(B) Gandhigram Institute	CS	1.25	0.00	1.25	2.50	0.00	2.50	1.87	0.00	1.87
	(C) Assistance to IMA	CS	0.00	0.00	0.00	0.30	0.00	0.30	0.00	0.00	0.00
	(D) Expenditure at HQrs (RCH)	CS	4.97	0.00	4.97	0.00	0.00	0.00	0.00	0.00	0.00
	(E) Research and Study activities under RCH	CS	0.01	0.00	0.01	1.80	0.00	1.80	0.00	0.00	0.00
	(F) Regional Health Offices (Direction & Admn)	CS	22.91	19.03	41.94	19.49	9.27	28.76	19.21	7.64	26.85
	(G) RCH training	CS	6.41	0.00	6.41	11.50	0.00	11.50	5.45	0.00	5.45
	(H) Information Technology	CS	2.66	0.00	2.66	2.50	0.00	2.50	2.06	0.00	2.06
	(I) NGOs (Public-Private Partnership)	CS	1.12	0.00	1.12	1.80	0.00	1.80	0.71	0.00	0.71
	(J) Management Information System (MIS)	CS	74.37	0.00	74.37	145.00	0.00	145.00	119.60	0.00	119.60
	(ix) International Contribution	CS	3.71	0.00	3.71	3.00	0.00	3.00	3.72	0.00	3.72
	Total- National Health Mission{excluding Provision for Projects/Schemes of North Eastern Areas and Sikkim(item 58)}		**16778.80**	**83.67**	**16862.47**	**18775.35**	**105.00**	**18880.35**	**18200.02**	**95.15**	**18295.17**
56	International Co-operation	CS	5.48	15.24	20.72	6.00	19.81	25.81	12.48	23.07	35.55
57	Forward Linkages to NRHM	CSS	58.02	0.00	58.02	0.00	0.00	0.00	55.47	0.00	55.47
58	Provision for Projects/Schemes of North Eastern Areas and Sikkim	CS/CSS	326.22	0.00	326.22	2916.50	0.00	2916.50	438.74	0.00	438.74
59	Secretariat- Social Services	CS	3.15	51.33	54.48	8.00	61.48	69.48	5.91	56.59	62.50
60	Discretionary Grant	CS	0.00	1.50	1.50	0.00	1.50	1.50	0.00	2.49	2.49
	Grand Total		**21029.77**	**4051.93**	**25081.70**	**29165.00**	**4113.00**	**33278.00**	**22378.97**	**4524.92**	**26903.89**

Note: The Expenditure Figures shown against Provision for Projects/Schemes of North Eastern Areas and Sikkim pertains to the Central Institutions in the NER and excludes expenditure of all other schemes implemented in North East. The expenditure for NER pertaining to other schemes are subsumed under the respective Schemes/Programmes.

as on 25th April, 2014

Chapter 4

MATERNAL HEALTH PROGRAMME

4.1 INTRODUCTION

Maternal Health is an important aspect for the development of any country in terms of increasing equity & reducing poverty. The survival and well-being of mothers is not only important in their own right but are also central to solving large broader, economic, social and developmental challenges.

Maternal Mortality Ratio is one of the important indicators of the quality of health services in the country. India has made remarkable progress in reducing maternal deaths in the last two decades. In 1990, Maternal Mortality Ratio (MMR) in India was very high with 600 women dying during child birth per hundred thousand live births, which meant approximately one and a half lakh women dying every year. Globally MMR at that time was 400, which translated into about 5.4 lakh women dying every year, India at that time contributing to 27 percent of the global maternal deaths. In the year 2010 global MMR was 210. Against this, MMR in India has declined to 178 per hundred thousand live births in 2011 as per latest SRS estimates. India now contributing to only 16 percent of the global maternal deaths. Globally, there has been a 47% decline between the years 1990 and 2010. Compared to this, India has registered a decline of 70% between 1990 and 2011. The pace of decline in India has shown an increasing trend from 4.1% annual rate of decline during 2001-03 to 5.5% in 2004-06, to 5.8% in 2007-09 and is maintained at almost the same level of 5.7% in 2010-12.

The highest rates of declines are evident from the years 2004-06, which incidentally coincides with the period immediately after the launch of NRHM and the numerous initiatives taken under this flagship scheme including the Janani Suraksha Yojana (JSY) which has resulted in a surge in institutional deliveries since its launch. Currently, as many as 1.66 crore women are reported to deliver in public health institutions.

Building on the phenomenal progress of the JSY scheme, Janani Shishu Suraksha Karyakram (JSSK) launched in 2011 provides service guarantees in the form of entitlements to pregnant women, sick new-borns and infants for free delivery including caesarean section and free treatment in public health institutions. This includes free to and fro transport between home and institution, diet, diagnostics, drugs, other consumables and blood transfusion if required. More than 2,000 crores have been sanctioned for this scheme in 2013-14.

However, still an estimated 47,000 mothers continue to die every year due to causes related to pregnancy, childbirth and the post-partum period. The major medical causes of these deaths are hemorrhage, sepsis, abortion, hypertensive disorders, obstructed labor and 'other' causes including anemia. A host of socio-economic-cultural determinants like illiteracy, low socio-economic status, early age of marriage, low women's empowerment, traditional preference for home deliveries & other factors contribute to the delays leading to these deaths.

4.2 DECLINING MATERNAL MORTALITY RATIO (MMR)

- Maternal Mortality Ratio (MMR) has declined from 301 per 100,000 live births in 2001-03 to 254 in 2004-06 and further declined to 212 in 2007-09 and 178 in 2010-12 as per RGI-SRS data.
- The pace of decline has shown an increasing trend from 4.1% annual rate of decline during 2001-03 to 5.5% in 2004-06, 5.8% in 2007-09 to 5.7% in 2010-12.
- India's MMR declined much faster than the global MMR during the period 1990 to 2010 with India showing an annual rate of decline of 5.6% as compared to 2.4% at the global level.

4.2.1 MMR (RGI-SRS 2010-12)

Salient features

- As per the latest figures released by Registrar General of India (RGI), the Maternal Mortality Ratio (MMR) of India for the period 2010-12 is 178 per 100,000 live births as compared to 212 for the period 2007-09. The annual decline in MMR has been 5.7% during 2007-09 to 2010-12 as compared to the annual decline of 5.8% during 2004-06 to 2007-09.
- The State of Assam continues to be the State with the highest MMR (328) followed by Uttar Pradesh/ Uttarakhand (292) and Rajasthan (255).
- The States of Kerala (66), Maharashtra (87) and Tamil Nadu (90) and have achieved the MMR level of below 100.
- It is heartening to note that the States of Andhra Pradesh (6.4%), Bihar/Jharkhand (5.7%), Gujarat (6.2%), Karnataka (6.8%), Kerala (6.6%), Rajasthan (7.1%), Uttar Pradesh/Uttarakhand (6.7%) and West Bengal (6.9%) have registered equal or higher decline as compared to the national decline.
- The highest annual decline has been observed in Rajasthan (7.1%) followed by Karnataka (6.8%), Uttar Pradesh (6.7%) and Kerala (6.6%).
- The States of West Bengal has done remarkably well to reduce the MMR and to reverse the increase observed during the period 2004-06 to 2007-09.

Comparison of MMR (SRS & AHS) for 9 High Focus States

State/ UT	MMR			
	SRS	SRS	AHS *	
	2010-12	2007-09	2010-11	2011-12
Assam	328	390	381	347
Bihar	219	261	305	294
Chhattisgarh	-	-	275	263
Jharkhand	-	-	278	267
Madhya Pradesh	230	269	310	277
Odisha	235	258	277	237
Rajasthan	255	318	331	264
Uttar Pradesh	292	359	345	300
Uttarakhand	-	-	188	162

4.3 OTHER MATERNAL HEALTH INDICATORS

Some of the key indicators for maternal health are antenatal check-up, institutional delivery and delivery by trained and skilled personnel, post natal care, etc. All these indicators are monitored regularly through Health Management Information System (HMIS) and also periodically through District Level Household Surveys (DLHS), National Family Health Surveys (NFHS) and Annual Health Survey (AHS). Independent surveys are also being done like Coverage Evaluation Surveys (CES) by UNICEF.

4.3.1 Comparison of MH indicators in DLHS II (2002-04), DLHS III (2007-08), CES (2009) and SRS 2010

Indicators	DLHS-2 (2002-04)	DLHS-3 (2007-08)	CES 2009	SRS 2010
Mothers who had received any Ante Natal Care (ANC) (%)	73.6	75.2	89.6	-
Mothers who had 3 or more ANC (%)	50.4	49.8	68.7	-
Mothers who had full ANC checkup (%)	16.5	18.8	26.5	-
Institutional Delivery (%)	40.9	47.0	72.9	60.5
Safe Delivery (%)	48	52.7	76.2	-
IFA tablets consumed for 100 days	20.5	46.6	-	
Mothers who received PNC within 2 weeks of delivery(%)	NA	49.7	60.1*	-

**-PNC within 10 days*

4.3.2 Key Maternal Health Strategies

Demand Promotion: Janani Suraksha Yojana (JSY), a demand promotion scheme was launched in April 2005 with the objective of reducing Maternal and Infant Mortality. This is a conditional cash transfer scheme for pregnant women coming into the institutional fold for delivery. It has been lauded as a successful scheme bringing about a surge in institutional deliveries since its launch.

The expenditure under JSY has risen from 38.29 crores in 2005-06 to Rs. 1640.00 crores in 2012-13. The number of JSY beneficiaries has also risen from 7.39 lakhs in 2005-06 to more than 106.00 lakhs in 2012-13. In 2013-14 (uptil Dec.) more than 78.27 lakhs beneficiaries has availed JSY benefits and expenditure under JSY is Rs. 1220.40 crores.

4.3.3 Free Service Guarantees at Public Health Facilities: Janani Shishu Suraksha Karyakram (JSSK)

To complement JSY, Government of India launched Janani Shishu Suraksha Karyakram (JSSK) on 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new- borns and infants on drugs, diet, diagnostics, user charges, referral transport, etc. The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns & infants accessing public health facilities.

More than Rs. 2000 crores have been allocated to the States for the year 2013-14 for providing the free entitlements under JSSK while Rs. 2107 crores was allocated during 2012-13 under Reproductive Child Health (RCH) & National Rural Health Mission (NRHM) Flexipool.

4.3.4 Essential and Emergency Obstetric Care

- *Skilled Attendance at birth (domiciliary & health facilities)* - Nearly 69,760 ANMs, LHVs and Staff Nurses have been trained in SBA, as per State reports.
- Multi-skilling of doctors to overcome shortage of skilled manpower in critical specialities-training on Life Saving Anaesthesia Skills (LSAS) and Comprehensive Emergency Obstetric Care (including C-Section). 1,862 Medical Officers have been trained in LSAS and 1,352 Medical Officers in Comprehensive Emergency Obstetric Care (EmOC).
- For placing emergency obstetric care services at the health facilities, once the women have come into the institutional fold, more than 17000

'Delivery Points' fulfilling certain bench marks of performance have been identified across the country. These are being strengthened in terms of infrastructure, equipments, trained manpower for provision of comprehensive Reproductive, Maternal, Newborn Child health services along-with services for Adolescents and Family Planning etc. These are being monitored for service delivery.

- **Maternal Health Tool Kit** has been developed as a ready reckoner/handbook for programme managers to plan, implement and monitor services at health facilities, with a focus on the Delivery Points, which includes setting up adequate physical infrastructure, ensuring logistics and supplies and recording/reporting and monitoring systems with the objective of providing good quality comprehensive RMNCH services.

4.4 COMPREHENSIVE ABORTION CARE SERVICES (CAC)

Eight percent of maternal deaths in India are attributed to unsafe abortions. Besides this, women who survive unsafe abortion are likely to suffer long-term reproductive morbidity. Comprehensive abortion care is an important element in the reproductive health component of the RMNCH+A strategy.

- Provision of comprehensive safe abortion services at public health facilities including 24x7 PHCs/ FRUs (DHs/SDHs/CHCs) with a focus on **"Delivery Points"** (about 16000 health facilities performing deliveries/ C- sections above certain benchmark).
- Funds are being provided to States/UTs for operationalisation of safe abortion services at health facilities including procurement of equipment and drugs for medical abortion.
- Capacity Building of Medical Officers in safe MTP Techniques and of ANMs, ASHAs and other field functionaries to provide confidential counseling for MTP and promote post-abortion care including adoption of contraception.
- Certification of private and NGO sector facilities through District level committees to provide quality MTP services.
- Supply of Nischay Pregnancy detection kits to sub centres for early detection of pregnancy.
- Print material for IEC/BCC on CAC shared with the States.

4.4.1 Management of Sexually Transmitted and Reproductive Tract Infections (RTI and STI)

- Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTIs) constitute an important public health problem in India. Studies suggest that 6% of the adult population in India is infected with one or more RTI/STI.
- These services are to be provided at all CHCs, and at 24x7 PHCs with priority on delivery points. Convergence with the National AIDS Control Programme (NACP) is essential for the provision of services for case management, laboratory services, HIV counselling services, anti-retroviral drugs, equipment and blood safety and skilled and trained manpower.
- For syndromic management of RTIs/STIs, availability of colour-coded kits, RPR testing kits for syphilis and also whole blood finger prick testing for HIV are being ensured.

4.4.2 Village Health & Nutrition Days (outreach services for comprehensive Maternal and Child Health care): More than 4.32 crore Village Health and Nutrition Days have been held upto September, 2013 (NRHM-MIS).

4.4.3 Mother and Child Protection (MCP) Card: A joint Mother and Child Protection (MCP) Card of Ministry of Health & Family Welfare and Ministry of Women and Child Development (MoWCD) is being used by all States as a tool for monitoring and improving the quality of MCH and Nutrition interventions.

4.5 MATERNAL DEATH REVIEW (MDR)

- The process of Maternal Death Review (MDR) has been institutionalized across the country both at facilities and in the community to identify not only the medical causes but also some of the socio-economic cultural determinants as well as the gaps in the system which contribute to the delays causing such deaths. This is with

the objective of taking corrective action at appropriate levels and improving the quality of obstetric care.

- The States are being monitored closely on the progress made in the implementation of MDR.

Capacity Building

- Skill Building through training programmes for all categories of service providers e.g. Training of MBBS doctors in Life Saving Anesthesia Skills (LSAS), Emergency Obstetric Care including C-sections; Training of Nurses and ANMs in Skilled Birth Attendance (SBA); Training of MOs in Comprehensive Abortion Care (CAC).
- 1352 doctors have been trained in Emergency Obstetric Care including C-sections and 1862 doctors in LSAS. 69760 SNs/LHVs/ANMs have been trained as SBAs as per State reports.

4.6 MATERNAL AND CHILD HEALTH (MCH) WING

Under NRHM, 100/50/30 bedded state of the art MCH Wings are being established in District Hospitals/District Women's Hospitals/Sub-District Hospitals/CHC-FRUs to overcome the constraints of increasing case loads and institutional deliveries at these facilities. 470 dedicated Maternal and Child Health Wings (MCH Wings) with more than 28,500 additional beds have been sanctioned in 18 States.

4.6.1 Skill Labs

To strengthen the quality of capacity building of different cadres of service providers training, Skill Labs are being established in the States.

4.6.2 Quality Assurance Guidelines

Quality Assurance Guidelines are on the anvil with the objective of providing standard guidelines to be uniformly adopted by all States. These Guidelines indicate the steps and processes and defines minimum standards to be followed to ensure quality of service provision.

4.7 MOTHER AND CHILD TRACKING SYSTEM (MCTS)

To catch every pregnant women and every neonates and infants for quality ANC, INC, PNC, FP, Immunization services, the pregnant women and neonates are being tracked by name. **Web Enabled Mother and Child Tracking System (MCTS)** is being implemented to register and track every pregnant woman, neonate, infant and child by name for quality ANC, INC, PNC, FP, Immunization services. As on March, 2014 more than 6.20 crores women and 5.17 crores children have been registered under MCTS.

A new initiative of prevention of PPH through Community Based Advanced distribution of Misoprostol by ASHAs/ANMs has been launched in the districts with high home delivery rates.

4.8 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) was launched in April 2005 to enable women especially from the vulnerable sections of the society to access institutional delivery and thereby effect reductions in maternal and neonatal mortality. The scheme provides conditional cash assistance to pregnant women for giving birth in a government health facility by providing access to skilled birth attendance and emergency obstetric care.

The scheme is under implementation in all States and Union Territories (UTs) with a special focus on Low Performing States (LPS). Around 9 lakh Accredited Social Health Activists (ASHAs) are working as an effective link between the government and poor pregnant women who get financial incentive to promote institutional delivery.

The scheme focuses on poor pregnant woman with a special dispensation for States that have low institutional delivery rates, namely, the States of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir. While these states have been named Low Performing States (LPS), the remaining States have been named High Performing States (HPS).

The number of beneficiaries under the scheme has increased manifold i.e. from 7.38 lakhs in 2005-06 to 1.05 crores in 2013-14. Similarly, expenditure has increased from Rs. 38.29 crores in 2005-06 to Rs. 1748 crores in 2013-14.

4.8.1 Eligibility for Cash Assistance for Pregnant Women

The eligibility for cash assistance under the JSY is shown below:

Low Performing States (LPS)	All pregnant women delivering in government health centres or accredited private institutions.
High Performing States (HPS)	All BPL/Scheduled Caste (SC)/Scheduled Tribe (ST) women delivering in a government health centre or accredited private institutions.

4.8.2 Cash Assistance for Institutional (in Rs.)

The cash entitlement for different categories of mothers is as follows:

Category	Rural area		Total	Urban area		Total
	Mother's package	ASHA's package*		Mother's package	ASHA's package**	
Low Performing States (LPS)	1400	600	2000	1000	400	1400
High Performing States (HPS)	700	600	1300	600	400	1000

**ASHA incentive of Rs. 600/- in rural area includes Rs. 300/- for ANC component and Rs. 300/- for accompanying pregnant woman for institutional delivery.*

***ASHA incentive of Rs. 400/- in urban area includes Rs. 200/- for ANC component and Rs. 200/- for accompanying pregnant woman for institutional delivery.*

Subsidizing cost of Caesarean Section

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

Assistance for Home Delivery

All BPL pregnant women regardless of age and number of children preferring to delivery at home are entitled to financial assistance of Rs. 500/- per delivery in all the States/UTs.

4.8.3 Janani Shishu Suraksha Karyakaram (JSSK)

Free Service Guarantees at Public Health Facilities: Janani Shishu Suraksha Karyakaram (JSSK):

- Capitalizing onthe surge in institutional deliveries brought about by JSY to provide service guarantees at health facilities, Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) in 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new-borns on drugs, diet, diagnostics, user charges, referral transport, etc. The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. Under this scheme, pregnant women are entitled to free drugs and consumables, free diagnostics, free blood wherever required, and free diet up to 3 days for normal delivery and 7 days for C-section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick new-borns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover the complications during ANC, PNC and also sick infants.
- To implement this scheme, more than Rs. 2107 crores have been allocated during the year

2012-13 and more than Rs. 2000 crores have been sanctioned up till now in 2013-14 under RCH and Mission Flexipool.

4.9 ADOLESCENT HEALTH PROGRAMME

Adolescents (10-19 years) constitute about one-fifth of India's population and represent a huge opportunity that can transform the social and economic fortunes of the country. The large and increasingly relative share and absolute numbers of adolescent population in India make it necessary that the nation ensures they become a vibrant, constructive force that can contribute to sustainable and inclusive growth. Investments in adolescent health will have an immediate, direct and positive impact on India's health goals and on the achievements of the Millennium Development Goals (MDGs).

Under Adolescent Health following three programmes are currently being implemented:

- Adolescent Reproductive and Sexual Health (ARSH);
- Scheme for Promotion of Menstrual Hygiene (MHS) and
- Weekly Iron Folic Acid Supplementation programme (WIFS).

A. Adolescent Reproductive and Sexual Health Programme (ARSH)

Adolescent Reproductive and Sexual Health programme (ARSH) focuses on reorganizing the existing public health system in order to meet service needs of adolescents. Steps are being taken to ensure improved service delivery for adolescents during routine sub-centre clinics and also to ensure service availability on fixed days and timings at the Primary Health Centre and Community Health Centre & District Hospital levels. Core package of services includes promotive, preventive, curative and counselling services being made available for all adolescents - married and unmarried, girls and boys through Adolescent Friendly Health Clinics. ARSH programme envisage creating an enabling environment for adolescent to seek health care services through a spectrum of programmatic approaches:

- Facility based health services- Adolescent Friendly Health Clinics;
- Counselling- Dedicated ARSH and ICTC counsellors;
- Community based interventions- Outreach activities and
- Capacity Building for service providers.

i. **Adolescent Friendly Health Clinics (AFHC):** Through Adolescent Friendly Health Clinics, routine check-up at primary, secondary and tertiary levels of care is provided on fixed day clinics. At present 6,302 AFHCs are functional across the country providing services, information and commodities to more than 2.5 million adolescents for varied health related needs such as contraceptives provision, management of menstrual problems, RTI/STI management, antenatal care and anaemia.

ii. **Facility based Counselling services:** Counselling services for adolescent on important issues such as nutrition, puberty, RTI/STI prevention and contraception and delaying marriage and child bearing & concerns related to contraception, abortion services, pre-marital concerns, substance misuse, sexual abuse and mental health problems are being provided through recruitment and training of dedicated counsellors. At present 881 dedicated ARSH counsellors are providing comprehensive counselling services to adolescent across country. In 23 States/UTs, 1439 ICTC counsellors have been enrolled to provide sexual and reproductive health counselling to adolescents.

iii. **Outreach activities:** Outreach activities are being conducted in schools, colleges, Teen clubs, vocational training centres, during Village Health Nutrition Day (VHND), Health melas and in collaboration with Self Help Groups to provide adequate and appropriate information to adolescents in spaces where they normally congregate.

To further strengthen the outreach component of ARSH programme, Peer Educators at village level have been enrolled in States and Union Territories. Across country 83,360 peer educators have been selected and trained in the last three years.

iv. **Capacity building through ARSH trainings:** The capacity building of health functionaries in Adolescent Friendly Health Services is undertaken through a systematic ARSH training module (5 days for Auxiliary Nurse Midwife/Staff Nurse and 3 days for Medical Officer) to enhance their skills in addressing health needs of the adolescents. Till date, a total number of 7,224 MOs and 19,112 SN/ANM/LHV have been trained on ARSH.

B. Weekly Iron and Folic Acid Supplementation (WIFS)

Ministry of Health and Family Welfare has launched the Weekly Iron and Folic Acid Supplementation (WIFS) Programme to meet the challenge of high prevalence and incidence of anaemia amongst adolescent girls and boys. The long term goal is to break the intergenerational cycle of anaemia, the short term benefits is of a nutritionally improved human capital. The programme, implemented across the country both (rural and urban areas) will cover 10.25 crore adolescents. The key interventions under this programme are as follows:

- Administration of supervised Weekly Iron-Folic Acid Supplements of 100mg elemental iron and 500ug Folic acid using a fixed day approach.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthes infestation.
- Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

Convergence with key stakeholder ministries like the Ministry of Women and Child Development and Ministry of Human Resource Development is an essential part of implantation plan of the WIFS programme.

Till date the programme has been launched in 32 States/ UTs which are: Odisha, Tripura, Andhra Pradesh, West Bengal, Maharashtra, Chandigarh, D&N Haveli, Uttarakhand, Haryana, Andaman & Nicobar, Daman and Diu, Puducherry, Kerala, Mizoram, UP, Gujarat, Jharkhand, Himachal Pradesh, Arunachal Pradesh, Sikkim, Nagaland, Punjab, Meghalaya, Goa, Chhattisgarh, Delhi, Karnataka, Rajasthan, Lakshadweep, Assam, Manipur and Madhya Pradesh. Total number of beneficiaries covered under this programme including both in-school adolescents and out of school girls is around 3 crore.

C. Menstrual Hygiene Scheme

The Ministry of Health and Family Welfare has launched **Scheme for Promotion of Menstrual Hygiene** among adolescent girls in the age group of 10-19 years in rural areas. This programme aims at ensuring that girls have adequate knowledge and information about menstrual hygiene and have access to high quality sanitary napkins along with safe disposal mechanisms. Key activities under the scheme include:

- Community based Health education and outreach in the target population to promote menstrual health;
- Ensuring regular availability of sanitary napkins to the adolescents;
- Sourcing and procurement of sanitary napkins
- Storage and distribution of sanitary napkins to the adolescent girls;
- Training of ASHA and nodal teachers in Menstrual Health and
- Safe disposal of sanitary napkins.

In the first phase, the scheme is covering 25% of the population i.e. 1.5 crore girls in the age group of 10-19 years in 115 districts of 17 States. The scheme has envisaged providing a pack of 6 sanitary napkins under the NRHM's brand 'Freedays'. These napkins are sold to the adolescents girls at Rs. 6 for a pack of 6 napkins in the village by the Accredited Social Health Activist (ASHA). On sale of each pack, the ASHA gets an incentive of Rs. 1 per pack besides a free pack of sanitary napkins per month.

D. Current Status

The scheme has been been rolled out in all the 17 States through Central supply. 1092 blocks in 115 districts are under Central supply wherein Sanitary Napkins are being supplied by Government of India. Till end December 2013, total consumption of sanitary napkins is 4 crore packs of sanitary napkins with a coverage of over 1.9 crore girls.

Chapter 5

CHILD HEALTH PROGRAMME

5.1 INTRODUCTION

The Child Health programme under the National Rural Health Mission (NRHM) comprehensively integrates interventions that improve child survival and addresses factors contributing to infant and under-five mortality. It is now well recognised that child survival cannot be addressed in isolation as it is intricately linked to the health of the mother, which is further determined by her health and development as an adolescent. Therefore, the concept of Continuum of Care, that emphasises on care during critical life stages in order to improve child survival, is being followed under the national programme. Another dimension of this approach is to ensure that critical services are made available at home, through community outreach and through health facilities at various levels (primary, first referral units, tertiary health care facilities). The newborn and child health are now the two key pillars of the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategic approach, 2013.

5.2 TRENDS OF CHILD HEALTH INDICATORS

5.2.1 Infant Mortality Rate

Infant Mortality Rate (IMR) refers to the number of deaths of children in the age 0-1 year per thousand live births. The all India IMR in 2012 was 42. The percentage annual compound rate of decline during 2005-12 has been higher (4.5%) as compared to the decline of 3.1% observed during 2000-05. IMR for the year 2012 was 46 in rural and 28 in urban India (about 64% higher in rural as compared to urban India). There is a constant gender differential of three points in IMR at national level over last five years.

Year	IMR			Average annual Compound Rate of change (%) over previous period		
	Total	Rural	Urban	Total	Rural	Urban
2000	68	74	44	-	-	-
2005	58	64	40	-3.1	-2.9	-1.9
2012	42	46	28	-4.5	-4.6	-5.0

5.2.2 Under-five Mortality Rate (U5MR)

Under-five mortality is defined as the probability of dying before the fifth birthday. As per the Sample Registration System 2012, the under five-mortality rate is 52 per thousand live births.

Encouraging progress has been made in the country in terms of reducing child mortality rates. In 1990, when the global U5M rate was 88 per 1000 live births, India carried a much higher burden of child mortality at 114 per 1000 live births. In 2011, India's under five child mortality (55 /1000 Live births) is much closer to the global average of 57.

5.2.3 Neo-natal Mortality Rate (NMR)

Neo-natal Mortality Rate refers to the number of deaths of children during the period of 0-28 days per thousand live births. NMR stands 29 per 1000 live births in India in 2012. Neo-natal mortality thus contributes 56% of all deaths in childhood (up to age 5 years).

Year wise Progress in Neo-natal Mortality Rate

Year	NMR (per1000 live births)	Average annual change (%) over previous year
2008	35	0
2009	34	-2.9
2010	33	-3.03
2011	31	-6.1
2012	29	-6.5

Source: Sample Registration System (SRS), RGI, India

5.2.4 Causes of Neo-natal Mortality

35 percent of newborn deaths are caused by complications of premature birth with surviving newborns facing a lifetime of disability, including learning disabilities, visual and hearing problems. Birth complications and septicaemia contributes 23% each towards new-born mortality. These three causes together contribute 80% of total mortality in newborns.

5.3 NEWBORN AND CHILD HEALTH INTERVENTIONS

5.3.1 Facility Based Newborn Care (FBNC)

Facility Based Newborn Care (FBNC) is one of the key components under the National Rural Health Mission to improve the status of newborn health in the country. A continuum of newborn care has been established with the launch of home based and facility based newborn care components ensuring that every newborn receives essential care right from the time of birth and first 48 hours at the health facility and then at home during the first 42 days of life. Newborns identified as sick or preterm /low birth weight soon after birth or during home visit are referred to special newborn care facilities for further management and long term follow up after discharge.

Newborn Care Corners (NBCCs) are established at delivery points to provide essential newborn care, while Special Newborn Care Units (SNCUs) and Newborn Stabilization Units (NBSUs) provide care for sick newborns. Till March 2014, a total of 13,653 NBCCs, 1,737 NBSUs and 507 SNCUs have been made operational across the country.

a. **Special Newborn Care Unit (SNCUs)** is located in close proximity to the labour room with 12 or more beds, and has dedicated and adequately trained doctors, staff nurses and support staff to provide 24x7 services. It delivers Level-II newborn care to sick and small newborns besides training to medical officers and nurses in facility based newborn care.

b. **Newborn Stabilization Unit (NBSU)** is a 4 bedded unit providing basic level of sick newborn care, established at Community Health Centers/ First Referral Units. Provision of newborn care at these units increases the chances of survival for babies with health conditions requiring observation and stabilization soon after birth or in the period thereafter.

c. **New Born Care Corners (NBCCs)** are operationalized within the labour rooms and operation theatres in public health facilities designated as delivery points. These units have NSSK (Navjaat Shishu Suraksha Karyakram) personnel who provide essential newborn care and resuscitation, when required, to all newborns delivered at these health facilities.

d. **Navjaat Shishu Suraksha Karyakram (NSSK)** training was initiated in September, 2009 with the purpose of training all health care providers in essential newborn care and resuscitation when required. About 1,24,352 health care providers have been trained in NSSK in the country till March, 2014.

e. **National Training Package for Facility Based Newborn Care:** This training package has been developed with participation of national neonatal experts, and facilitated by the National Collaborative Centre for Facility Based Newborn Care at Kalawati Saran Children's Hospital under the mandate of Ministry of Health & Family Welfare. This package will improve the cognitive knowledge and build psychomotor skills of the medical officers and staff nurses posted in these units to provide quality newborn care.

f. **Empowering frontline health service providers:** The ANMs are now empowered to give a pre-referral dose of antenatal corticosteroid (Injection Dexamethasone) in pregnant women going into preterm labour. The use of antenatal corticosteroids is to corticosteroids at all levels of health facilities. ANMs will also administer pre-referral dose of Injection Gentamycin to newborns for the management of sepsis in young infants (upto 2 months of age).

5.4 HOME BASED NEWBORN CARE SCHEME (HBNC)

Under National Rural Health Mission, Home Based New Born Care is being implemented since 2011 for

reduction of neonatal mortality in the first month of life in rural areas. Under this scheme, funds are allocated for training of ASHAs, supportive supervision by ASHA facilitators, incentive to ASHAs for home visits and purchase of HBNC kits. ASHAs are paid an incentive of Rs. 250 for visiting each newborn 6 times (in case of hospital delivery)/ 7 times (in case of home delivery) in the first six weeks of life as per the schedule.

The Home Based New Born Care Programme is being implemented under NRHM in all States and UTs except for Himachal Pradesh, Goa, Kerala, Chandigarh, Daman & Diu and Puducherry.

Out of 8.8 lakh ASHAs in the country, 5.6 lakhs have been trained in 6 &7 module, which provide necessary skills to conduct home visits. Around 12 lakh babies have been visited by ASHAs (all 6/7 visits).

Linking home based newborn care to facility based care is important in order to save newborn lives. While home based care provides opportunity for early diagnosis of danger signs, prompt referral to an appropriate health facility with provision for newborn care facility, saves lives. JSSK provides for free referral transport of newborns from the community to health facility and between different levels of health facilities, drugs, diagnostics and treatment at newborn care facilities established in the public health system.

5.5 INFANT AND YOUNG CHILD FEEDING (IYCF)

The importance of breastfeeding as the preventive intervention with potentially the single largest impact on reducing child mortality has been well recognised. Considering that reducing infant mortality is one of the goals of the NRHM, promotion of Breastfeeding and optimal Infant and Young Child Feeding practices through the public health system is another important intervention area under child health.

With multiple MCH contacts with the health system, there is an opportunity to promote optimal IYCF practices. Provision of Home Based New Born Care has presented valuable opportunity for community health workers to reach out to mothers and newborns at home during the first 6 weeks of life. Village Health and Nutrition Day (VHND), Outreach sessions for Routine Immunisation, management of newborn and childhood illnesses at community level are all entry points for IYCF information and counselling.

The Child Health Division has developed national operational guidelines, presenting options to the States to plan and implement a set of activities that are best suited locally. In this guideline various MCH contact opportunities have been clearly identified. Key actions that can be taken by health care providers at facility and community level have been clearly defined.

5.6 NUTRITIONAL REHABILITATION CENTRES (NRC)

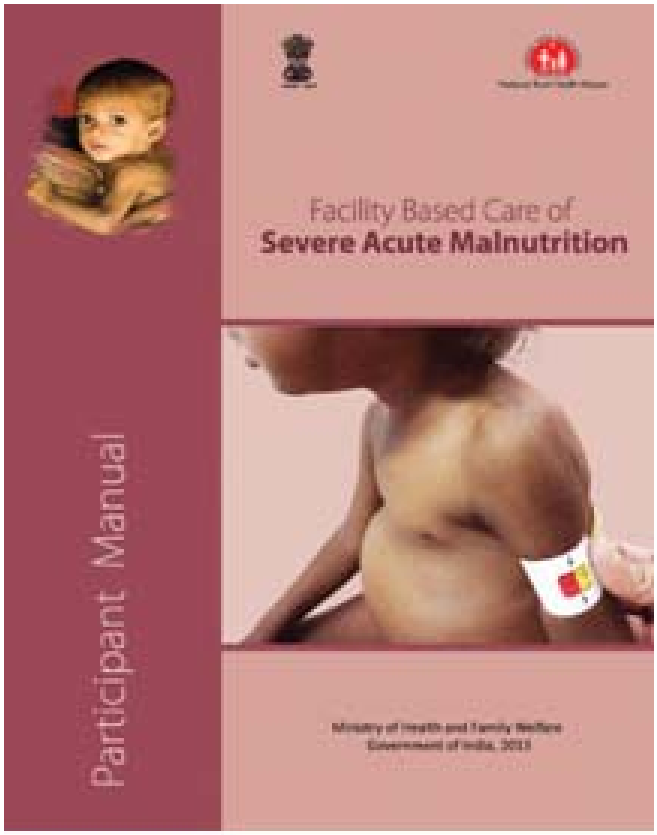
Nutritional Rehabilitation Centers are facility based units providing medical and nutritional care to Severe Acute Malnutrition (SAM) children under 5 years of age who have medical complications. In addition special focus is on improving the skills of mothers on child care and feeding practices so that child continues to receive adequate care at home.

NRCs play a crucial role in averting deaths due to under-nutrition and promoting physical and psychosocial growth of children with severe under nutrition.

Services provided at the NRCs include:

- 24 hour care and monitoring of the child,
- Treatment of medical complication,
- Therapeutic feeding,
- Sensory stimulation and emotional care,
- Counseling on appropriate feeding, care & hygiene and
- Demonstration and practice-by-doing on the preparation of energy dense food using locally available, culturally acceptable and affordable food items.

Presently 872 Nutrition Rehabilitation Centers are functional across 17 States/UTs with 9377 dedicated beds. The States are directed to prioritise High Focus Districts and the Tribal Districts identified as having high burden of malnutrition for establishment of NRCs, during approval of Annual PIP budgets. As a result, 75% of High Priority Districts in 14 States now have at least one functional NRC.



5.6.1 Training Package for Facility Based Care of Severe Acute Malnutrition: National Operational Guideline on Facility Based Management of Children with Severe Acute Malnutrition (MoHFW, 2011) recommends that various cadres of health service providers working in the Nutrition Rehabilitation Centres (NRCs) be provided relevant knowledge and skills for managing children with malnutrition.

The training package for facility based care of Severe Acute Malnutrition (SAM) in Children has been developed to train staff of Nutritional Rehabilitation Centres on diagnostic and treatment protocols. The package aims to improve the clinical skills of the Medical Officers and Nursing staff of NRCs, particularly for the management of children with SAM.

5.7 SUPPLEMENTATION WITH MICRONUTRIENTS

Iron Folic Acid: Anemia continues to be significant public health problem affecting 69.5 percent of under five children in India. Till recently a daily regime of iron and folic acid supplementation was provided to children for a period of 100 days for prevention of iron deficiency anemia. Considering the underutilization of Iron and Folic Acid syrup in the programme, it has been decided to initiate intermittent bi-weekly provision of Iron and folic acid syrup to children through ASHA for better compliance of this intervention. This intervention is a part of the **National Iron Plus Initiative**, which lays a renewed emphasis on tackling high prevalence of anemia comprehensively across age groups. The national guidelines have been released by Ministry of Health & Family Welfare, in January, 2013. The details of the guidelines have been circulated to all States and UTs for compliance.

Vitamin A: Under the national programme, 1st dose of Vitamin A (1 lakh I.U.) is being given to the child at the time of immunization at 9 months of age, and thereafter, the child is administered doses of Vitamin A (2 lakh I.U. of Vitamin A) at 6 monthly interval, so that a child receives a total of 9 doses of Vitamin A till the age of 59 months. Bi-annual rounds for Vitamin A supplementation are being conducted in 14 States (including EAG States and some Southern States) and one UT with the co-ordination between Health & ICDS functionaries.

From 2012-13 onwards, the procurement process has been decentralised and as a result, the States/UTs are provided budget for procurement of Vitamin A according to the number of beneficiaries (under five children).

5.8 REDUCTION IN MORBIDITY AND MORTALITY DUE TO ACUTE RESPIRATORY INFECTIONS (ARI) AND DIARRHOEAL DISEASES

a) Childhood Diarrhoeal Diseases

Diarrhoea is one of the leading causes of under-five mortality in India. The guidelines under the national programme recommend use of low osmolarity Oral Rehydration Solution (ORS), Zinc and continued feeding (energy dense feeds) in addition to breastfeeding for management of diarrhoea. Antimicrobials are recommended only for specific cases. Zinc has been approved as an adjunct to ORS for the management of diarrhoea. Children aged 2-6 months are given 10 mg

of elemental Zinc per day and children 7 months - 5 years, 20 mg per day for a total period of 14 days from the day of onset of diarrhoea.

Funds are provided to the States for procurement of ORS and Zinc and supplies maintained at each public health facility and ASHA who is the village level depot holder of ORS packets and Zinc tablets. It is to be ensured that Zinc and ORS is provided to all cases of childhood diarrhoea seeking care at DH/CHC/PHC/ Additional PHC/Sub Centres. The aim is that every child treated for diarrhoea should get 14 tablets of Zinc along with one/two ORS packets at the start of therapy and counselled properly for continued administration.

b) Acute Respiratory Infections (ARI)

While acute upper respiratory tract infections are very frequent in children, pneumonia is the leading cause of under-five mortality. Early recognition and treatment of pneumonia can be lifesaving. For children with non-severe pneumonia, the ARI control programme recommends oral Cotrimoxazole as the first line drug. This is supplied at the sub-centre level and is recommended as drug for community based management of pneumonia by frontline health workers.

Amoxicillin has been recommended as the preferred drug for treatment of non-severe pneumonia at facility level by the physician. It has been estimated that about 10% of children presenting with pneumonia may require referral for hospital based management. Use of oxygen and injectable antibiotics is recommended for inpatient treatment of severe cases and the recommended antibiotics included in the essential drug list.

c) Facility Based-Integrated Management of Neonatal and Childhood Illnesses (F-IMNCI)

Presently, 25,412 medical officers and staff nurses have been trained in facility based IMNCI to provide care to sick children and newborns at CHCs/FRUs.

5.9 NEW INITIATIVES

5.9.1 Rashtriya Bal Swasthya Karyakram (RBSK)

This is a new initiative launched in February 2013 which includes provision for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability. An estimated 27 crore children in the age group of zero to eighteen (0-18) years are expected to be covered across the country in a phased manner. Child Health Screening and Early Intervention Services will cover 30 common health conditions for early detection and free treatment and management.

Dedicated mobile health teams placed in every block screen children from birth to till 6 years at Anganwadi centres at least twice a year and screen children enrolled in Government and Government aided schools atleast once a year. Newborn are screened for birth defects in health facilities where deliveries take place and during the home visit by ASHA.

- Health screening of children is carried out by block level mobile health teams consisting of AYUSH doctors and paramedics duly trained in the use of necessary tools for screening.
  - o In 2013-14, 11,839 Mobile Health teams have been approved of which till January, 2014, 5,491 teams in 22 State/UTs have been recruited.
- Early Intervention Centres are being operationalized at District Hospitals for management of cases referred from block upwards. Linkages with secondary and tertiary level health services are provided in case higher level of management is required, including surgical interventions, free of cost.
  - o 445 master trainers across State/UTs have been trained. 225 District Early Intervention Centres (DEICs) are being established.
  - o By January, 2014, the number of children screened has exceeded 5.82 crore, (69.80 lakhs children from birth to 6 years and 5.13 crores children enrolled in Government and Government aided school). 1.30 lakh have received free treatment including surgeries for congenital heart disease, cleft lip and correction of club foot etc.
- Through early identification and linkages to care, support and treatment, screening will help in providing a comprehensive package of services to reduce the household expenditure of the poor and

marginalized, reduce the disease burden and build health awareness. The scheme will diminish the burden on the health system besides encouraging caregivers / parents to seek health care early for their children. This is likely to translate into economic benefits both for the country and for individual families in the long run.

5.10 UNIVERSAL IMMUNIZATION PROGRAMME (UIP)

Immunization Programme (IP) 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 of 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 become 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. Immunization is one of the key areas under National Rural Health Mission (NRHM) launched in 2005 and now it is under the umbrella of National Health Mission (NHM).

Under the Universal Immunization Programme, Government of India is providing vaccination to prevent seven vaccine preventable diseases i.e.:

- Diphtheria, Pertussis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B.
- In addition vaccination to prevent Hib infection is provided in selected States and vaccination to Japanese Encephalitis provided in selected districts.

5.10.1 Immunization Schedule

S. No	Vaccine	Protection	Number of doses	Vaccination Schedule
1	BCG (Bacillus Calmette Guerin)	Tuberculosis	1	At birth (upto 1 year if not given earlier)
2	OPV (Oral Polio Vaccine)	Polio	5	Birth dose for institutional deliveries within 15 days, Primary three doses at 6, 10 & 14 week and one booster dose at 16-24 month of age. given orally
3	Hepatitis B	Hepatitis	4	Birth dose for institutional deliveries within 24 hour, Primary three doses at 6, 10 14 week
4	DPT (Diphtheria, Pertussis and Tetanus Toxoid)	Diphtheria, Pertussis and Tetanus	5	Three doses at 6, 10 & 14 week and two booster dose at 16-24 month and 5 years of age
5	Measles	Measles	2	9-12 months of age and 2nd dose at 16-24 months.
6	TT (Tetanus Toxoid)	Tetanus	2 2	***Children:*** 10 years and 16 years of age ***Pregnant woman:*** Two doses given (one dose, if previously vaccinated within 3 Year)
7	JE vaccination (in selected 113 JE endemic districts in 15 States)	Japanese Encephalitis (Brain disease)	2	1st dose at 9-12 months of age & 2nd dose 16-24 month of age in JE endemic districts after 6 months of campaign
8	Hib containing Pentavalent vaccine (Hib+DPT+Hep B) Presently in eight States (Tamil Nadu, Kerala, Gujarat, Haryana, Karnataka, Goa, J & K and Puducherry)	Diphtheria, Pertussis, Tetanus, Hepatitis B and Haemophilus influenzae type B associated Pneumonia meningitis	3	6, 10 & 14 week of age

5.10.2 Status of Universal Immunization Programme (UIP)

The achievements in terms of immunization coverage is improving over the years however, there is further need for improvement especially in DPT3 & OPV3 coverage and reducing drop outs. Following table outlines achievements as per evaluated coverage.

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

(Figures are in %)

The recent Annual Health Survey (AHS 2011-12) conducted in 9 States documented improvement in immunization coverage in all States except Rajasthan which has shown decline when compared to AHS-1 and Chhattisgarh is stagnant with no change in full immunization coverage.

Odisha has shown maximum improvement by 7.3% in AHS-2. The Full Immunization was observed highest in Uttarakhand at 77.9% while lowest in Uttar Pradesh at 48.1%.

Annual Health Survey (2011-2012)

States	BCG	OPV 3	DPT3	Measles	FI	Polio (Birth dose)	No Immu-nization
Uttarakhand	92.9	84.8	84.1	84.5	77.9	75.8	5.3
Chhattisgarh	96.8	83.0	81.7	89.4	74.1	87.0	2.5
Rajasthan	91.1	78.1	76.1	81.5	69.2	78.6	5.4
Bihar	93.5	80.4	79.6	76.7	65.6	66.1	4.5
Jharkhand	93.6	79.9	78.0	81.9	69.1	75.2	3.6
Assam	94.3	76.6	74.8	79.3	61.4	78.5	3.4
Odisha	97.8	78.9	77.9	87.8	62.3	80.7	1.0
Madhya Pradesh	94.7	73.1	71.5	82.6	59.7	84.4	4.3
Uttar Pradesh	84.8	60.9	59.8	63.1	48.1	69.1	9.5

All the States / UTs prepare their own State Programme Implementation Plan (PIP) for Immunization as part 'C' of NRHM PIP from the year 2005-06 to address specific needs.

5.10.3 Year 2012: Year of Intensification of Routine Immunization (IRI)

Immunization coverage in India has been variable with areas of low coverage in both urban and rural areas. In an effort to enhance the immunization profile in the country, ***Government of India declared 2012 as "Year of Intensification of Routine Immunization" (IRI).***

- In the year of intensification of Routine Immunization 2012-13, more than 160 lakh doses of various antigens under UIP Programme have been administered to the beneficiaries.
- More than 10 lakh children were able to receive vaccines for the first time. These children would probably have remained unvaccinated had it not been planned to approach them strategically through Immunization weeks.

Special Immunization Weeks (SIWs), 2013-14: A drive to reach the unreached

As a continuation of strategy for Intensification of RI, four SIWs have been carried out during the months of April, June, July and August in the year 2013-14. These SIWs are targeted to children, 2 years and pregnant mothers in nearly 4000,000 high risk areas identified through polio eradication programme. The antigen wise coverage is as under.

Figure in lakh

BCG	5.46	**Penta**	2.11
DPT	25.18	**Hep B**	17.53
Measles	10.40	**OPV**	28.76
JE	3.69	**TT**	11.61

For year 2014, these SIWs are planned in all 35 States/ UTs during the months of (February, March, April, and May). More than 13.58 lakh doses of various antigens have been administered to beneficiaries (as on 23 April, 2014)

5.10.4 Introduction of Pentavalent Vaccine (DPT+Hep-B +Hib)

India introduced Pentavalent Vaccine containing DPT, Hepatitis-B and Hib vaccines initially in two States viz.

Kerala and Tamil Nadu under routine immunization programme from December 2011. Under the programme, DPT and Hepatitis B were part of the immunization schedule and required 6 injections to deliver the primary doses. With the introduction of Pentavalent vaccine, a new antigen i.e. Hib has been added which protects against Haemophilus influenzae type B associated Pneumonia and Meningitis and the number of injection have been reduced to 3. The Pentavalent vaccine has been expanded to 6 more States i.e. Haryana, J&K, Gujarat, Karnataka, Goa and Puducherry in 2012-13. More than 168 lakh doses of Pentavalent vaccine have been administered to children in these 8 States since inception (as on Feb, 2014).

Further Expansion of Pentavalent vaccine is planned in entire State: 11 States from October 2014: Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Punjab, Rajasthan, West Bengal, Delhi and Uttarakhand and remaining 16 States/UTs from April 2015.

5.10.5 Hepatitis B Vaccine

In 2010-2011, Government of India universalized Hepatitis B vaccination to all States/UTs in the country. Monovalent Hepatitis B vaccine is given as Intra-Muscular (IM) injections to the infants at 6th, 10th and 14th week along with primary series of DPT & Polio vaccines. In addition one dose of Hepatitis B is given at birth for institutional deliveries within 24 hours of birth.

5.10.6 Measles Second Dose

Measles immunization directly contributes to the reduction of under-five child mortality and hence to the achievement of Millennium Development Goal number 4. In order to accelerate the reduction of measles related morbidity and mortality second opportunity for measles vaccination is introduced w.e.f. 2010-11 as per the recommendation made by National Technical Advisory Group on Immunization (NTAGI). The strategy was to provide another dose of measles vaccine through measles Supplementary Immunization Activity (SIA) for 14 States where evaluated coverage for measles vaccine is less than 80%, followed 6 month later integration into routine immunization programme. For the remaining 21 States where evaluated coverage was more than 80% measles second dose introduced through routine immunization except States/UT of Delhi, Puducherry, Sikkim and Goa where they introduced 2nd measles containing vaccine (mumps-measles-rubella vaccine) as second dose on their own as state initiative.

Measles Supplementary Immunization Activity (SIA) in 14 States: SIA carried out in 3 phases. During Phase I, 1.2 crore children were vaccinated with Measles vaccine in 45 districts in 13 States with 87.2% coverage. During Phase II, 3.6 crore children were vaccinated in 152 districts in 14 States. The Phase III of the campaign 11.8 crore children (85%) had been vaccinated in 167 districts in 5 States i.e. Madhya Pradesh, Uttar Pradesh, Gujarat, Rajasthan and Bihar.

Government of India along with the 11 SEARO countries and all partners have resolved to eliminate Measles and control Rubella in India and the South East Asian Region of WHO by the end of 2020.

5.10.7 Introduction of Japanese Encephalitis (JE) Vaccine

Japanese Encephalitis (JE) is an acute viral illness with high case fatality and long term complications. JE vaccination was started in 2006 and covered 113 endemic districts in a phased manner targeting all children between 1 to 15 years of age with a single dose of JE vaccine (SA 14-14-2) manufactured by Chengdu, China. Currently JE endemic districts have introduced JE vaccine as two doses at 9-12 months and 16-24 months under routine immunization w.e.f. April 2013. National Vector Borne Disease Control Programme (NVBDCP) has identified another 64 new JE endemic districts and 5 districts of Bihar for re-campaign. The JE vaccination campaign is being conducted in a phased manner to cover all these

endemic districts. JE vaccination drive is being carried out in 144 districts in 16 States. In addition, there is a plan to cover another 33 districts in next year.

Coverage Data JE second dose (16-24 month dose) under RI

Year	Target (in lakhs)	Total children vaccinated (in lakhs)	Total coverage %
2012-13	66.56 lakhs	31.59 lakhs	58.08%
2013-14	66.92 lakhs	37.03 lakh (as on Apr-2014)	55.34 %

5.11 PULSE POLIO IMMUNIZATION (PPI)

With the global initiative of eradication of polio in 1988 following World Health Assembly resolution in 1988, Pulse Polio Immunization programme was launched in India in 1995. Children in the age group of 0-5 years administered polio drops during National and Sub-national immunization rounds (in high risk areas) every year. About 172 million children are immunized during each National Immunization Day (NID).

Progress

- India has not reported any case of polio due to wild polio virus since more than three years. The last polio case in the country was reported from Howrah district of West Bengal with date of onset 13th January 2011.
- WHO on 24th February 2012 removed India from the list of countries with active endemic wild polio virus transmission.
- On 27thMarch 2014, India along with South-East Asia Region of WHO has been certified polio free by Regional Certification Commission for polio eradication.

Last Reported Polio Case		
Polio Virus Type	**Date of last case**	**Location**
P1	13 January 2011	Howrah (Panchla), WB
P2	24 October 1999	Aligarh, UP
P3	22 October 2010	Pakur(Pakur), Jharkhand

- There are 24 lakh vaccinators and 1.5 lakh supervisors involved in the successful implementation of the Pulse Polio Programme.
- The total number of cases and number of affected districts during past 7 years is as below:

Year	Cases of Polio	Number of districts
2005	66	35
2006	676	114
2007	874	99
2008	559	90
2009	741	56
2010	42	17
2011	01	1
2012	00	00
2013	00	00
2014	00	00 (as on 30th Mar 2014)

Steps taken by the Government to achieve target of polio eradication

- All States and Union Territories in the country have developed a Rapid Response Team (RRT) to respond to any polio outbreak in the country. An Emergency Preparedness and Response Plan (EPRP) has also been developed by all States indicating steps to be undertaken in case of detection of a polio case.
- Special booths are established in areas bordering neighbouring countries like Wagah border and Attari train station in Punjab and Munabo train

stations in Barmer district of Rajasthan to ensure that all children under 5 years of age coming from across the border are given polio drops.

- Government of India has made mandatory requirement of polio vaccination to all international travellers before their departure from India to polio affected countries namely: Afghanistan, Nigeria, Pakistan, Ethiopia, Kenya, Somalia and Syria. The mandatory requirement is effective for travellers from 1st March 2014.
- To reduce risk of importation from neighbouring countries, international border vaccination is being provided to all eligible children round the clock. These are provided through special booths set up at the international borders that India shares with Pakistan, Bangladesh, Nepal and Myanmar.
- Environmental surveillance established in Mumbai, Delhi, Patna, Kolkata and Punjab. The possibility for Gujarat is being explored.
- An extremely high level of vigilance through surveillance across the country for any importation or circulation of poliovirus and VDPV is being maintained.
- A rolling emergency stock of OPV is being maintained to respond to any WPV or cVDPV.
- An expert sub-group is established to discuss issues related to tOPV to bOPV switch in routine immunization and IPV introduction in the country along with India specific timelines for these activities.
- Government of India has identified 107 High risk blocks for polio where a multi-pronged strategy is being implemented to ensure sanitation, hygiene and clean drinking water in addition to vaccinating each and every child OPV.

- Migratory populations from UP and Bihar are being identified in the States of Punjab, Haryana, Gujarat and West Bengal and these migratory children are being covered during the SNID in UP and Bihar.
- Social Mobilization activities are being intensified by involving the local influencers, community and religious leaders to improve community participation and acceptance of polio vaccine.
- In the States of UP and Bihar every new born child is being identified and vaccinated during the polio immunization campaigns and is being tracked for subsequent rounds.
- In order to reach every eligible child during the pulse polio round, apart from the strategy of vaccinating children at fixed booths and house to house visit, efforts in vaccinating children in transit at railway stations, inside long distance trains, major bus stops, market places, religious congregations, major road crossings etc, throughout the country have been intensified.

Maternal and Neo-natal Tetanus Elimination (MNTE): Government of India with support of national and international agencies (WHO, UNICEF and others) Maternal and Neo-natal Tetanus Elimination (MNTE) validated in 18 States (2005-2013), the most recent states to have been validated are Uttarakhand, Delhi and Mizoram. In 2014, it is proposed for five more States i.e. Rajasthan, Madhya Pradesh, Tripura, Jharkhand and Odisha.

National Cold Chain Management Information System: A web enabled National Cold Chain Management Information System (NCCMIS) developed in 2011-13 to track the status of cold chain equipment at the country level. It is aimed to capture real time data of functionality of cold chain equipment at all levels across the country. All States have uploaded the data.

IEC/BCC Strengthening

- New logo and tag-line developed and launched in April 2013.
- Radio spots and TV commercial developed.
- Print prototypes for banners and posters created.

Chapter 6

NATIONAL PROGRAMMES UNDER NRHM

6.1 INTRODUCTION

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

6.2 NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP)

The National Vector Borne Disease Control Programme (NVBDCP) is an umbrella programme for prevention and control of vector borne diseases viz. Malaria, Japanese Encephalitis (JE), Dengue, Chikungunya, Kala-azar and Lymphatic Filariasis. Out of these six diseases, two diseases namely Kala-azar and Lymphatic Filariasis have been targeted for elimination by 2015. The States are responsible for implementation of programme, whereas the Directorate of NVBDCP, Delhi provides technical assistance, policies and assistance to the States in the form of cash & commodity, as per approved pattern. Malaria, Filaria, Japanese Encephalitis, Dengue and Chikungunya are transmitted by mosquitoes whereas Kala-azar is transmitted by sand-flies. The transmission of vector borne diseases depends on prevalence of infective vectors and human-vector contact, which is further influenced by various factors such as climate, sleeping habits of human, density and biting of vectors etc.

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

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

(ii) **Disease Management** including early case detection with active, passive and sentinel surveillance and complete effective treatment, strengthening of referral services, epidemic preparedness and rapid response.

(iii) **Supportive Interventions** including Behaviour Change Communication (BCC), Inter-sectoral Convergence, Human Resource Development through capacity building.

(iv) **Vaccination** only against J.E.

(v) **Annual Mass Drugs Administration** (only against Lymphatic Filariasis)

6.2.1 Malaria

a) Malaria is an acute parasitic illness caused by Plasmodium falciparum or Plasmodium vivax in India. The main clinical presentation is with fever with chills; however, nausea and headache can also occur. The diagnosis is confirmed by microscopic examination of a blood smear and Rapid Diagnostic Tests. Majority of the patients recover from the acute episode within a week. Malaria continues to pose a major public health threat in different parts of the country, particularly due to *Plasmodium falciparum* severity may develop and may cause fatality, if not treated early.

b) In India, out of 9 species of Malaria vectors, the major vector for rural malaria is *Anopheles culicifacies*, found all over the country and breeds in clean ground water collections. Other important Anopheline species namely *An.minimus* and *An.fluviatilis* breed in running channels, streams

with clean water. Some of the vector species also breed in forest areas, mangroves, lagoons, etc, even in those with organic pollutants.

c) In urban areas, Malaria is mainly transmitted by Anopheles stephensi which breeds in man-made water containers in domestic and peri-domestic situations such as tanks, wells, cisterns, which are more or less of permanent nature and hence can maintain density for malaria transmission throughout the year. Increasing human activities, such as urbanization, industrialization and construction projects with consequent migration, deficient water and solid waste management and indiscriminate disposal of articles (tyres, containers, junk materials, cups, etc.) create mosquitogenic conditions and thus contribute to the spread of vector borne diseases.

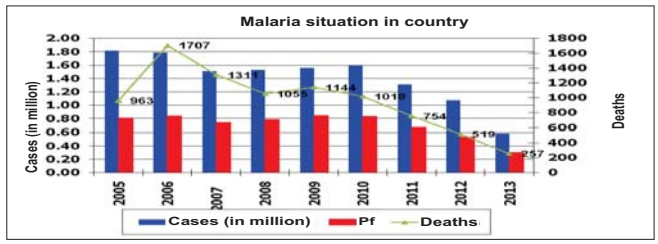
Epidemiological Situation: The status of total cases, Pf cases, deaths and API from 2005 to 2013 is given in the table and the Graph as follows. The state-wise data on malaria cases & deaths since 2010 is at ***Appendix- 1***.

Malaria Situation in the country during 2005-2013

Year	Cases (in millions)		Deaths	API
	Total	Pf		
2005	1.82	0.81	963	1.68
2006	1.79	0.84	1707	1.66
2007	1.50	0.74	1311	1.39
2008	1.53	0.78	1055	1.36
2009	1.56	0.84	1144	1.36
2010	1.60	0.83	1018	1.37
2011	1.31	0.67	754	1.10
2012	1.06	0.53	519	0.88
2013 (P)	0.84	0.45	379	0.21

Pre-independence estimates of Malaria were about 75 million cases and 0.8 million deaths annually. The problem was virtually eliminated in the mid-sixties but resurgence led to an annual incidence of 6.47 million cases in 1976. Modified Plan of Operation was launched in 1977 and annual malaria incidence started declining. The cases were contained between 2 to 3 million cases annually till 2001 afterwards the cases have further started declining.

During 2011, the malaria incidence was around 1.31 million cases, 0.67 million Pf cases and 754 deaths; while during 2012, 1.01 million cases, 0.53 Pf cases and 519 deaths were reported. About 91% of malaria cases and 99% of deaths due to malaria are reported from high disease burden states namely North Eastern (NE) States, Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and West Bengal. However, other States are also vulnerable and have local and focal upsurge. During 2013 (P), 0.84 million cases, 0.45 million Pf cases and 379 deaths have been reported.



Resistance in *Plasmodium falciparum* to Chloroquine was observed to be very high and frequent in the studies conducted during 2001 onwards. Therefore, Artemisine Combination Therapy (ACT) is now being used as first line of treatment for all Pf cases in whole of the county. However, in North-Eastern States early signs of resistance to currently used SP-ACT, has been noticed and so, as per the advice of Technical Advisory Committee, effective combination of Artemether-Lumefantrine (ACT-AL) has been recommended for the treatment of Pf cases in the North Eastern States. For strengthening surveillance, Rapid Diagnostic Test (RDT) for diagnosis of *P.falciparum* malaria has also been introduced in high endemic areas and being scaled up. Considering that about 50% of the malaria cases are due to *P vivax* in the country, bivalent RDT (detecting both Pv and Pf infection) has been introduced in the country at the field level from this year. ASHAs have been trained in diagnosis and treatment of malaria cases and are involved in early case detection and treatment.

The Government of India provides technical assistance and logistics support including anti malaria drugs, DDT, larvicides, etc. under NVBDCP within overall umbrella of NRHM. State Governments have to implement the programme and required human resource and other logistics are to be ensured.

Externally supported projects:

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

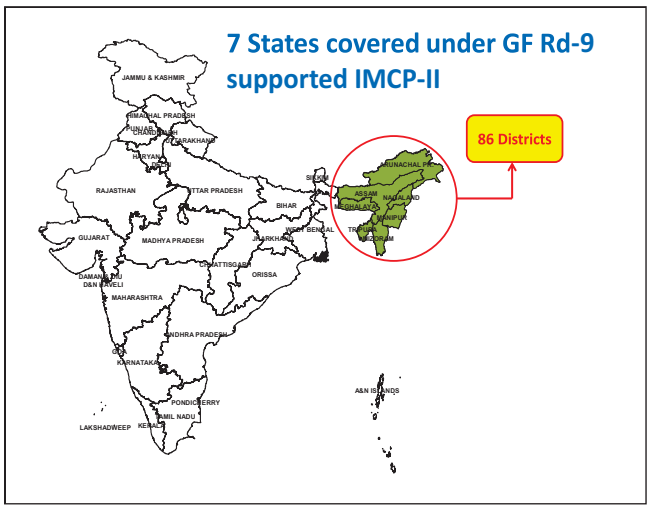
i. Global Fund Supported Intensified Malaria Control Project (IMCP-II)

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

The areas covered under these projects are as under:

(i) The Global Fund supported 'Intensified Malaria Control Project- Phase II' (IMCP-II)

Global Fund Round 9 supported Intensified Malaria Control Project (IMCP-II) is being implemented since October 2010 for a period of five years in 7 NE States. The project area covers a population of 46 million in 86 districts as shown in the map.

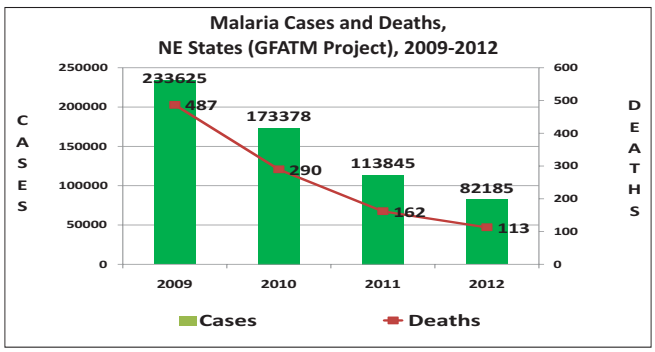


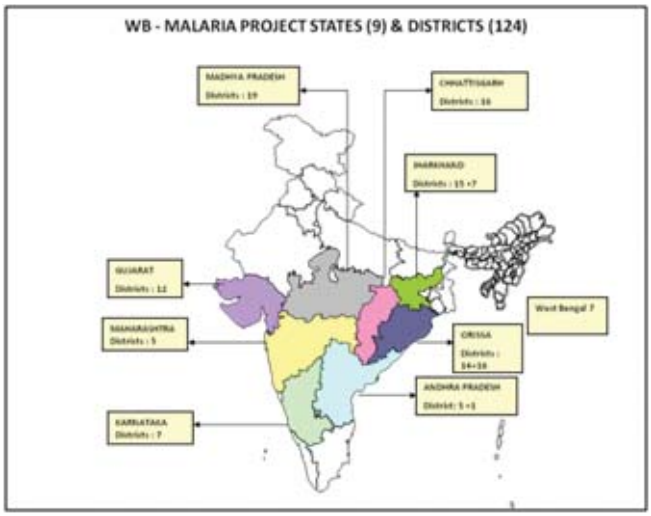
The strategies of the project are early diagnosis and complete treatment, integrated vector control including promotion of ITN (LLINs), through intensive IEC and capacity building & training of the health workers & community volunteers. Specific inputs are provided to these project areas in the form of manpower, RDTs, drugs and LLINs. The period for first phase is for two years starting from October 2010 to Sept. 2012. The Phase-II is granted by the GFATM based on the experience of the phase I. CARITAS India is the partner Principal Recipient 2 (PR2) in the project.

Additional Support provided in project area is listed below:

- Human resource such as Consultants and support staff for project monitoring units at state and district level and malaria technical supervisor and laboratory technicians at sub-district level.
- Capacity building of Medical Officer/Lab. Technicians/ Fever Treatment Depots/Volunteers etc.
- Commodities such as Long-Lasting Insecticidal Nets (LLINs), Rapid Diagnostic tests for quick diagnosis of Malaria, alternate drugs i.e. Artemesinin based Combination Therapy and Inj. Artesunate for treating severe malaria cases.
- Planning & administration including mobility support, monitoring, evaluation and operational research (studies on drug resistance and entomological aspects).

The impact of the project activities is reflected in sharp reduction of malaria cases and deaths due to malaria in project states (7) as shown in the graph.





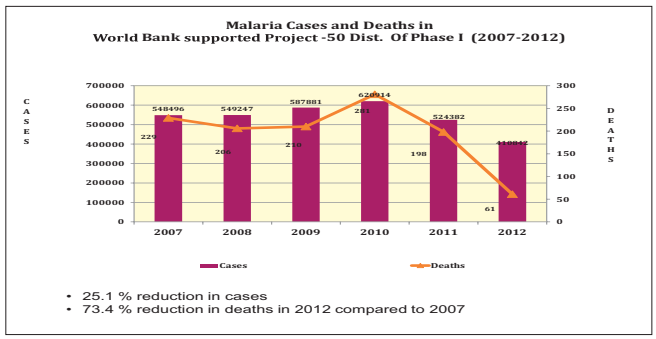
(ii) The World Bank Supported Project on Malaria Control & Kala-azar Elimination

This project has been approved for 5 years effective from 2009 to December 2013. The total financial outlay for this project is Rs.1000 crore. This project covers 124 malarious districts of nine (9) States namely Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Karnataka & West Bengal and 46 Kala-azar districts in three States namely Bihar, Jharkhand and West Bengal. The project is being implemented in two phases. Phase one covered 50 most malaria endemic districts in five States namely Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Odisha and Jharkhand and 46 Kala-azar districts in Bihar, Jharkhand & West Bengal. From 3rd year, Phase two is being implemented in remaining 74 high malaria endemic districts.

Additional support provided in this project is:

- Provision of Human Resource like Consultants & Support staff at National, State, District & Sub District level for Surveillance & monitoring.
- Promotion & use of long lasting Insecticide Nets (LLINs) in high malaria endemic areas.
- Social Mobilization and vulnerable community plan to address the issues of marginalized sections.
- Strong BCC/IEC activities at Sub district level through identified agencies.
- The project also envisaged the safe guard policies by undertaking Environmental Management Plan (EMP) on safe disposal & for prevention of environmental hazards.
- Capacity building of Medical Officer/Lab Technicians/Fever Treatment Depots/Volunteers etc.
- Supply of rapid kits for Malaria and drug Artemesinin based combination therapy (ACT) for treatment of PF cases.

Impact: With this additional support the impact in malaria cases and deaths in phase I districts shows that there has been 25.1% reduction in malaria cases and 73.4% decline in deaths due to malaria in the 50 districts of Phase I implementation.



6.2.2 Urban Malaria Scheme

The Urban Malaria Scheme (UMS) under NVBDCP was sanctioned in 1971 by Govt. of India with main objectives of preventing deaths due to malaria and reduction in transmission and morbidity. This scheme is currently being implemented in 131 towns in 19 States and Union Territories protecting about 130 million population. Under this scheme, the larvicides are supported by Govt. of India through cash assistance, however, the entire staff for implementation and operational cost is to be borne by the state/corporation/municipality.

Epidemiological Situation: About 10% of the total cases of malaria are reported from urban areas. Maximum numbers of malaria cases are reported from Ahmedabad, Chennai, Kolkata, Mumbai, Vadodara, Vishakapatnam, Vijayawada etc. The comparative epidemiological profile

of malaria during 2008-2012 in all urban towns of the country is given below:

Comparative Epidemiological profile of malaria in 19 States under UMS during 2008-12							
Year	**Population**	**Total cases**	**P.f**	**P.F %**	**SPR**	**SFR**	**Deaths**
2008	113334073	115424	18971	16.44	2.48	0.41	102
2009	114699850	166075	31132	18.75	2.99	0.56	213
2010	116136978	220062	33174	15.08	3.79	0.58	149
2011	130316971	142502	13910	9.77	2.07	0.21	147
2012	130329138	82554	8236	9.98	1.35	0.14	61

P.f = Plasmodium falciparum, SPR= Slide positivity rate, SFR= Slide falciparum rate.

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

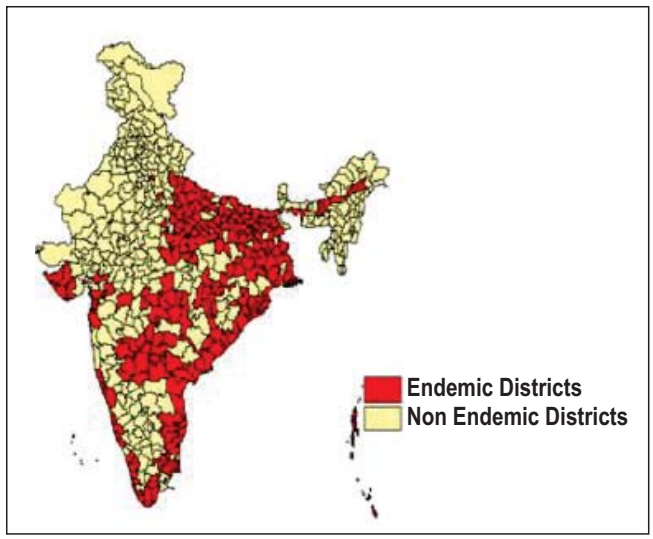
i. **Parasite Control:** Treatment is done through passive agencies viz. hospitals, dispensaries both in private & public sectors. In mega cities malaria clinics are established by each health sector/ malaria control agencies viz. Municipal Corporations, Railways, Defence services

ii. **Vector Control:** Source reduction, use of larvicides, use of larvivorous fish, space spray, minor engineering and Legislative measures.

The control of urban malaria depends primarily on the implementation of urban bye-laws to prevent mosquito breeding in domestic and peri-domestic areas or residential blocks and government/commercial buildings, construction sites. The Bye-laws have been enacted and being implemented in Delhi, Chennai, Mumbai, Chandigarh, Ahmedabad, Bhavnagar, Surat, Rajkot, Bhopal, Agartala and Goa etc.

6.2.3 Elimination of Lymphatic Filariasis

Lymphatic Filariasisin India is mainly caused by *Wuchereria bancrofti* and is transmitted mainly by mosquito Culexquinque fasciatus which breeds in dirty and polluted water, however, it can also breed in clear water in the absence of polluted water. The infection is prevalent in both urban and rural areas. The disease is also caused by another positive agent namely Brugia malayi which is transmitted mainly by *Mansonia annulifera* which is also the principal vector of this parasite. *M.uniformis* also plays a role in transmission of the disease and, therefore, is the secondary vector for transmission of brugia infection. Prevalence of *brugia* infection is restricted to small foci of Kerala.



The disease is reported to be endemic in 250 districts in 20 States and UTs. The population of about 600 million in these districts is at risk of lymphatic filariasis. This disease causes personal trauma to the affected persons and is associated with social stigma, even though it is not fatal.

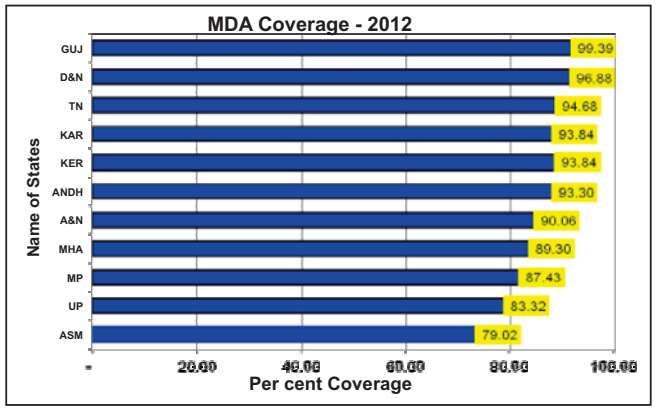
The target year for **Global** elimination of this disease is by the year 2020. Government of India is signatory

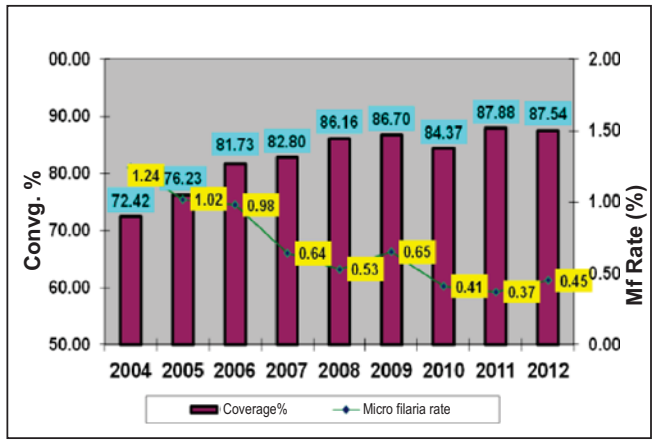
to the World Health Assembly Resolution in 1997 for Global Elimination of Lymphatic Filariasis. The National Health Policy (2002) has envisaged elimination of Lymphatic Filariasis in India by 2015.

The strategy of Lymphatic Filariasis elimination is through:

- Annual Mass Drug Administration (MDA) of single dose of DEC + Albendazole for a minimum five rounds or more to the eligible population (except pregnant women, children below 2 years of age and seriously ill persons) to interrupt transmission of the disease.
- Home based management of lymphoedema cases and up-scaling of hydrocele operations in identified CHCs/ District hospitals/medical colleges.

To achieve elimination of Lymphatic Filariasis, the Government of India during 2004 launched annual Mass Drug Administration (MDA) with annual single recommended dose of DEC tablets in addition to scaling up home based foot care and Hydrocele operation. The co-administration of DEC+ Albendazole has been up scaled since 2007. The programme covered 202 districts in 2004 whereas by the year 2007, all the 250





LF endemic districts where covered. MDA starts the month of November; however, the dates of observance of MDA are staggered depending on the preparedness of the states. The coverage has improved from 72.4% in 2004 to 87.5% in 2012.

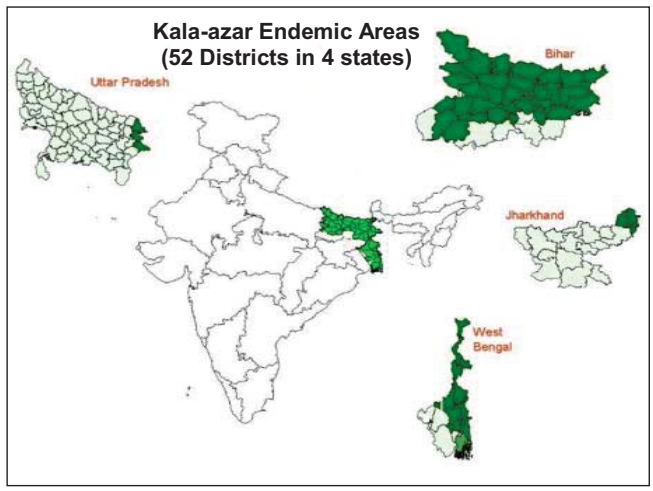
During 2012, two districts of Goa, Puducherry, Daman & Diu and 16 districts of Tamil Nadu stopped MDA as validation process was initiated. Out of these Goa, Puducherry and one districts of Tamil Nadu has successfully completed validation through Transmission Assessment Survey (TAS). In rest of districts, the validation process has been initiated. In addition, during 2013, the validation process has been initiated in Andhra Pradesh (4 districts), Assam (2 districts), Gujarat (4 districts), Karnataka (3 districts), Kerala (2 districts), Madhya Pradesh (3 districts), Maharashtra (9 districts), Odisha (5 districts), West Bengal (2 districts) and Chhattisgarh (2 districts). MDA-2012 round was delayed in Odisha and Chhattisgarh, however, MDA-2012 round has been scheduled in October 2013. Jharkhand and Lakshadweep has missed the MDA-2012 round. The state wise coverage is indicated in **Appendix-2**.

The Line listing of lymphoedema and Hydrocele cases was initiated since 2004 by door to door survey in these filaria endemic districts. The enlisted cases are regularly being updated by state health authorities and more cases are being recorded. This increase is mainly due to incomplete surveys during initial years and reluctance on part of community to reveal their manifestations of lymphoedema and Hydrocele. The updated figure till December 2012 revealed about 12 lakh cases with clinical manifestations (8 lakhs lymphoedema and 4 lakhs Hydrocele). The initiatives have also been taken to demonstrate the simple washing of foot to maintain hygiene for prevention of secondary bacterial and fungal infection in chronic lymphoedema cases so that the patients get relief from frequent acute attacks. The states regularly update the list and intensify the hydrocele operations in their respective states.

The microfilaria survey in all the implementation units (districts) is being done through night blood survey before MDA. The survey is done in 4 sentinel and 4 random sites collecting total 4000 slides (500 from each site). The data provided by the states indicate reduction in overall microfilaria rate in the MDA districts (1.24% in 2004 to 0.45% in 2012).

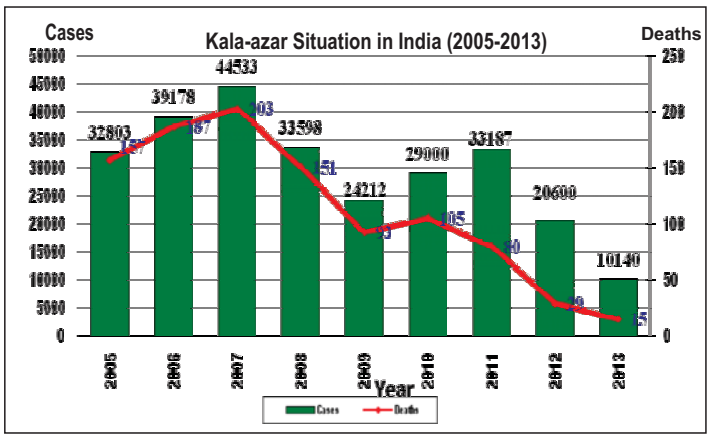
6.2.4 Kala-Azar

Kala-azar is caused by a protozoan parasite Leishmania donovani and spread by sandfly (phelbotomus argentipes), which breeds in shady, damp and warm places in cracks and crevices in the soft soil, in masonry and rubble heaps, etc. Proper sanitation and hygiene are critical to prevent sand fly breeding. The disease has also been targeted for elimination by 2015 as per tripartite agreement between India, Nepal and



Bangladesh. In pursuance to achieve the elimination goal, case detection and treatment compliance has been strengthened and Rapid Diagnostic Test for Kala-azar and oral drug miltefosine has been introduced. World Bank is providing State & District level VBD Consultants, Kala azar Technical Supervisor (KTS), mobility for monitoring & supervision and capacity building/training in 46 districts in 3 states namely Bihar, Jharkhand and West Bengal.

Kala-azar is endemic in 52 districts (31 in Bihar, 4 in Jharkhand, 11 in West Bengal and 6 in UP). The Kala-azar Control Programme was launched in 1990-91. The annual incidence of disease has come down from 77,102 cases in 1992 to 29000 cases in 2010 and deaths from 1,419 to 105 respectively. The cases recorded during 2011 were 33187 with 80 deaths, 2012, 20600 cases and 29 deaths & whereas during the year 2013 (Upto Dec.), 13869 cases and 20 deaths have been reported. - **Appendix 3**.



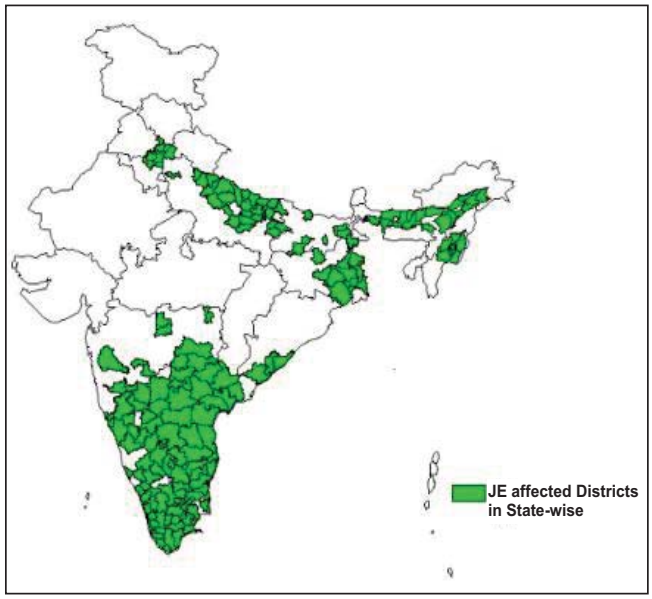
Strategy for Kala-azar elimination is through:

- **Parasite elimination and disease management**
  - o Early case detection and complete treatment;
  - o Strengthening of referral;
- **Integrated vector control**
  - o Indoor Residual Spraying (IRS);
  - o environmental management by maintenance of sanitation and hygiene;
- **Supportive interventions**
  - o Behaviour Change Communication for social mobilization;
  - o Inter-sectoral convergence;
  - o Capacity building by training and Monitoring and Evaluation

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

Initiatives undertaken for Kala-azar elimination are as follows:

- Diagnostic tools i.e. RDK for Kala-azar has been introduced in all the Kala-azar endemic districts.
- Effective Oral drug - Miltefosine has been introduced and expanded in all the affected districts as first line of treatment.
- Indoor residual spray with DDT 50% for vector control.
- Incentive to the Kala-azar patient towards loss of wages @ Rs.50/- per day during the period of treatment.
- Free diet support to the patient and one attendant accompanying the patient.
- Incentive to ASHA for Rs.200/- per patient (Rs.50/- for referring a suspected case and Rs.150/- after completion of the treatment after confirmation through RDK).
- Support to states for engaging 46 VBD Consultants and 276 Kala-azar Technical Supervisors (KTS) in 46 districts under World Bank Supported Project.



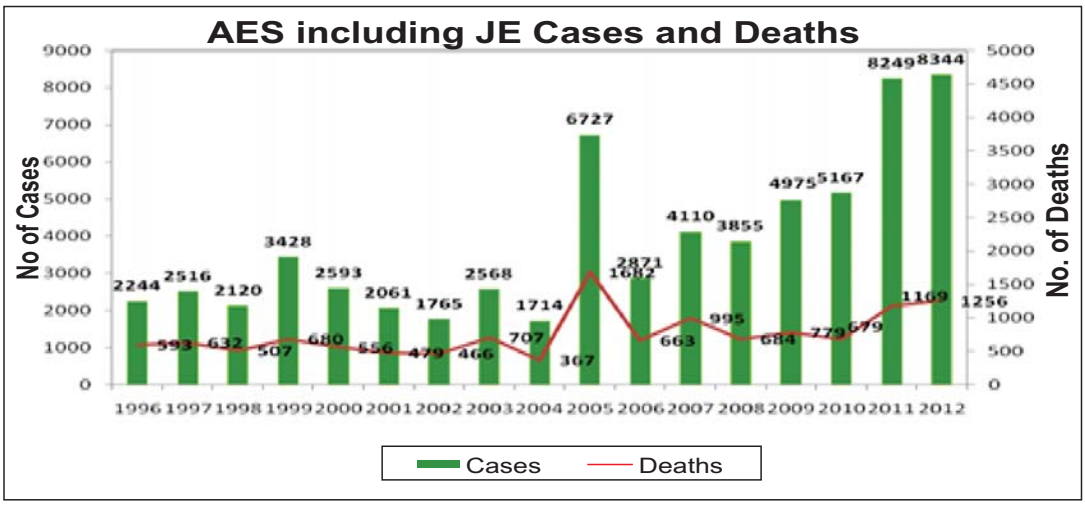
6.2.5 Japanese Encephalitis

Japanese Encephalitis is a zoonotic disease which is transmitted by vector mosquito mainly belonging to *Culex vishnui* group. The transmission cycle is maintained in the nature by animal reservoirs of JE virus like pigs and water birds. Man is the dead end host, i.e. JE is not transmitted from one infected person to other. Outbreaks are common in those areas where there is close interaction between pigs/birds and human beings. The vectors of JE breed in large water bodies rich in aquatic vegetations such as paddy fields. The population at risk is about 375 million.

JE is reported under the umbrella of Acute Encephalitis Syndrome (AES). Therefore, the data reported from states are for total AES including JE cases.

Epidemiological Situation: JE has been reported from different parts of the country. The disease is endemic in 18 states of which Assam, Bihar, Tamil Nadu, Uttar Pradesh and West Bengal have been reporting outbreaks. During 2011, 8249 cases and 1169 deaths and during 2012, 8344 cases and 1256 deaths due to Acute Encephalitis Syndrome (AES) including JE were reported. During 2013 (till 24.4.2013), 7825 cases and 1273 deaths due to Acute Encephalitis Syndrome (AES) including JE have been reported.

State-wise AES and JE cases with deaths as reported by states are given in **Appendix - 4**.



There is no specific cure for this disease. Symptomatic and early case management is very important to minimize risk of death and complications. Govt. of India launched JE vaccination programme as an integral component of Universal Immunization Programme (UIP) with single dose live attenuated JE (SA- 14-14-2) in 11 endemic districts of 4 States namely Uttar Pradesh, Assam, West Bengal and Karnataka for children between 1 and 15 years of age. However, 130 districts have been covered under JE Vaccination till 2013 (till September), however, in additional 5 districts immunization is ongoing.

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

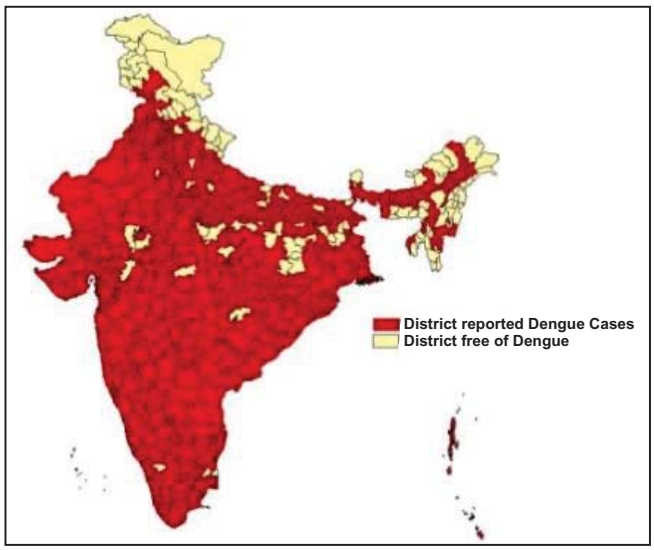
Realizing the gravity of the situation mainly due to non JE viruses in Uttar Pradesh, Group of Ministers (GoM) was constituted on 4.11.11 which suggested a multi pronged strategy for combating the menace of encephalitis. Group of Ministers (GoM) met four times (21st November, 25th November, 9th December, 2011 and 2nd February, 2012). The recommendation of GoM was approved by the Cabinet on 18.10.2012. The main thrust is on an integrated approach for strengthening prevention and control measures in 60 high priority districts in states of Assam, Bihar, Uttar Pradesh, West Bengal and Tamil Nadu, with involvement of following Ministries:

1. Ministry of Drinking Water Supply & Sanitation
2. Ministry of Housing and Poverty Elevation
3. Ministry of Women & Child Development
4. Ministry of Social Justice & Empowerment
5. Ministry of Health & Family Welfare as the nodal ministry for initializing the following activities:
   - Strengthening public health measures
   - Establishment of Paediatrics ICUs in 60 district hospitals
   - JE vaccination in 62 additional districts
   - Establishing PMR in 10 different medical colleges across 5 states
   - Providing safe drinking water, sanitation in rural and slum areas
   - Setting up of District Rehabilitation and counseling centers in 60 identified districts

- Improving the nutritional status of the children in endemic areas
- Involvement of ASHAs for helping in early referral of encephalitis cases

6.2.6 Dengue Fever/Dengue Haemorrhagic Fever

Dengue Fever is an outbreak prone viral disease, transmitted by *Aedes* mosquitoes. Both *Aedes aegypti* and Ae.albopictus are involved in transmission. Aedes aegypti mosquitoes prefer to 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. This is a day biting mosquito and prefers to rest in hard to find dark areas inside the houses. *Aedes albopictus* mosquitoes prefer to breed in natural habitats like tree holes, plantation etc. The risk of dengue has increased in recent years due to rapid urbanization, and deficient water management including improper water storage practices in urban, peri-urban and rural areas, leading to proliferation of mosquito breeding sites. The cases peak after monsoon and it is not uniformly distributed throughout the year. However, in the Southern States and Gujarat the transmission is perennial. Dengue is a self-limiting acute disease characterized by fever, headache, muscle, joint pains, rash, nausea and vomiting. Some infections results in Dengue Haemorrhagic Fever (DHF) and in its severe form Dengue Shock Syndrome (DSS) can threaten the patient's life primarily through increased vascular permeability and shock due to bleeding from internal organs. Though during 2010, highest numbers of cases were reported (28292) the deaths have declined. The case fatality rate (CFR) which was 3.3 % in 1996 had come down to 0.4% in 2010, 0.9% in 2011 and 0.5 in 2012. The disease is spreading to newer geographical areas every year.



Open Overhead Tanks

Epidemiological Situation: Dengue is endemic in 34 states/UTs. After 1996, outbreak with a total number of 16517 cases and 545 deaths upsurge of cases were recorded in 2003, 2005 and 2008. In 2009 total 15535 cases and 99 deaths have been reported. During 2011, 18860 cases and 169 deaths and during 2012, 50222 cases and 242 deaths were reported. Highest number of deaths were reported by Tamil Nadu (66) followed by Maharashtra (59). During 2013-14 (till 28.04.2014), 5730 cases and 20 deaths have been reported (**Appendix-5**).

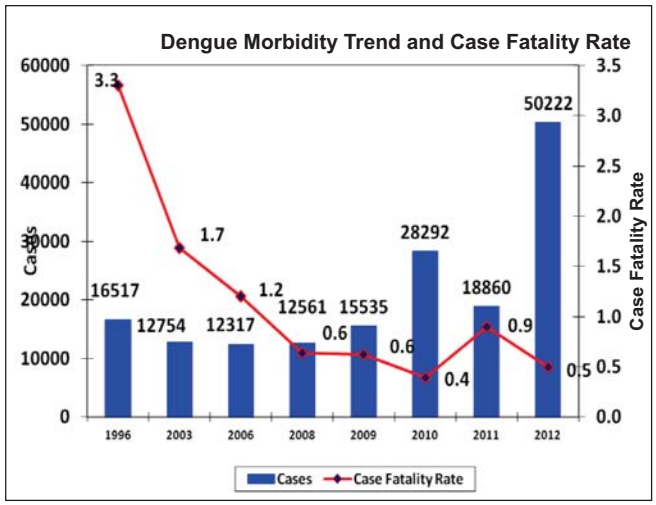
There is no specific anti-viral drug or vaccine against dengue infection. Mortality can only be minimized by early diagnosis and prompt symptomatic management of the cases. A strategic action plan has been developed for prevention and control of Dengue and issued to the endemic States for implementation. Guidelines for clinical management of dengue fever/dengue haemorrhagic fever and dengue shock syndrome cases have been developed and sent to the states for wider circulation. Advisories have been sent to the endemic

Discarded Tyres

Jung Materials

areas for effective vector control through inter-sectoral collaboration and active community involvement, regular monitoring of Dengue cases as well as entomological parameters to forecast likely outbreaks and to take timely remedial measures. The States have been communicated to undertake widespread campaigns for community awareness and mobilization through different media like mass media, miking, inter-personal communication, etc. The emphasis is on elimination of mosquito breeding sources like avoidance of water collection in and around houses, removal of all discarded and disposed/junk materials, keeping all water containers/ storage facilities tightly covered and cleaning the water coolers at least once a week before re-filling. Since early reporting of cases is crucial to avoid any complication and mortality, the community is given full information about the signs and symptoms as well as availability of health services at health centres/hospitals. Alerting the Hospitals for making adequate arrangements for management of Dengue/Dengue Haemorrhagic Fever cases have also been advised.

The Directorate of National Vector Borne Disease Control has provided detailed guidelines for the prevention and control of dengue to the affected states. Intensive health education activities through print, electronic and inter-personnel media, outdoor publicity as well as an inter-sectoral collaboration with civil society organization (NGOs/CBOs/Self-Help Groups), PRIs and Municipal bodies have been emphasized. Regular supervision and monitoring is conducted by the Programme. The Government of India in consultation with States has identified 347 sentinel surveillance hospitals with laboratory support for augmentation of diagnostic facilities in the endemic states. The number of these sites are increasing to provide more diagnostic services for dengue. Further, for advanced diagnosis and backup support 14 Apex Referral Laboratories **(Appendix-6)** have been identified and linked with sentinel surveillance hospitals. To make these functional, IgM capture ELISA test kits are provided through National Institute of Virology, Pune free of cost. Contingency grant is also provided to meet the operational costs.



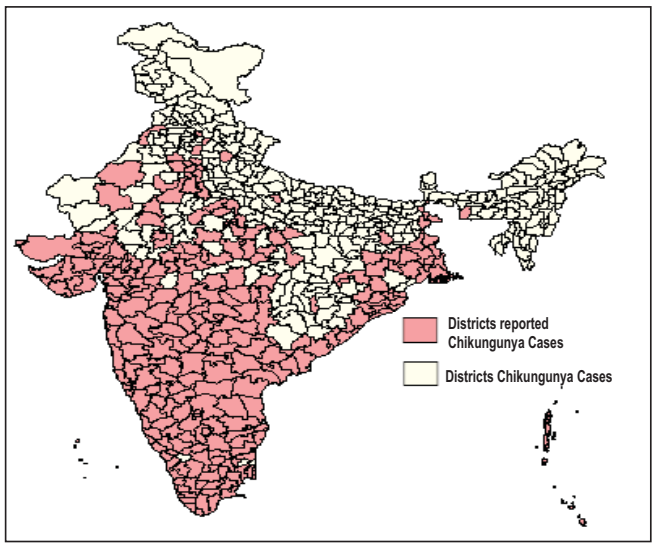
For early diagnosis ELISA based NS1 kits have been introduced under the programme which can detect the cases from 1st day of infection. IgM capture ELISA tests can detect the cases after 5th day of infection.

The Government of India has taken the following steps for prevention and control of Dengue:

- Monitoring the situation through reports received from State Health Authorities.
- A Mid Term Plan for prevention and control of dengue has been developed in 2011 and circulated to the states for implementation. The main components of Mid Term Plan for Prevention and control of Dengue are as follows:
    - o Surveillance - Disease and Entomological Surveillance
    - o Case Management - Laboratory Diagnosis and Clinical Management.
    - o Vector Management - Environmental Management for Source Reduction, Chemical Control, Personal Protection and Legislation
    - o Outbreak Response - Epidemic Preparedness and Media Management
    - o Capacity building- Training, Strengthening Human Resource and Operational Research
    - o Behaviour Change Communication - Social mobilization and Information Education and Communication (IEC)
    - o Inter-sectoral Coordination - with Ministries of Urban Development, Rural Development, Panchayati Raj, Surface Transport and Education sector
    - o Monitoring and Supervision - Analysis of reports, review, field visit and feedback

6.2.7 Chikungunya

Chikungunya is a debilitating non-fatal viral illness caused by Chikungunya virus. The disease re-emerged in the country after a gap of three decades. In India a major epidemic of Chikungunya fever was reported during 60s & 70s; 1963 (Kolkata), 1965 (Puducherry



and Chennai in Tamil Nadu, Rajahmundry, Vishakapatnam and Kakinada in Andhra Pradesh; Sagar in Madhya Pradesh and Nagpur in Maharashtra) and 1973 (Barsi in Maharashtra). This disease is also transmitted by Aedes mosquito. Both Ae.aegyptiand Ae. albopictus can transmit the disease. Humans are considered to be the major source or reservoir of Chikungunya virus. Therefore, the mosquitoes usually transmit the disease by biting infected persons and then biting others. The infected person cannot spread the infection directly to other person (i.e. it is not contagious disease). Symptoms of Chikungunya fever are most often clinically indistinguishable from those observed in dengue fever. However, unlike dengue, hemmorrhagic manifestations are rare and shock is not observed in Chikungunya virus infection. It is characterized by fever with severe joint pain (arthralgia) and rash. Chikungunya outbreaks typically result in large number of cases but deaths are rarely encountered. Joint pains sometimes persist for a long time even after the disease is cured.

During 2006, total 1.39 million clinically suspected Chikungunya cases reported in the country. Out of 35 States/UTs 16 were affected: Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Madhya Pradesh, Gujarat, Kerala, Andaman & Nicobar Islands, Delhi, Rajasthan, Puducherry, Goa, Odisha, West Bengal, Lakshadweep and Uttar Pradesh. There are no reported deaths directly related to Chikungunya. In 2007, total 14 States were

affected and reported 59535 suspected Chikungunya fever cases with nil death. Subsequently in 2008, 2009, 2010 and 2011, 95091, 73288, 48176 and 20402 suspected Chikungunya fever cases with nil death were reported. During 2012, 15977 suspected Chikungunya cases were reported whereas during 2013 (till 28.04.2014) 18840 suspected Chikungunya cases have been reported **(Appendix-7)**.

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

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

Government of India is continuously monitoring the situation, sending guidelines and advisories for prevention and control of Chikungunya fever to the states. Since same vector is involved in the transmission of Dengue and Chikungunya strategies for transmission risk reduction by vector control are also same. A comprehensive Mid Term Plan for prevention & control of Chikungunya and Dengue/Dengue Haemorrhagic Fever has been prepared and disseminated for guidance to the states. Support in the form of logistics and funds are provided to the States. The central teams are deputed to the affected states for technical guidance of the state health authorities. As most transmission occurs at home, therefore, community participation and co-operation is of paramount importance for successful implementation of programme strategies for prevention and control of Chikungunya. For effective community participation, people are informed about Chikungunya and the fact that major epidemics can be prevented by taking effective preventive measures by community itself. Therefore, considerable efforts have been made through advocacy and social mobilization for community education and awareness.

For carrying out proactive surveillance and enhancing diagnostic facilities for Chikungunya, the 347 Sentinel Surveillance hospitals involved in dengue **(Appendix- 8)**

in the affected states also carries Chikungunya tests. Both Dengue and Chikungunya Diagnostic kits (IgM capture ELISA) to these institutes are provided through National Institute of Virology, Pune and cost is borne by Government of India. Further, rapid response by the concerned health authorities has been envisaged on report of any suspected case from the Sentinel Surveillance Hospitals to prevent further spread of the disease.

The overall strategies for prevention and control are same as in Dengue such as symptomatic management of cases, reduction of breeding sources, personal protection and intensive IEC and capacity building.

Initiatives undertaken by Government of India for prevention and control of Dengue/Chikungunya are as follows:

- Continuous monitoring of Chikungunya and Dengue situation in states.
- Circulation of guidelines and advisories for prevention and control of diseases to affected states.
- Launch of intensive IEC and Behaviour Change Communication activities through print, electronic media, interpersonal communication, outdoor publicity as well as inter sectoral collaboration with civil society organizations (NGOs/CBOs/ Self Help Groups), PRIs.
- Provision of larvicides and adulticides to affected states.
- Identification and strengthening of Apex Referral Laboratories and sentinel surveillance hospitals for diagnosis and regular surveillance.
- NIV, Pune has been entrusted for supply of test kits to the identified institutions free of cost.
- Contingency grant provided to the Apex Referral Laboratories and sentinel surveillance hospitals to meet the operational cost.
- Training is imparted on various aspects of prevention and control of Dengue and Chikungunya to programme personnel, Medical Officers on Case Management and laboratory personnel on case diagnosis.

Appendix-1

State-wise Malaria situation in the Country

STATEs/UTs.	2010		2011		2012		2013 (P)	
	Cases	Deaths	Cases	Deathss	Cases	Deaths	Cases	Deaths
Andhra Prd.	33393	20	34949	5	24699	2	16406	0
Arunachal Prd.	17944	103	13950	17	8368	15	5412	13
Assam	68353	36	47397	45	29999	13	20492	7
Bihar	1908	1	2643	0	2605	0	2249	0
Chhattisgarh	152209	47	136899	42	124006	90	110899	17
Goa	2368	1	1187	3	1714	0	1530	0
Gujarat	66501	71	89764	127	76246	29	55703	21
Haryana	18921	0	33401	1	26819	1	11582	1
Himachal Prd.	210	0	247	0	216	0	141	0
J&K	802	0	1091	0	864	0	701	0
Jharkhand	199842	16	160653	17	131476	10	97215	6
Karnataka	44319	11	24237	0	16466	0	12023	5
Kerala	2299	7	1993	2	2036	3	1604	0
Madhya Pradesh	87165	31	91851	109	76538	43	73129	49
Maharashtra	139198	200	96577	118	58517	96	43676	80
Manipur	947	4	714	1	255	0	120	0
Meghalaya	41642	87	25143	53	20834	52	23860	62
Mizoram	15594	31	8861	30	9883	25	11783	21
Nagaland	4959	14	3363	4	2891	1	2286	1
Odisha	395651	247	308968	99	262842	79	216568	66
Punjab	3477	0	2693	3	1689	0	1737	0
Rajasthan	50963	26	54294	45	45809	22	25409	7
Sikkim	49	0	51	0	77	0	41	0
Tamil Nadu	17086	3	22171	0	18869	0	15054	0
Tripura	23939	15	14417	12	11565	7	6227	6
Uttarakhand	1672	0	1277	1	1948	0	1417	0
Uttar Pradesh	64606	0	56968	0	47400	0	48086	0
West Bengal	134795	47	66368	19	55793	30	28040	17
A&N Islands	2484	0	1918	0	1539	0	1005	0
Chandigarh	351	0	582	0	201	0	150	0
D & N Haveli	5703	0	5150	0	4940	1	1772	0
Daman & Diu	204	0	262	0	186	0	91	0
Delhi	251	0	413	0	382	0	382	0
Lakshadweep	6	0	8	0	9	0	0	0
Puducherry	175	0	196	1	143	0	126	0
Total	**1599986**	**1018**	**1310656**	**754**	**1067824**	**519**	**836916**	**379**

Appendix-2

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

Sl. No.	States/UTs	2009	2010	2011	2012	2013
1	Andhra Pradesh	91.85	92.50	92.74	93.30	92.59
2	Assam	ND	76.08	76.75	79.02	78.67
3	Bihar	77.91	78.61	ND	NR	ND
4	Chhattisgarh	91.53	92.99	90.06	ND	ND
5	Goa	95.37	94.63	96.21	MDA Stopped	MDA Stopped
6	Gujarat	97.63	98.33	97.66	99.39	99.38
7	Jharkhand	85.99	63.64	86.53	ND	ND
8	Karnataka	89.30	91.46	91.81	93.84	ND
9	Kerala	77.81	81.91	89.62	80.90	73.33
10	Madhya Pradesh	87.59	90.74	89.27	87.43	ND
11	Maharashtra	89.51	89.38	89.28	89.30	91.21
12	Odisha	89.81	90.63	90.55	ND	91.1
13	Tamil Nadu	94.13	ND	93.58	94.68 (4 districts as MDA stopped in 16 districts)	MDA Stopped
14	Uttar Pradesh	ND	81.04	80.45	83.32	71.73
15	West Bengal	86.93	ND	79.23	ND	ND
16	A&N Islands	91.40	77.12	90.15	90.06	Report awaited
17	D & N Haveli	95.84	96.20	98.51	96.88	93.83
18	Daman & Diu	91.56	92.04	90.89	MDA stopped	MDA Stopped
19	Lakshadweep	83.86	80.09	73.94	ND	94.22
20	Puducherry	96.02	96.92	97.14	MDA Stopped	MDA Stopped
	Total	**86.70**	**84.37**	**87.92**	**87.54**	**86.87**

ND: - Not Done NR: Not reported

Appendix-3

State-wise Kala-azar Situation in Country

Sl. No.	Affected States	2010		2011		2012 (Provisional)		2013 (P)	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Bihar	23084	95	25222	76	16036	27	10730	17
2	Jharkhand	4305	5	5960	3	3535	1	2515	0
3	West Bengal	1482	4	1962	0	995	0	595	2
4	Uttar Pradesh	14	0	11	1	5	0	11	1
5	Uttarakhand	1	0	0	0	7	1	0	0
6	Delhi *	92	0	19	0	11	0	6	0
7	Assam	12	0	5	0	6	0	4	0
8	Sikkim	3	0	7	0	5	0	8	0
9	Madhya Pradesh	0	0	0	0	0	0	0	0
10	Himachal Pradesh	6	1	1	0	0	0	0	0
11	Punjab*	1	0	0	0	0	0	0	0
	Total	**29000**	**105**	**33187**	**80**	**20600**	**29**	**13869**	**20**

* *Imported*

Appendix-4

State-wise AES cases including JE in the country

Sl.	States/UTs.	2010		2011		2012		2013 (P)	
		Cases	Deaths	Cases	Deathss	Cases	Deaths	Cases	Deaths
1	Andhra Pradesh	139	7	73	1	64	0	345	3
2.	Arunachal Pradesh	0	0	0	0	0	0	0	0
2	Assam	469	117	1319	250	1343	229	1388	272
3	Bihar	50	7	821	197	745	275	417	143
5	Delhi	0	0	9	0	0	0	0	0
4	Goa	80	0	91	1	84	0	48	1
6	Haryana	1	1	90	14	5	0	2	0
8	Jharkhand	18	2	303	19	16	0	270	5
7	Karnataka	143	1	397	0	189	1	162	0
9	Kerala	19	5	88	6	29	6	53	6
10	Maharashtra	34	17	35	9	37	20	0	0
11	Manipur	118	15	11	0	2	0	1	0
12	Nagaland	11	6	44	6	21	2	20	0
13	Punjab	2	0	0	0	0	0	0	0
14	Tamil Nadu	466	7	762	29	935	64	77	8
15	Uttar Pradesh	3540	494	3492	579	3484	557	3096	609
16	Uttarakhand	7	0	0	0	174	2	0	0
17	West Bengal	70	0	714	58	1216	100	1735	226
18	Tripura	0	0	0	0	0	0	211	0
	Total	**5167**	**679**	**8249**	**1169**	**8344**	**1258**	**7825**	**1273**

Appendix-4 (contd.)

State-wise JE situation in the country

Sl.	STATEs/UTs.	2010		2011		2012		2013 (P)	
		Cases	Deaths	Cases	Deathss	Cases	Deaths	Cases	Deaths
1	Andhra Pradesh	7	5	4	1	3	0	7	3
2	Arunachal Pradesh	0	0	0	0	0	0	0	0
3	Assam	142	40	489	113	463	100	495	134
4	Bihar *	0	0	145	18	8	0	14	0
5	Delhi	0	0	9	0	0	0	0	0
6	Goa	9	0	1	0	9	0	3	1
7	Haryana	1	0	12	3	3	0	2	0
8	Jharkhand	2	2	101	5	1	0	89	5
9	Karnataka	3	0	23	0	1	0	2	0
10	Kerala	0	0	37	3	2	0	2	0
11	Maharashtra	0	0	6	0	3	0	0	0
12	Manipur	45	5	9	0	0	0	0	0
13	Meghalaya	0	0	0	0	0	0	0	0
14	Nagaland	2	0	29	5	0	0	4	0
15	Punjab	0	0	0	0	0	0	0	0
16	Tamil Nadu	11	1	24	3	25	4	33	0
17	Tripura	0	0	0	0	0	0	14	0
18	Uttarakhand	7	0	0	0	1	0	0	0
19	Uttar Pradesh	325	59	224	27	139	23	281	47
20	West Bengal	1	0	101	3	87	13	140	12
	Grand Total	**555**	**112**	**1214**	**181**	**745**	**140**	**1086**	**202**

Appendix-5

State-wise Dengue Situation in Country

Sl. No.	State	2010		2011		2012 (Provisional)		2013 (P)	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Andhra Pd.	776	3	1209	6	2299	2	910	1
2	Arunachal Pd.	0	0	0	0	346	0	0	0
3	Assam	237	2	0	0	1058	5	4526	2
4	Bihar	510	0	21	0	872	3	1246	5
5	Chhattisgarh	4	0	313	11	45	0	83	2
6	Goa	242	0	26	0	39	0	198	2
7	Gujarat	2568	1	1693	9	3067	6	6272	15
8	Haryana	866	20	267	3	768	2	1784	5
9	Himachal Pd.	3	0	0	0	73	0	89	2
10	J & K	0	0	3	0	17	1	1837	3
11	Jharkhand	27	0	36	0	42	0	161	0
12	Karnataka	2285	7	405	5	3924	21	6408	12
13	Kerala	2597	17	1304	10	4172	15	7938	29
14	Madhya Pd.	175	1	50	0	239	6	1255	9
15	Meghalaya	1	0	0	0	27	2	43	0
16	Maharashtra	1489	5	1138	25	2931	59	5610	48
17	Manipur	7	0	220	0	6	0	9	0
18	Mizoram	0	0	0	0	6	0	7	0
19	Nagaland	0	0	3	0	0	0	0	0
20	Odisha	29	5	1816	33	2255	6	7132	6
21	Punjab	4012	15	3921	33	770	9	4117	25
22	Rajasthan	1823	9	1072	4	1295	10	4413	10
23	Sikkim	0	0	2	0	2	0	38	0
24	Tamil Nadu	2051	8	2501	9	12826	66	6122	0
25	Tripura	0	0	0	0	9	0	8	0
26	Uttar Pradesh	960	8	155	5	342	4	1414	5
27	Uttrakhand	178	0	454	5	110	2	54	0
28	West Bengal	805	1	510	0	6456	11	5920	6
29	A&N Island	25	0	6	0	24	0	67	0
30	Chandigarh	221	0	73	0	351	2	107	0
31	Delhi	6259	8	1131	8	2093	4	5574	6
32	D&N Haveli	46	0	68	0	156	1	190	0
33	Daman & Diu	0	0	0	0	96	0	61	0
34	Puducherry	96	0	463	3	3506	5	2215	0
	TOTAL	**28292**	**110**	**18860**	**169**	**50222**	**242**	**75808**	**193**

Appendix-6

APEX REFERRAL LABORATORIES

1. National Institute of Virology, Pune.
2. National Center for Disease Control (former NICD), Delhi.
3. National Institute of Mental Health & Neuro-Sciences, Bengaluru.
4. Sanjay Gandhi Post-Graduate Institute of Medical Sciences, Lucknow.
5. Post- Graduate Institute of Medical Sciences, Chandigarh.
6. All India Institute of Medical Sciences, Delhi.
7. ICMR Virus Unit, National Institute of Cholera & Enteric Diseases, Kolkata.
8. Regional Medical Research Centre (ICMR), Dibrugarh, Assam.
9. King's Institute of Preventive Medicine, Chennai.
10. Institute of Preventive Medicine, Hyderabad.
11. B J Medical College, Ahmedabad.
12. State Public Health Laboratory, Thiruvananthapuram, Kerala.
13. Defence Research Development and Establishment, Gwalior.
14. Regional Medical Research Centre for Tribals, (ICMR) Jabalpur, Madhya Pradesh.

Appendix-7

State-wise Clinically Suspected Chikungunya Cases in Country

Sl. No.	Name of the States/ UTs	2010	2011	2012 (Prov.)	2013 (Prov. upto 28.04.14)
1	Andhra Pd.	116	99	2827	4827
2	Assam	0	0	0	742
2	Bihar	0	91	34	0
3	Goa	1429	664	571	1049
4	Gujarat	1709	1042	1317	2890
5	Haryana	26	215	9	1
6	Jharkhand	0	816	86	61
7	Karnataka	8740	1941	2382	5295
8	Kerala	1708	183	66	273
9	Madhya Pd.	113	280	20	139
10	Meghalaya	16	168	0	0
11	Maharashtra	7431	5113	1544	1578
12	Odisha	544	236	129	35
13	Punjab	1	0	1	0
14	Rajasthan	1326	608	172	76
15	Tamil Nadu	4319	4194	5018	859
16	Uttar Pradesh	5	3	13	0
17	Uttarakhand	0	18	0	0
18	West Bengal	20503	4482	1381	646
19	A&N Island	59	96	256	202
20	Chandigarh	0	1	0	1
21	Delhi	120	110	6	18
22	D&N Haveli	0	0	100	2
23	Lakshadweep	0	0	0	0
24	Puducherry	11	42	45	146
	Total	**48176**	**20402**	**15977**	**18840**

Appendix-8

List of Sentinel Surveillance Hospitals (SSH) for Dengue & Chikungunya

Sl. No.	State	Number of SSH
1	A & N Island	3
2	Andhra Pradesh	32
3	Arunachal Pradesh	1
4	Assam	9
5	Bihar	5
6	Chandigarh	1
7	Chhattisgarh	2
8	Delhi	33
9	Daman & Diu	1
10	D&N Haveli	1
11	Goa	3
12	Gujarat	16
13	Haryana	14
14	Himachal Pradesh	2
15	Jammu	7
16	Jharkhand	4
17	Karnataka	22
18	Kerala	20
19	Lakshadweep	1
20	Madhya Pradesh	17
21	Maharashtra	23
22	Manipur	2
23	Meghalaya	3
24	Mizoram	1
25	Nagaland	2
26	Odisha	8
27	Puducherry	4
28	Punjab	15
29	Rajasthan	20
30	Sikkim	2
31	Tamil Nadu	30
32	Tripura	1
33	Uttar Pradesh	22
34	Uttrakhand	7
35	West Bengal	13
	Total	**347**

6.3 NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

Since the inception of National Leprosy Eradication Programme (NLEP) in the year 1983 spectacular success have been made in reducing the burden of Leprosy. The country achieved the goal of leprosy elimination as a public health problem. i.e. prevalence rate (PR) of less than 1 case / 10,000 population at National level by December 2005, as set by National Health Policy 2002. Although prevalence has come down at national and state level, new cases are being continuously detected and these cases will have to be provided quality leprosy services through GHC system.

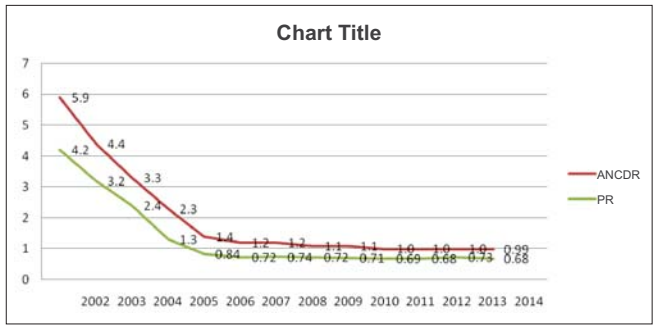
The plan budget has been substantially increased from Rs. 219.00 crore in 11th plan to Rs. 500.00 crore in the 12th plan.

Following are the programme components:

- Case Detection and Management
- Disability Prevention and Medical Rehabilitation
- Information, Education and Communication (IEC) including Behaviour Change Communication (BCC)
- Human Resource and Capacity building
- Programme Management

6.3.1 Epidemiological Situation:

- 33 States/UTs have achieved leprosy elimination status. Only 2 States/UT (Chhattisgarh and Dadra & Nagar Haveli) are yet to achieve elimination. One State (Chhattisgarh) and One U.T. (Dadra & Nagar Haveli) has remained with PR between 2 and 4 per 10,000 population. Two other States/UTs viz. Odisha and Chandigarh which have achieved elimination earlier have shown slight increase in PR (1-1.5) in the year 2013 -14. **(Table 1)**.
- At the end of March 2014, there were 86134 leprosy cases on record (under treatment).
- In 2013-14, total 126900 new leprosy cases were detected and put under treatment as compared to 134752 leprosy cases detected during corresponding period of previous year, giving Annual New Case Detection Rate (ANCDR) of 9.98 per 1,00,000 population.
- 2707 reconstructive surgeries were conducted in 2013-14 for correction of disability in leprosy affected persons.
- The trend of Prevalence and Annual New Case Detection Rate per 10,000 population since 2002 is shown in the graph below:



6.3.2 Activities under NLEP

1. **Diagnosis and treatment of leprosy:-** Services for diagnosis and treatment (Multi drug therapy) are provided by all health facilities throughout the country free of cost. Difficult to diagnose and complicated cases and cases requiring reconstructive surgery are referred to district hospital for further management. Accredited Social Health Activists (ASHAs) under National Rural Health Mission (NRHM) are being involved to bring out leprosy cases from villages for diagnosis at Primary Health Centre (PHC) and follow up cases for treatment completion. ASHAs are being paid incentive for this purpose.
2. **Training:-** Training of general health staff like medical officer, health supervisors, laboratory technicians, health workers, ASHAs are conducted regularly to develop skills in diagnosis and management of leprosy cases. The District Nucleus staffs under the District Leprosy Officer monitor the activities in the PHCs and provide on job training wherever needed to the General Health Care Staff.
3. **Urban Leprosy Control:-** Urban Leprosy Control activities are being implemented in 524 urban areas having population size of more than 1 lakh. These activities include MDT delivery services & follow

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

4. **Information, Education & Communication (IEC):-** Intensive IEC activities are conducted for awareness generation and particularly reduction of stigma and discrimination against leprosy affected persons. These activities are carried through mass media, outdoor media, rural media and advocacy meetings. More focus is given on inter personnel communication. Anti-leprosy fortnight is observed annually from 30th January to 13th February in which IEC at the village level is also supported with leprosy services.

5. **NGO services under NLEP:-** Presently, 43 NGOs are getting grants from Govt. of India under Survey, Education and Treatment (SET) scheme. The various activities undertaken by the NGOs are, IEC, Prevention of Impairments and Deformities, Case Detection and MDT Delivery. From financial year 2006 onwards, Grant-in-aid is being disbursed to NGO through State Health (Leprosy) Societies.

6. **Disability Prevention and Medical Rehabilitation:**

   - More emphasis is being given on correction of disability in leprosy affected persons through reconstructive surgery (RCS). To strengthen RCS services, Government of India has recognized 111 institutions for conducting RCS based on the recommendations of the state government. Out of these, 60 are Govt. institutions and 51 are NGO institutions.
   - For prevention of disability among persons with insensitive hands and feet, they are given dressing material, supportive medicines and Micro-Cellular Rubber (MCR) footwear. MCR footwear were provided to 69331 Leprosy Affected Persons during 2013-14. The patients are also empowered with self-care procedure for taking care of themselves. Self Care Kits were provided to 44412 Leprosy Affected Persons during the year.

7. **Supervision and Monitoring:-** Programme is being monitored at different level through analysis of monthly progress reports, through field visits by the supervisory officers from Central and States, programme review meetings held at central, state and district level. For better epidemiological analysis of the disease situation, emphasis is given to assessment of New Case Detection and Treatment Completion Rate and proportion of grade II disability among new cases. Visit by Joint monitoring Teams with members from Government of India, ILEP and WHO has been initiated from the year 2012-13 and to be continued annually.

6.3.3 Initiatives:

1. **Special Activity in High Endemic District:-** 209 Districts had reported ANCDR more than 10 per lakh population in 16 States/UTs. Special activity for early detection and complete treatment, capacity building and extensive IEC, adequate availability of MDT, strengthening of district nucleus, regular monitoring & supervision and review, regular follow up for neuritis and reaction, self-care practices, supply of MCR footwear in adequate quantity and improvement in RCS performance through camp approach have been carried out during 2012-13 to reduce the disease burden.

2. **Disability Prevention and Medical Rehabilitation:-** An amount of Rs. 8000/- is provided as incentive to leprosy affected persons for undergoing each major reconstructive surgery in identified Govt./NGO institutions to compensate loss of wages during their stay in hospital. Support is also provided to Government institutions in the form of Rs. 5000/- per RCS conducted, for procurement of supply & material and other ancillary expenditure incurred for the surgery. Additional Rs. 5000/- is paid per RCS conducted in Camps.

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

   - On confirmed diagnosis of case brought by them - Rs. 100/-

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

4. Discriminatory laws relating to leprosy-: There are certain provisions under laws/acts which are discriminatory in nature against leprosy affected persons. The Ministry of Health & Family Welfare has taken up the matter with concerned Ministries/ Departments/State Governments for modification or repealment of various such discriminatory acts/laws.

6.3.4 Budget:- The Budget allocation under NLEP for 2013-14 was Rs. 51 crore and expenditure incurred was Rs. 47.73 crores.

Table-1 State - wise Prevalence Rate (PR) and Annual New Case Detection Rate (ANCDR) in 2013-14

Sl.No.	States/UTs	Cases on record as on 31.03.2013	PR	New Cases detected	ANCDR
1	Andhra Pradesh	4809	0.55	7108	8.13
2	Arunachal Pr.	29	0.20	23	1.55
3	Assam	965	0.30	1048	3.21
4	Bihar	10100	0.91	18188	16.39
5	Chhattisgarh	5700	2.10	8519	31.38
6	Goa	60	0.40	72	4.82
7	Gujarat	5282	0.83	9721	15.27
8	Haryana	714	0.27	622	2.32
9	Himachal Pradesh	157	0.22	161	2.26
10	Jharkhand	2457	0.70	4021	11.48
11	J&K	200	0.15	175	1.30
12	Karnataka	2800	0.44	3466	5.43
13	Kerala	839	0.25	782	2.31
14	Madhya Pradesh	5399	0.70	6369	8.30
15	Maharashtra	10813	0.92	16400	13.96
16	Manipur	9	0.03	12	0.42
17	Meghalaya	26	0.08	24	0.75
18	Mizoram	25	0.22	30	2.59
19	Nagaland	123	0.62	158	7.99
20	Odisha	6405	1.47	10645	24.40
21	Punjab	529	0.18	648	2.25
22	Rajasthan	1237	0.17	1079	1.48
23	Sikkim	15	0.24	18	2.86
24	Tamil Nadu	2993	0.40	3810	5.06
25	Tripura	47	0.12	37	0.97
26	Uttar Pradesh	14428	0.68	22565	10.70
27	Uttarakhand	237	0.22	376	3.53
28	West Bengal	8242	0.87	9121	9.60
29	A & N Islands	28	0.72	32	8.26
30	Chandigarh	135	1.22	144	13.02
31	D & N Haveli	158	4.04	320	81.77
32	Daman & Diu	1	0.04	4	1.45
33	Delhi	1138	0.64	1145	6.46
34	Lakshadweep	0	0.00	0	0.00
35	Puducherry	34	0.25	57	4.26
	Total	**86134**	**0.68**	**126900**	**9.98**

6.4 REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

The Revised National TB Control Programme (RNTCP), based on the internationally recommended Directly Observed Treatment Short-course (DOTS) strategy, was launched in 1997 expanded across the country in a phased manner with support from World Bank and other development partners. Full nation-wide coverage was achieved, then covering over a billion population (1114 million) in March 2006, expanding to 1247 million people in first quarter of 2013. In terms of treatment of patients, RNTCP has been recognized as the largest and the fastest expanding TB control programme in the world. RNTCP is presently being implemented throughout the country.

Estimated TB Burden in India

- **Incidence:** 2.2 million new TB cases annually- 176 cases per 100,000 population
- **Prevalence:** 2.8 million cases - 230 cases per 100,000 population
- **Deaths:** About 270,000 deaths each year - 22 deaths per 100,000 population
- Approximately 5% of TB patients estimated to be HIV +ve
- DR-TB (Drug resistant-TB):-
  - o 2.2% in New cases and
  - o 15% in previously treated cases

India is highest TB burden country in the world, accounting for about 23.3% of the global prevalence and in 2012. Out of the estimated global annual incidence of 8.6 million TB cases; 2-2.4 million were estimated to have occurred in India, with a best case estimate of 2.2 Million cases. India has contributed to approximately 25.5% of the total global new cases detection during the year 2012 as per the WHO Global Report 2013.

Goal of the programme

The goal of TB control Programme is to decrease mortality and morbidity due to TB and cut transmission of infection until TB ceases to be a major public health problem in India.

Objectives of the programme

- To reduce the incidence of and mortality due to TB;
- To prevent further emergence of drug resistance and effectively manage drug-resistant TB cases;
- To improve outcomes among HIV-infected TB patients;
- To involve private sector on a scale commensurate with their dominant presence in health care services and
- To further decentralize and align basic RNTCP management units with NRHM block level units within general health system for effective supervision and monitoring.

RNTCP Achievements

- In 2005, 1.29 million, in 2006, 1.39 million; in 2007, 1.48 million patients; in 2008, 1.51 million; in 2009, 1.53 million TB patients; in 2010, 1.52 million TB patients, in 2011, 1.51 million, and in 2012, 1.46 million TB patients have been registered for treatment. Till the end of 2nd quarter 2013, 725332 patients have been registered.
- Treatment success rates have tripled from 25% in pre-RNTCP era to 88% presently (2012) and TB death rates have been reduced from 29% to 4% during the same period.
- Since 2007, RNTCP has also achieved the NSP case detection rate of more than 70% in line with the global targets for TB control while maintaining the treatment success rate of >85%. In 2010 the NSP Case detection rate was 72% and treatment success rate 87%. In 2011 the NSP Case detection rate was 71% and treatment success rate 88%. In 2012 the NSP Case detection rate was 68.4% and treatment success rate 88%.
- Quality assured diagnostic facilities are available through more than 13209 Designated Microscopy Centers (DMCs) across the country.
- To ensure quality of sputum microscopy, external quality assurance is being routinely conducted

throughout the country as per a standardized protocol based on international guidelines with all components for ensuring quality-on site evaluation, panel testing and blinded crosschecking.

- All states are implementing the 'Supervision and Monitoring strategy'-detailing guidelines, tools and indicators for monitoring the performance from the PHI level to the national level.
- The programme is focusing on the reduction in the default rates amongst all new and re-treatment cases and is undertaking steps for the same.
- To improve access to tribal and other marginalized groups the programme has developed a Tribal action plan which is being implemented with the provision of additional TB Units and DMCs in tribal/difficult areas, additional staff, compensation for transportation of patient & attendant and higher rate of salary to contractual staff.
- The programme has introduced Pediatric patient wise boxes, in 2006, with formulations and doses specifically designed for convenient usage in children.
- 2708 NGOs collaborations and 13311 Private practitioners are involved in the programme in different signed schemes under NGO/PP schemes. 319 medical colleges (including private ones) have been involved in RNTCP by the end of Quarter 2 of 2013.
- Health facilities in government sectors outside Health Ministry have been involved viz. ESI, Railways, Ports and the Ministries of Mines, Steel, Coal, etc.
- Intensified Public Private Mix project is being undertaken with Indian Medical Association (IMA) in 16 states and with Catholic Bishop Conference of India (CBCI), a faith based organization (FBO), in 19 States under the Global Fund supported Single Stream Funding Project.
- Under the Global Fund Round 9 project civil society organizations are undertaking activities in 374 districts across 23 States to enhance the visibility and reach of the programme and engage with communities and community based care providers to improve TB care and control.

6.4.1 Scale-up of Programmatic Management of Drug-resistant TB (PMDT)

The Revised National Tuberculosis Control Programme has a vision to provide universal access to quality TB care including access to quality assured diagnosis and management of Drug Resistant Tuberculosis. The RNTCP rolled out services for diagnosis and management of multi-drug resistant TB (MDR-TB) in the states of Gujarat and Maharashtra in the year 2007. These services since then have been scaled up and currently these services are available across the country from March 2013. Till date RNTCP as on June 2013, >2,29,796 MDR TB Suspects have been tested and >32,622 confirmed MDR-TB patients have been initiated on standard treatment regimen for MDR TB under RNTCP, through 51 quality assured laboratories and 89 Drug Resistance-TB centers.

TB HIV Collaboration

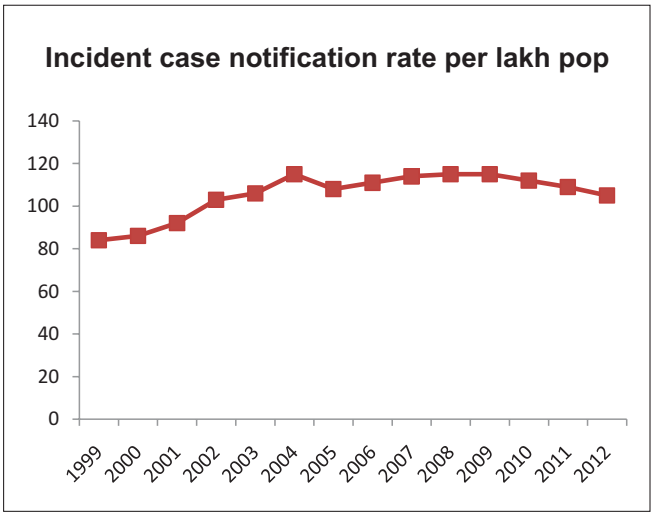
- NACP (National AIDS Control Programme) & RNTCP have developed "National framework of Joint TB/HIV Collaborative activities" in 2007 and revised it in 2009. The framework articulates the policy of TB/HIV collaborative activities in the country.
- In 2012, out of total registered cases, HIV status of 8,21,807 (56%) TB patients was known of them about 44,063 were HIV positive. 92% of these patients were put on CPT while 74% of them received ART.
- The intensified TB-HIV package was scaled up in the entire country in June 2012.
- In 2013, out of total registered cases (7,25,332) in first two quarters, HIV status of 4,57,572 TB patients was known of them about 22,355 were HIV positive.

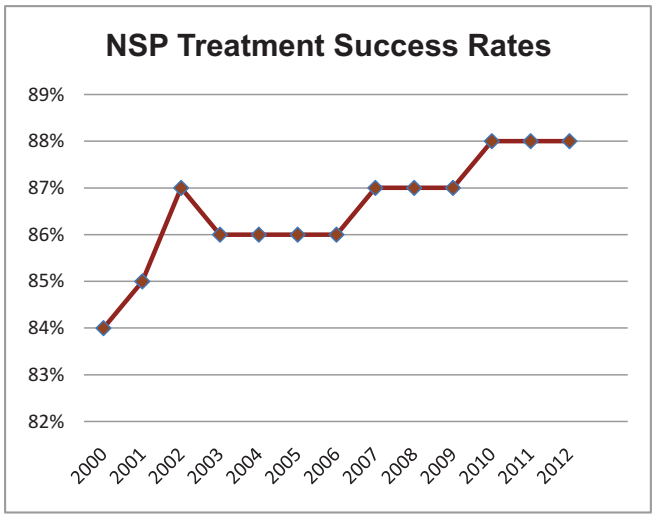
Impact of the programme

Prevalence of all forms of TB has been brought down from 465/ lakh population (1990) to 230/ lakh population in 2012 and TB mortality in the country has reduced from over 38/lakh population in 1990 to 22/lakh population in 2012 as per the WHO global report 2013.

The programme has been monitoring two important indicators, incident case notification rate and treatment

success rate among New Smear Positives, among many others. The indicators reflect that there has been consistent progress towards achieving Millennium Development Goals.





6.4.2 Advocacy Communication and Social Mobilization (ACSM)

ACSM is a priority activity in the programme. The ACSM activities are inbuilt into the programme and are implemented intensively from the National level to the most peripheral level, the community. RNTCP has a well-conceived ACSM strategy in place. There is a dedicated IEC Resource Centre in the programme website with relevant communication materials in various languages for local use. RNTCP has established its own branding of DOTS with a logo which has been widely recognized, further provision of dedicated human resources at State and district levels for ACSM activities has been made in the programme. In addition large number of partners are also associated with the Programme for implementation of ACSM activities.

6.4.3 Newer Initiatives:

6.4.3.a TB Notification: RNTCP provides quality assured diagnostic and treatment services to all the TB patients including necessary supportive mechanisms for ensuring treatment adherence and completion. But these services could not be made available to large number of patients availing services from private sector, as they were not reported to the programme.

To curb this situation, Government of India declared Tuberculosis a notifiable disease on 7th May 2012. Till date, 57000 health facilities have been registered and 35000 patients have been notified.

6.4.3.b Nikshay (case based online patient tracking system)

RNTCP since implementation followed international guidelines for recording and reporting for Tuberculosis Control Programme with minor modifications. Epi-info based EPI-CENTRE software was being used for the purpose of electronic data transmission from district level upwards. Initially DOS version was in use and the programme shifted to windows version in 2007. However, the data available at district, state or national level is in aggregated form. Central TB Division (CTD) in collaboration with National Informatics Centre (NIC) has undertaken the initiative to develop a Case Based Web Based application named Nikshay to Tuberculosis surveillance in the country & individual patient wise monitoring & tracking of TB treatment.

Till date, 1.9 million cases have been registered in Nikshay. The system has been extended to include drug resistant TB cases, online referral and transfer of patients.

6.4.3.c Ban on TB Serology

The serological tests are based on antibody response, which is highly variable in Tuberculosis (TB) and may reflect remote infection rather than active disease.

Currently available serological test are having poor specificity and do not provide direct evidence of active TB in infectious material. The World Health Organization experts Group and Strategic and Technical Advisory Group for Tuberculosis (STAG-TB) which reviewed the data and concluded that currently available commercial serological test provide inconsistent and imprecise estimates of sensitivity and specificity and strongly recommended that these test should not be used for the diagnosis of pulmonary and extra-pulmonary TB. The Gazette of India, Ministry of Health and Family Welfare (Department of Health and Family Welfare) has banned import, manufacture, sale, distribution and use of the serodiangostic test kits for tuberculosis, with due approval of Hon'ble Union Minister of Health & Family Welfare.

6.4.4 Twelfth Five Year Plan - Key Activities Proposed

In addition to the continuation of existing activities as per 11th five year plan the following key activities are proposed during the 12th five year plan for achieving the objectives of RNTCP including universal access:

- Ensuring early and improved diagnosis of all TB patients, through improving outreach, vigorously expanding case-finding efforts among vulnerable populations, deploying better diagnostics, and by extending services to patients diagnosed and treated in the private sector.
- Improving patient-friendly access to high-quality treatment for all diagnosed cases of TB, including scaling-up treatment for MDR-TB nationwide.
- Re-engineering programme systems for optimal alignment with NRHM at block level and human resource development for all health staffs.
- Enhancing supervision, monitoring, surveillance, and programme operations for continuous quality improvement and accountability for each TB case, with programme-based research for development and incorporation of innovations into effective programme practice.

6.4.5 Financial Allocation to RNTCP

Proposed budget for the RNTCP under the XIIth Five year plan is Rs. 4500.15 crores.

(in crores)

Year	Budget Outlay
2012-13	467.00
2013-14	710.00
2014-15	1100.04
2015-16	1076.82
2016-17	1146.29
Total	**4500.15**

6.5 NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

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

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

6.5.1 Main Objectives of the Programme:

- To reduce the backlog of avoidable blindness through identification and treatment of curable blind at primary, secondary and tertiary levels, based on assessment of the overall burden of visual impairment in the country;
- Develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment; through provision of comprehensive universal eye-care services and quality service delivery;
- Strengthening and upgradation of Regional Institutes of Ophthalmology (RIOs) to become centre of excellence in various sub-specialities of ophthalmology and also other partners like Medical College, District Hospitals, Sub-district Hospitals, Vision Centres, NGO Eye Hospital;

- Strengthening the existing infrastructure facilities and developing additional human resources for providing high quality comprehensive Eye Care in all Districts of the country;
- To enhance community awareness on eye care and lay stress on preventive measures;
- Increase and expand research for prevention of blindness and visual impairment and
- To secure participation of Voluntary Organizations/ Private Practitioners in delivering eye care.

6.5.2 Salient features/strategies adopted to achieve the objectives:

- Continued emphasis on free cataract surgery through the health care delivery system as well as by the involvement of NGO sector and private practitioners.
- Emphasis on the comprehensive eye care programmes by covering diseases other than cataract like diabetic retinopathy, glaucoma, corneal transplantation, vitreo-retinal surgery, treatment of childhood blindness etc. These emerging diseases need immediate attention to eliminate avoidable blindness from the Country.
- Reduction in the backlog of blind persons by active screening of population above 50 years, organizing screening eye camps and transporting operable cases to fixed eye care facilities.
- Refractive Errors comprises a major part of avoidable blindness. Screening of children for identification and treatment of refractive errors and provision of free glasses to those affected and belonging to poor socio-economic strata.
- Coverage of underserved area for eye care services through public-private partnership.
- Capacity building of health personnel for improving their knowledge and skill in delivery of high quality eye services.
- Information Education Communication (IEC) activities for creating awareness on eye-care within the community.
- Regional Institutes of Ophthalmology and Medical Colleges of the states to be strengthened in a phased manner with latest equipments & training of manpower so that they can be upgraded as Centres of Excellence in the regions
- The District Hospitals to be strengthened by upgrading infrastructure, equipment and providing adequate manpower like Ophthalmologists and PMOAs on contractual basis and provide earmarked funds for basic medicines and drugs.
- Continuing emphasis on primary healthcare (eye care) by establishing Vision centres in all PHCs with a PMOA in position.
- Multipurpose District Mobile Ophthalmic Units better coverage.

6.5.3 New Initiatives introduced during the 12th Five Year Plan:

Out of a total projected budget of Rs. 2800 crore, a provision of Rs. 2506.90 crore has been approved by the Empowered Programme Committee (EPC) for continuation of NPCB during the 12th Five Year Plan. A provision of Rs. 130 crore has been approved by the Expenditure Finance Committee (EFC) for continuing tertiary level activities during the years 2013-14 and 2014-15 under NPCB. The following new initiatives have been introduced under the programme during the 12th Five Year Plan:

- Provision for setting up 400 Multipurpose District Mobile Ophthalmic Units @ Rs.30 lakh per unit in the District Hospitals of States/UTs.
- Provision for distribution of 10 lakh spectacles @ Rs.100/- per spectacles to old persons suffering from pressbyopia.

6.5.4 Major performance indicators

Budget allocation and expenditure

(Rs. in crore)

Year	Budget allocated (BE/FE)	Expenditure
2009-10	253.02	252.90
2010-11	202.58	202.41
2011-12	222.00	221.64
2012-13	210.00	212.46
2013-14	102.34	101.94

6.5.5 Physical targets and achievements

Cataract operations

(Rs. in crore)

Year	Target	Cataract operations performed	% surgery with IOL
2009-10	60,00,000	58,10,684	95
2010-11	60,00,000	60,32,724	95
2011-12	70,00,000	63,49,205	95
2012-13	66,00,000	63,02,894	95
2013-14	66,00,000	52,15,583*	95

School Eye Screening Programme

(Rs. in crore)

Year	No. of free spectacles provided to school age group children with refractive errors	
	Target	Achievement
2009-10	4,73,472	5,05,843
2010-11	6,00,000	6,26,839
2011-12	6,00,000	6,58,061
2012-13	10,00,000	7,08,861
2013-14	9,00,000	3,70,876*

Collection of donated Eyes

(Rs. in crore)

Year	Collection of donated eyes	
	Target	Achievement
2009-10	55,000	46,589
2010-11	60,000	44,926
2011-12	60,000	49,410
2012-13	50,000	53,543
2013-14	50,000	34,492*

Training of Eye Surgeons

(Rs. in crore)

Year	Target	No. of eye surgeons trained
2009-10	400	400
2010-11	400	350
2011-12	400	350
2012-13	500	350
2013-14	500	125

* = Reports for the month of February and March, 2014 are awaited from most of the States/UTs

6.6 NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME (NIDDCP)

Iodine is an essential micronutrient required daily at 100-150 micrograms for the entire population for normal human growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, stillbirth, deaf, mutism, squint, loss of IQ, compromised school performance & various types of goiter etc. Results of sample surveys conducted in 365 districts covering all the States/Union Territories have revealed that 303 districts are endemic where the prevalence of Iodine Deficiency Disorders is more than 10%. No State/UT is free from IDD.

6.6.1 Objectives:

- Surveys to assess the magnitude of the Iodine Deficiency Disorders in districts.
- Supply of iodized salt in place of common salt.
- Resurveys to assess iodine deficiency disorders and the impact of iodized salt after every 5 years in districts.
- Laboratory monitoring of iodized salt and urinary iodine excretion.
- Health Education and Publicity.

6.6.2 Significant Achievements:

- Consequent upon liberalization of Iodized salt production, Salt Commissioner has issued licenses to 824 salt manufacturers out of which 532 units have commenced production. These units have an annual production capacity of 120 lakh Metric tonnes of Iodized salt.
- The production/supply of iodized salt from April 2013 to March 2014 was 58.64 lakh tones and 55.08 lakh tones.
- Notification banning the sale of non-iodized salt for direct human consumption in the entire country is already issued under Food Safety & Standards Act 2006 and Regulations 2011.
- For effective implementation of National Iodine Deficiency Disorders Control Programme 33 States/ UTs have established Iodine Deficiency Disorders Control Cells in their State Health Directorate.

- In order to monitor the quality of Iodized salt and Urinary Iodine excretion 33 States/UTs have already set up Iodine Deficiency Disorders monitoring laboratories while the remaining States are in the process of establishing the same.
- For estimation of iodine content in iodized salt, a total of 39921 salt samples were analyzed in the year 2013-14 (up to February/March, 2014) out of which 37412(93.71%) salt samples were found confirming to the standard (iodine content > 15 ppm).
- For estimation of urinary iodine excretion for bio-availability of iodine 10472 urine samples were collected and analyzed in the year 2013-14 (February/March, 2014) out of which 9991samples were found confirming to the standard (95.0%).
- For ensuring the quality of iodized salt at consumption level, a total of 1560818 salt samples were tested by salt testing kit during the year 2013-14, (February/March, 2014)out of which 1149118 (74.0%) salt samples indicated normal quality i.e. salt having iodine > 15 ppm.)
- Global IDD Prevention day was observed throughout the country on 21st October, 2013. Massages on benefits of consumption of iodized salt in prevention and control of IDD were published in National & Regional Newspapers on the eve of Global IDD Prevention Day through DAVP.
- Visible goitre has reduced significantly in the country.

6.6.3 Information Education & Communication Activities:

a. **Activities through Doordarshan:-** IDD Spots containing messages on consequences of Iodine Deficiency Disorders and benefits of consuming iodated salt are being telecast through the National Network of Doordarshan daily and telecast of the IDD messages under Swasth Bharat Programme. Telecast of message of Secretary (HFW) on National & Regional channels of Doordarshan on Global IDD Prevention Day 21st October, 2013.

b. **Activities through All India Radio:**- IDD Spots containing messages on major consequences of iodine deficiency disorders and benefits of consuming iodated salt in all 18 regional languages are broadcast by the All India Radio through its 37 Vividha Bharthi channels, 129 primary channels and 24 F.M channels (including 4 FM Gold channels).

c. **Activities through Railways:**- Messages on IDD and consumption of Iodated salt are being carried out through computerized railway reservation tickets in 8 different railway zones covering approximately covering 16 States/UTs.

d. **Activities through the State Health Directorate:-** State Governments have also been provided grants for undertaking IEC activities at the local level in their regional languages to make the impact of IEC activities more effective including celebration of Global IDD Prevention Day in all districts.

Chapter 7

INFORMATION, EDUCATION & COMMUNICATION

7.1 INTRODUCTION

Information, Education and Communication is now rightfully recognized as an integral part of policy making procedure. Over the years, the thrust of the Department has been to place the IEC as an intervention tool to generate demand for the range of services under National Rural Health Mission and various other schemes implemented by this Department. The communication strategy aims to facilitate awareness, disseminate information regarding availability and access to quality health care within the Government run public health system. The key objective of the IEC strategy is to encourage a health seeking behaviour that is achievable 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 under report, the communication strategy has focused on sustaining behaviour changes on key health issues through multimedia tools. The strategy framework thus incorporates a variety of activities involving communities and the various media channels. A judicious mix of the following media channels were used for information, education and communication during the year. Interpersonal communication, Community mobilization, Mass media, Folk and traditional media, Outdoor media, advocacy, events and exhibitions as also Print media.

The success of communication programmes takes years to measure. It is the success of a programme which tells how the communication campaign has worked. The sustained IEC campaign on Polio and hard work of health functionaries over several years has a great unprecedented success as no incident of Polio has been reported since 13th January 2011, thus paving the way for Polio free India. Three years continuous without Polio is without doubt the result of a focused and well-coordinated IEC campaign for Polio free India.

Among prominent initiatives of the Department, the Health magazine programme "Swasth Bharat" has been produced & telecast and broadcast through 30 Regional Kendras of Doordarshan and 29 Stations of All India Radio covering 27 States. The half an hour programme is telecast for five days a week in Regional languages at primetime.

The objective of the programme is to empower citizens with information on health related issues. The Ministry of Health and Family Welfare is the first Ministry in Government of India to have signed a Memorandum of Understanding with Prasar Bharti to start such an outreach programme to be able to reach out to wider spectrum of population through Mass media. During April 2012 - March 2014, about 12,460 programmes were telecast by Regional Kendras of Doordarshan in which about 15405 specialists, super specialists and health experts participated in the discussions. During this period, about 14913 programmes were broadcast through Regional Stations of All India Radio in which about 15201 health experts participated.

An agreement was reached to advertise/publicise our national programmes for one hour during a week. The Programme 'Healthy India' produced and telecast through Lok Sabha TV on every Saturday at 5.00 - 6.00 pm.

To supplement Swasth Bharat Programme on DD a series of 20 folders in various national health programmes/schemes are published in Urdu, Hindi and English. Among them, folders on Janani Shishu Swasthya Karyakram, Janani Suraksha Yojana, Child Health, Immunization Programme for the Elderly, Blindness

Control Programme, Programme on Mental Health, Financial Assistance to Poor Patients, National Programme on Malaria Control, Kala Azar, Japanese Encephalitis, TB, Cancer, Diabetes, Tobacco Control, Cardiovascular diseases and Family Planning have been published for distribution across the country.

Special issues of NRHM Newsletter in multiple languages have been brought out on issues relating to preventive measures of Dengue, Malaria and H1N1. Besides, issues on Non-Communicable Diseases, Healthcare of the Elderly, Population Stabilization and Family Planning etc. and health awareness focusing on behavioural change communication strategy have been brought out for health functionaries/health workers.

The target audiences for IEC-BCC campaigns include citizens all over the country in various age groups (adolescents, adults-married or unmarried, parents, local opinion makers, grass root level health care providers-ANMs, ASHA, Anganwadi workers, health care programme managers and other administrative functionaries of Health Departments as also associated Departments such as Panchayati Raj Institution, WCD, Water and Sanitation Departments as also NGOs, civil society stakeholders and media personnel.

7.2 DOORDARSHAN

- Doordarshan telecast programmes such as panel discussions, interviews covered by Doordarshan time to time related with NRHM.
- An MOU has been signed between Doordarshan, Prasar Bharti and Ministry of Health and Family Welfare with an amount of Rs. 190.28 crores for production and telecast of programme in different format five days in a week from 29 Doordarshan Kendras and three days in a week from Delhi Doordarshan Kendra for the year 2013-14. This programme is called “Swasth Bharat” in Hindi belt area and "Arogyam Bharatam" in southern belt. The purpose of this programme is to highlight and also make aware about the issues related with schemes, policies and programmes of this Ministry at grass root levels. The programme has been started from 7th April, 2012 till March 2014, 12460 programmes have been held all over India and 15405 experts have participated in the programmes.
- A programme called 'Healthy India' produced & telecast through Lok Sabha Channel on every Saturday at 05.00 to 06.00 PM.

7.3 DIRECTORATE OF ADVERTISING AND VISUAL PUBLICITY (DAVP)

- DAVP has been assigned to produce video and audio spots on NRHM for telecast/broadcast by electronic media through private FM channels, digital cinema theatre and satellite channels at grass root levels. The spots highlighted the schemes, policies and programme for the common masses in different channels.
- DAVP has released a number of press advertisements.
- DAVP was engaged for awareness campaign on behalf of Ministry of Health & Family Welfare for 15 minute magazine based radio programme broadcast from 188 primary channels in 19 languages including the stations of Vivid Bharati. The programme on Adolescent Health highlighting the critical health issues on adolescent were broadcast through all FM stations of AIR through DAVP.

7.4 ALL INDIA RADIO (AIR)

- An MoU has been signed between All India Radio, Prasar Bharti and Ministry of Health and Family Welfare with an amount of Rs. 17.29 crores for production and broadcast of programme in different format 5 days in a week from 29 Kendras of AIR for the year 2013-14. This programme is called "Swastha Bharat" in Hindi belt area and "Arogyam Bharatam" in southern belt. The purpose of this programme is to highlight and also make aware about the issues related with schemes, policies and programmes of this Ministry at grass root levels. The programme has been started from 7th April, 2012. Total of 14913 programmes have been held and 15201 experts have participated till March 2014.

- AIR has been assigned to broadcast the programme "Ek Kadam Khushhaal Zindagi Ki Aur" for broadcast through AIR from 188 primary channels, 44 Vivid Bharati including stations of north-east in 19 languages twice in a week. AIR has also been assigned to broadcast of radio programme based on adolescent health under titled 'Teen Teen to Ninteen' from 22 FM Stations in 10 languages.

7.5 HEALTH PAVILION AT IITF 2013

The annual exhibition at Health Pavilion was organised at Pragati Maidan, New Delhi associating the Directorate of Advertising and Visual Publicity of Ministry of I&B during the India International Trade Fair 2013. The theme for Health Pavilion IITF 2013 was "Health with Equity" keeping in mind the initiatives taken by the Department during the year on various Health issues/programmes. Nearly fifty thousand persons a day visited the pavilion at Pragati Maidan, New Delhi. Highlights of 2013 Health Pavilion include live MCTS demonstrations, life cycle approach display on adolescent health, safe institutional delivery initiatives, neonatal care services, immunisation services particularly highlighting provisions of the newly initiated programme of Janani Shishu Suraksha Karyakram and intensification of routine immunization. Health check-up services for children, counseling for population stabilisation, HIV AIDS, family planning methods particularly No Scalpel Vasectomies, yoga intervention for life style diseases, diabetes and hypertension check-ups and quizzes proved to be major attractions of the pavilion also Drawing Competition for school children and specific outdoor publicity for the pavilion was organised at the ITPO, Pragati Maidan premises.

The Health Pavilion at IITF - 2013 was awarded silver medal among the pavilions of Ministry category.

7.6 PRINT, OUTDOOR MEDIA

Press Advertisements

The IEC Campaign through Press Advertisement enabled the division to highlight key initiatives in both national and regional media. A number of campaigns were launched through the national and regional press. Especially designed full and half page colour advertisements were published in the newspapers across the country on the occasion of World Population Day, Pulse Polio National Immunization Day, Rashtriya Kishor Swsathya Karyakram, Independence Day, Gandhi Jayanti, important Health days, etc.

The IEC Division also released full and half page advertisements based on focused theme such as Maternal & Child Health Care, Adolescent Health, National Teeka Express, Health Pavilion in IITF- 2013 etc. The Division as part of an integrated IEC campaign covered a range of issues on NRHM related themes which provided a platform for information dissemination, awareness building and advocacy through the print media.

Printed Publicity Material

In order to highlight the Ministry's consistent efforts, a series of print materials viz; folders, leaflets and other documents were published.

Folders: A series of twenty folders on various National Health programmes/schemes were published in Urdu, Hindi and English. Among them, folders on Janani Shishu Swasthya Karyakram, Child Health, Immunization, Programme for the Elderly, Blindness Control programme, Programme on Mental Health, Financial Assistance to Poor Patients, National Programme on Malaria Control, Kala Azar and Japanese Encephalitis etc. have been published during the year 2013. The folders were meant to supplement mass awareness of the various Health programmes being broadcast through the Swasth Bharat programme on DD.

Leaflets: Leaflets on Safe Motherhood, Reproductive Tract Infections, Safe Abortion practices, Non communicable diseases etc. were also published in English, Hindi and regional languages for circulation to beneficiaries.

Publication on 5 years of Achievements & Initiatives: Publication documented the performance, Achievements and new initiatives of the four Departments of the Ministry in the last 5 years. Information on all major Programmes were compiled with updated data with a vision for the future. This 90 page document is a series of publication being brought out every year for dissemination of information to media, stakeholders, development partners, social, political and religious leaders across the country.

Other documents published during the year were: i) 'Bulletin of Rural Health Statistics in India'- which gives an insight into the position of infrastructure and manpower in various Health set-ups in the field. ii) Book on 'Health & Family Welfare Statistics in India', which provides the latest demographic data and data on Health & Family Welfare indicators from various sources.

NRHM Newsletter

The NRHM Newsletter is now established as an important publication for promotion of the programmes under National Rural Health Mission as well as other Health programmes. The NRHM Newsletter is being published in English, Assamese, Urdu, Oriya, Punjabi, Marathi, Kannada, Tamil, Hindi & Bengali for health functionaries working at the Sub-Centres, PHCs, CHCs and District level and for NGOs. The Newsletter publishes view points of all development partners, viz. NGOs, donor agencies etc. This is the best medium for reaching out to the grass roots health workers across the country. During the year newsletter issues were brought out on Non-Communicable Diseases, Healthcare of the Elderly, Population Stabilization and Family Planning etc. There has been tremendous response to the Newsletter, especially from the grass roots health workers from different regions. A number of health related issues, in the form of reader's responsehave been discussed through these Newsletter editions.

Journal 'Hamara Ghar'

Hamara Ghar is an established quarterly house journal of the Department of Health & Family Welfare. It has been published by the Department since last 42 years for generating awareness of mass people on various health issues. The journal focuses Health issues/ programmes for promotion of healthy living. It is published in Hindi and distributed to health functionaries working at the PHCs, CHCs and District Hospitals, grass root level workers, NGOs etc. across the country.

Annual Wall Calendar

Department of Health & Family Welfare brought out a unique Wall Calendar 2014 on the theme of 'Mother and Child'. The simple design of Calendar with big close-up of Mother & Child with clean tidy date sheet has been well received. The Calendar covered several issues highlighting on Mother and Child Healthcare like - Antenatal check-up, Janani Shishu Suraksha Karyakram (JSSK), Role of ASHAs in Safe Motherhood, Delivery at Hospital, Immunization, Family Planning, Rashtriya Kishor Swasthya Karyakram, Newborn Care, Hygiene & Nutrition, Menstrual Hygiene, Breastfeeding etc. The Calendar was distributed to various health set ups in the States/UTs, NGOs etc.

Publicity Campaign at Tirupati Shrine through Access Cards

The IEC Division conducted publicity campaign on various health issues. Under the scheme of Innovative Publicity at pilgrim centers, Health messages on several issues were printed on the access cards of Tirupati Tirumala Devasthanamas publicity campaign. Health messages printed on Access Cards were on New born care, Breastfeeding, Immunization, Safe Motherhood, Spacing methods, Population Stabilization, Small family, Right age of marriage etc. About 50000 to 70000 pilgrims visit the Devasthanam everyday, on special days it peaks over one lakh.

7.7 MASS MAILING UNIT

Mass Mailing Unit established in 1969, is dispatching a large number of publicity material in Hindi, English and Regional Languages to different destinations throughout

country such as Primary Health Centres, Community Health Centres, District Hospitals, State Level Health Functionaries and Officers, Central Government Hospitals, Medical Colleges, ANM Training Colleges, Health & Family Welfare Training Centres, Mother NGOs, Field Publicity Officers of Ministry of I&B, Regional Directors, Donor Organizations etc.

The material included NRHM News Letter, Hamara Ghar, Folders, Annual Wall Calendar, Leaflets & various other publication/IEC material developed by Ministry of Health & Family Welfare. The material is being dispatched through Department of Posts via Un-Registered Post (URP) and Express Parcel Post (EPP). During the year under report MMU mailed 1,27,103 Un-Registered Posts (URPs) and 8,211 Express Parcel Post (EPP) to different Health Centres /Institutes/ NGOs and grass root level functionaries across the country.

Chapter 8

PARTNERSHIP WITH NON-GOVERNMENT ORGANIZATION

8.1 REGIONAL RESOURCE CENTERS (RRCS)

The NGO Division releases grant-in-aid to the Regional Resource Centers (RRCs) for providing the technical and managerial support to the Mother NGOs/Field NGOs who are involved in the implementation of the Reproductive Child Health Programme at field level in various States. The RRCs use grants to conduct capacity building programmes in a phased manner and submit Quarterly Progress Reports to the Ministry.

As on date, there are 10 functional Regional Resource Centers (RRCs). A list of Regional Resource Centers (RRCs) and States covered by them are enclosed at Statement-I. The Grant-in-Aid released to them during 2012-13 is given at Statement-II.

Statement-I

Regional Resources Centers (RRCs) with States covered

S.No.	Name of Regional Resource Center	States Covered
1.	Voluntary Health Association of India, Delhi	1. Rajasthan 2. Delhi 3. Uttarakhand 4. Jammu & Kashmir
2.	MAMTA-Health Institute for Mother & Child, New Delhi	5. Punjab 6. Haryana 7. Chandigarh
3.	Hindustan Latex Family Planning Promotion Trust (HLFPPT), Andhra Pradesh	8. Himachal Pradesh 9. Andhra Pradesh
4.	The Gandhigram Institute of Rural Health & Family Welfare Trust, Tamil Nadu	10. Tamil Nadu 11. Kerala 12. Karnataka 13. Puducherry 14. Lakshdweep
5.	Family Planning Association of India (FPAI), Mumbai	15. Maharashtra 16. Goa 17. Madhya Pradesh.
6.	Child In Need Institute(CINI), Kolkata (West Bengal)	18. A & N Islands 19. West Bengal 20. Jharkhand

7.	Population Foundation of India (PFI), New Delhi	21. Bihar 22. Chhattisgarh
8.	Centre for Health Education Training & Nutrition Awareness (CHETNA), Gujarat	23. Gujarat 24. Daman & Diu 25. Dadar & Nagar Haveli
9.	Voluntary Health Association of Assam (VHAA), Assam	26. Sikkim 27. Assam 28. Meghalaya 29. Arunachal Pradesh 30. Tripura 31. Nagaland 32. Mizoram 33. Manipur
10.	Swasthya Shikhya, Odisha	34. Odisha

Statement-II

Statement of Grant-in-Aid released to Regional Resources Centres (RRCs) during 2012-13

S.No.	Name of the RRC	Amount Released 2012-13
1.	Centre for Health Education Training & Nutrition Awareness (CHETNA), Gujarat	22,64,479/-
2.	Voluntary Health Association of India (VHAI), New Delhi	23,38,088/-
3.	MAMTA-Health Institute for Mother & Child, New Delhi	16,85,009/-
4.	Hindustan Latex Family Planning Promotion Trust (HLFPPT), Andhra Pradesh	10,00,000/-
5.	Child In Need Institute (CINI), Kolkata (West Bengal)	10,00,000/-
6.	Population Foundation of India (PFI), New Delhi	---
7.	Swasthya Shikhya, Odisha	5,12,374/- (not released because of some clarification to be received)
8.	Family Planning Association of India (FPAI), Mumbai	5,00,000/-
9.	The Gandhigram Institute of Rural Health & Family Welfare Trust, Tamil Nadu	5,00,000/-
10.	Voluntary Health Association of Assam (VHAA), Assam	18,79,000/-

Chapter 9

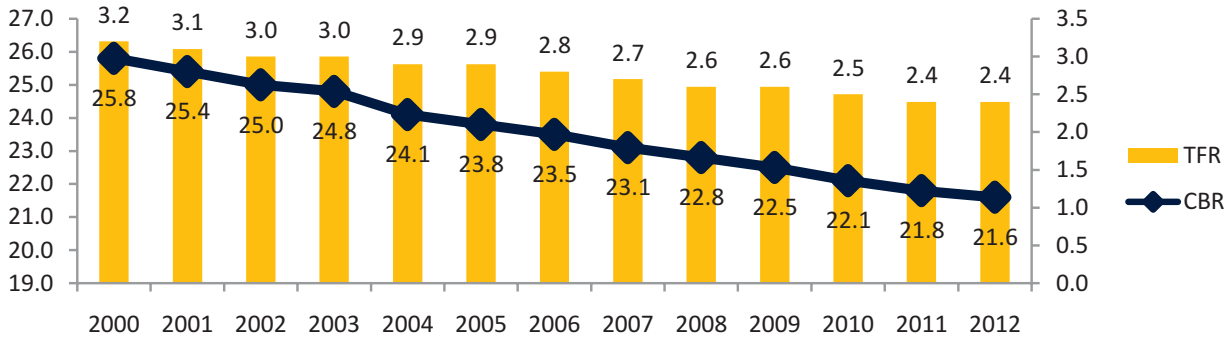
FAMILY PLANNING

9.1 INTRODUCTION

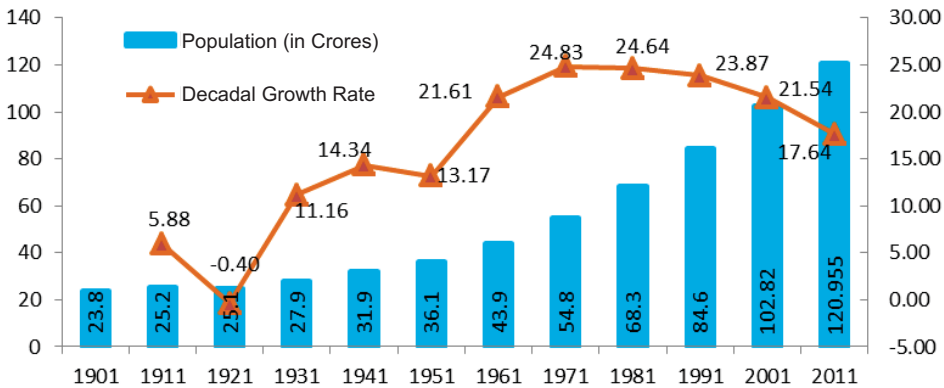
With its historic initiation in 1952, the family planning programme has undergone transformation in terms of policy and actual programme implementation. There occurred a gradual shift from clinical approach to the reproductive child health approach and this holistic and target free approach helped in reduction of fertility.

The target free approach is now reflected in the State project implementation plans based on community needs assessment. Presently the expected level of achievement is estimated for each State by the indicators reflecting the community needs like contraceptive usage, parity, unmet need and existing fertility.

Over the years, the programme has been expanded to reach every nook and corner of the country and has penetrated into PHCs and SCs in rural areas, Urban Family Welfare Centers and Postpartum Centers in the urban areas. Technological advances, improved quality and coverage for health care have resulted in a rapid fall in the Crude Birth Rate (CBR) and growth rate (2011 Census showed the steepest decline in the decadal growth rate.)



The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals, Family Planning (FP) 2020 Summit and others).



1. Current Scenario of Population and Family Planning in India

Expected increase of population of 15.7% in fifteen years	• From 1210 million in 2011 to 1400 million in 2026.
Decline in TFR	• Helps to stabilize India's population growth which in turn spurs the economic and social progress
Greater investments in family planning	• Helps to mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies • Reduce maternal mortality by 35% • Reduce infant mortality and abortions significantly
Govt. of India's commitment by 2015	• Maternal Mortality Ratio (MMR) to 100/100,000 • Infant Mortality Rate (IMR) to 30/1000 live births • Total Fertility Rate (TFR) to 2.1

2. Factors that Influence Population Growth

Unmet need of Family Planning	• 21.3% as per DLHS-III (2007-08)
Age at Marriage and first childbirth	• 22.1% of the girls get married below the age of 18 years • Out of the total deliveries 5.6% are among teenagers i.e. 15-19 years • Marriages below legal age is more alarming in few States like, Bihar (46.2%), Rajasthan (41%), Jharkhand (36%), UP (33%), and MP (29.2%)
Spacing between Births:	• Spacing between two childbirths is less than the recommended period of 3 years in 57.4% of births (SRS 2012) • 46% of women have spacing less than 30 months
15-24 age group (women)	• 52.5% contribution in total fertility • 46% contribution in maternal mortality

3. Current Demographic Scenario in the Country (Census 2011)

2.4% of world's land mass	• 17.5% of the world's population
1.21 billion	• India's population as per Census-2011
200 million	• Population of Uttar Pradesh - more than the population of Brazil

Census Year	Population (in crores)	Decadal Growth (%)	Average Annual Exponential Growth (%)
1971	54.82	24.80	2.20
1981	68.33	24.66	2.22
1991	84.64	23.87	2.16
2001	102.87	21.54	1.97
2011	121.02	17.64	1.64

Perceptible decline (in last 5 decades)

- Crude birth rate - 40.8 per 1000 in 1951 to 21.6 in 2012.
- Infant mortality rate - from 146 in 1951 to 42 in 2012.
- Total Fertility rate - from 6.0 in 1951 to 2.4 in 2011 (Ref: Appendix -I).
- Steepest decline in growth rate between 2001 and 2011 from 21.54% to 17.64%.
- Decline in 0-6 population by 3.08% compared to 2001.

Population added

- Lesser than the previous decade, 18.14 crores added during 2001-2011 compared to 18.23 crores during 1991-2011.

Significant decline

- There is a 4.1 percentage point fall from 24.99% in 2001 to 20.92% in 2011 in the growth rate of population in the EAG States (UP, Bihar, Jharkhand, MP, Chhattisgarh, Rajasthan, Odisha and Uttaranchal) after decades of stagnation.

4. Progress in TFR

TFR decline

- From 2.9 in 2005 to 2.4 in 2012.
- Decline more significant in High Focus States.

TFR of 2.1 or less

- 23 States and Union Territories

TFR 2.1-3.0

- **10 States-**Haryana-2.3, Gujarat-2.3, Arunachal Pradesh-2.3, Assam-2.4, Chhattisgarh-2.7, Jharkhand-2.8, Rajasthan-2.9, Madhya Pradesh-2.9, Meghalaya-2.9 and Dadara & Nagar Haveli-2.9

TFR above 3.0

- 2 States - Bihar-3.5, Uttar Pradesh-3.3

Note: *refer Appendix - I for details.*

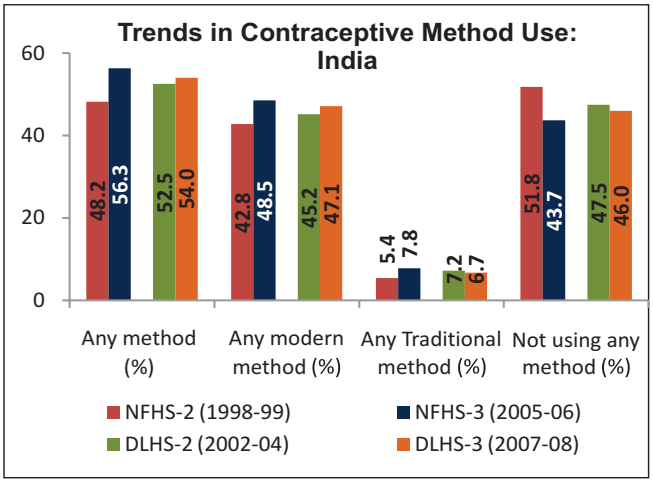
Impact of High Focus Approach of the Government of India- Government of India has categorized States as per the TFR level as very high-focus (more than or equal to 3.0), high-focus (more than 2.1 and less than 3.0) and non-high focus (less than or equal to 2.1)

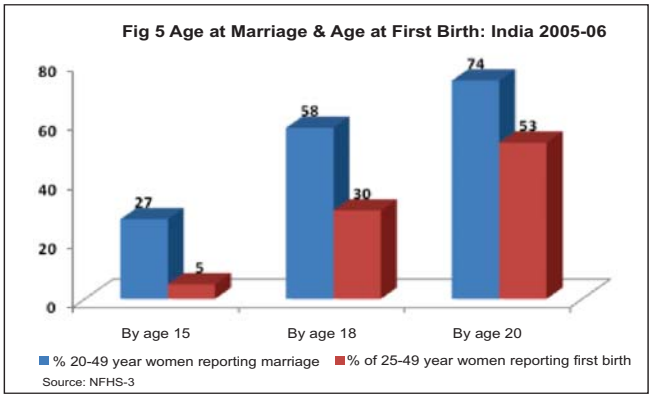
- Decline in TFR
  - All the very high focus States have shown a decline of 0.1 points

Category	State	SRS 2010	SRS 2011	SRS 2012	Point Change
Very High Focus States for Family Planning	Bihar	3.7	3.6	3.5	-0.1
	Uttar Pradesh	3.5	3.4	3.3	-0.1
	Madhya Pradesh	3.2	3.1	2.9	-0.1
	Rajasthan	3.1	3.0	2.9	-0.1
	Jharkhand	3.0	2.9	2.8	-0.1
High Focus States for Family Planning	Chhattisgarh	2.8	2.7	2.7	0.0
	Assam	2.5	2.4	2.4	0.0
	Gujarat	2.5	2.4	2.3	-0.1
	Haryana	2.3	2.3	2.3	-0.1
	Odisha	2.3	2.2	2.1	-0.1

9.2 FAMILY PLANNING SCENARIO (NHFS, DLHS AND AHS)

The last survey figures available are from NFHS-3 (2005-06) and DLHS-3 (2007-08), which are being used for describing current family planning situation in India. Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9 (NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure). Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). The proximate determinants of fertility like, age at marriage and age at first childbirth (which are societal preferences) are also showing good improvement at the national level. The adjoining figure indicates the current position of social determinants of fertility in the country.





AHS survey has been conducted in 9 States (8 EAG States + Assam) which indicates that:

- All the States except Uttarakhand has shown an increase in use of modern contraceptives.

9.3 CURRENT FAMILY PLANNING EFFORTS

Family planning have undergone a paradigm shift and emerged as one of the interventions to reduce maternal and infant mortalities and morbidities. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities.

Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. Studies show that if the current unmet need for family planning could be fulfilled over the next 5 years, we can avert 35,000 maternal deaths, 1.2 million infant death, save more than Rs. 4450 crores and save Rs. 6500 crores, if safe abortion services are coupled with increased family planning services. This strategic direction is the guiding principle in implementation of family planning programme in future.

9.3.1 Contraceptive services under the National Family Welfare programme

The methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (emergency contraceptive pill) to be used in cases of emergency.

9.3.1.a Spacing Methods- These are the reversible methods of contraception to be used by couples who wish to have children in future. These include:

A. Oral contraceptive pills

- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. The strip also contains additional placebo/iron pills to be consumed during the hormonal pill free days. The method may be used by majority of women after screening by a trained provider.

- At present, there is a scheme for delivery of OCPs at the doorstep of beneficiaries by ASHA with a minimal charge. The brand "MALA-N" is available free of cost at all public healthcare facilities.

B. Condoms

- These are the barrier methods of contraception which offer the dual protection of preventing unwanted pregnancies as well as transmission of RTI/STI including HIV. The brand "Nirodh" is available free of cost at government health facilities and supplied at doorstep by ASHAs for minimal cost .

C. Intrauterine contraceptive devices (IUCD)

- Copper containing IUCDs are a highly effective method for long term birth spacing.
- Should not be used by women with uterine anomalies or women with active PID or those who are at increased risk of STI/RTI (women with multiple partners).
- The acceptor needs to return for follow up visit after 1, 3 and 6 months of IUCD insertion as the expulsion rate is highest in this duration.
- Two types:
  - Cu IUCD 380A (10 yrs)
  - Cu IUCD 375 (5 yrs)
- New approach of method delivery- postpartum IUCD insertion within 48 hours of delivery by specially trained providers to tap the opportunities offered by institutional deliveries. Service providers and ASHAs accompanying clients are being provided with incentive of Rs. 150/-.

9.3.1.b Permanent Methods- These methods may be adopted by any member of the couple and are generally considered irreversible.

A. Female Sterilisation

- Two techniques:
  - **Minilap -** Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.
  - **Laparoscopic-** Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen. Can be done only by trained and certified gynaecologist/surgeon.

B. Male Sterilisation

- Through a puncture or small incision in the scrotum, the provider locates each of the 2 vas deference that carries sperm to the seminal vesicle and cuts and then ties the two cut ends. The procedure is performed by MBBS doctors trained in the procedure. However, the couple needs to use an alternative method of contraception for first three months after sterilization till no sperms are detected in semen.
- Two techniques being used in India:
  - Conventional
  - Non-scalpel vasectomy- no incision, only puncture and hence no stiches.

9.3.1.c Emergency Contraceptive Pill

- To be consumed in cases of emergency arising out of unplanned/unprotected intercourse.
- The pill should be consumed within 72 hours of the sexual act and should never be considered a replacement for a regular contraceptive.

9.3.1.d Other Commodities - Pregnancy testing kits

- Helps to detect pregnancy as early as one week after the missed period, thus proving an early opportunity for medical termination of pregnancy, thus saving lives lost to unsafe abortions.
- These are available at the subcentre level and also carried by ASHA.

9.3.1.e Service Delivery Points

- All the spacing methods, viz. IUCDs, OCPs and condoms are available at the public health facilities beginning from the sub-centre level. Additionally, OCPs condoms, and emergency contraceptive pills (since are not skill based services) are available at the village level also through trained ASHAs.

- Permanent methods are generally available at primary health centre level or above. They are provided by MBBS doctors who have been trained to provide these services. Laparoscopic sterilization is being offered at CHCs and above level by a specialist gynaecologist/surgeon only.
- These services are provided to around 20 crores eligible couples; Details of services provided at different level of:

Family Planning Method	Service Provider	Service Location
Spacing Methods		
IUD 380 A/IUCD 375	Trained & certified ANMs, LHVs, SNs and doctors	Subcentre & higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Subcentre & higher levels
Limiting Methods		
Minilap	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Laparoscopic Sterilization	Trained & certified Specialist Doctors (OBG & General Surgeons)	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Emergency Contraception		
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level, Subcentre & higher levels

Note: *Contraceptives like OCPs, Condoms are also provided through Social Marketing Organizations*

9.3.2 The Salient Features of the Family Planning Programme

A. On-going interventions:

- More emphasis on Spacing methods like IUCD.
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilap tubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate gynaecologists/surgeons.
- A rational human resource development plan is in place for provision of IUCD, minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels.
- Accreditation of more private/NGO facilities to increase the provider base for family planning services under PPP.
- Increasing male participation and promoting Non-Scalpel Vasectomy.

- Compensation scheme for sterilization acceptors - under the scheme of Ministry of Health & Family Welfare provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations.
- 'National Family Planning Indemnity Scheme' under which clients are indemnified in the eventualities of deaths, complications and failures following sterilization. The providers/accredited institutions are indemnified against litigations in those eventualities.
- Improving contraceptives supply management up to peripheral facilities.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities.
- Strong political will and advocacy at the highest level, especially in states with high fertility rates.

B. New interventions to improve access to contraception:

Home Delivery of Contraceptives (HDC):

- A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. The scheme was launched in 233 pilot districts of 17 States on 11 July 2011 and is now expanded to the entire country from 17th Dec 2012.
- ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Rs. 1 for a pack of 3 condoms, Rs. 1 for a cycle of OCPs and Rs. 2 for a pack of one tablet of ECP.

C. Ensuring Spacing at Birth (ESB)

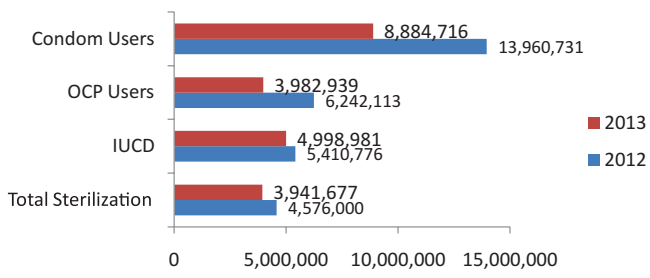
- Under a new scheme launched by the Government of India, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child. The scheme is operational in 18 States (EAG, North-Eastern and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:
  - o Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.
  - o Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child.
  - o Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only.
- Ministry of Health & Family Welfare has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning programme. Training of State level trainers has already been completed and process is underway to train service providers up to the sub-center level.
- A new method of IUCD insertion (post-partum IUCD insertion) has been introduced by the Government.
- Promoting Post-partum Family Planning services at district hospitals by providing for placement of dedicated Family Planning Counsellors and training of personnel.

D. Pregnancy Testing Kits

- Nishchay-Home based pregnancy test kits (PTKs) was launched under NRHM in 2008 across the country.
- The PTKs are being made available at subcenters and to the ASHAs.
- The PTKs facilitate the early detection and decision making for the outcomes of pregnancy.

9.3.3 Progress made under Family Planning Programme

Service Delivery 2012-13- The performance of family planning services during 2012 and 2013 (provisional figures) is provided below (source: HMIS):



- Number of IUCDs and sterilisations has remained static in spite of declining CBR and TFR. There is a need to sustain momentum to reach the replacement level fertility.
- Considering the current efforts to focus on spacing, it is expected that IUCD performance would increase in near future.
- State wise sterilisation and IUCD achievements is provided at **Appendix-2**.

9.3.4 Promotion of IUCDs as a short & long term spacing method

In 2006, Government of India launched "Repositioning IUCD in National Family Welfare Programme" with an objective to improve the method mix in contraceptive services and has adopted diverse strategies including advocacy of IUCD at various levels; community mobilization for IUCD; capacity building of public health system staff starting from ANMs to provide quality IUCD services and intensive IEC activities to dispel myths about IUCD. Currently, increased emphasis is given to promotion of IUCD insertion as a key spacing method under Family Planning programme.

"Alternative Training Methodology in IUCD" using anatomical, simulator pelvic models incorporating adult learning principles and humanistic training technique was started in September 2007 to train service providers in provision of quality IUCD services.

Actions taken and achievements:

- Approval of around Rs. 39.28 crores in 2013-14 PIP for IUCD training.
- HLFPPT has been engaged to support States to conduct interval IUCD training and also post training follow-up of trained personnel. HLFPPT would also follow-up sample cases of IUCD insertion to ensure retention.
- Directive has been issued to the States to notify fixed days/ per week at SHC and PHC level for conducting IUCD insertions.
- Introduction of Cu IUCD-375 (5 years effectivity) under the Family Planning Programme:
  - Training of State master trainers completed in December 2011.
  - Sample Cu IUCD 375 despatched to States for conducting district level training
  - Funds approved under PIP for conduct of training and orientation of other staff

9.3.5 Emphasis on Postpartum Family Planning (PPFP) services:

- In order to capitalize on the opportunity provided by increased institutional deliveries, the Government of India is focusing on strengthening post-partum FP services.
- PPFP services are not being offered uniformly at all levels of health system across different States of India resulting in missed opportunities.
- Insertion of IUCD during the postpartum period, known as Postpartum Intrauterine Contraceptive Device (PPIUCD), is being focused to address the high unmet need of spacing during postpartum period.

Actions taken and achievements:

- **Strengthening Post-Partum IUCD (PPIUCD)** services at high case load facilities:
  - Currently the focus is on placement of trained providers for PPIUCD insertion at district and sub-district hospital level only, considering the high institutional delivery load at these facilities.
  - Jhpiego is providing technical support to 6 high focus states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttar Pradesh) to train service providers at DH and SDH level.
  - Around Rs. 3.10 crores has been approved for training in PPIUCD.
  - Total PPIUCD insertions for the year 2013-14 have been 3,24,974.
- **Appointing dedicated counsellors at high case load facilities:**
  - Ministry of Health & Family Welfare has decided to appoint counsellors at all high case load facilities to provide counselling services in following areas:

- Post-partum Family Planning (IUCD and Sterilisation)
- Other family planning methods such as condoms, pills etc.
- Ensuring healthy timing and spacing of pregnancy
- Mother & baby care
- Early initiation of breast feeding
- Immunization
- Child nutrition.

o Government of India has approved around Rs. 8.07 crores for appointment of 1301 counsellors.

9.3.6 Assured delivery of family planning services

9.3.6.a *Fixed Day Services (FDS) for IUCD Insertion*: Decision has been taken to ensure fixed days IUCD insertion services at the level of SC and PHC (at least 2 days in a week).

9.3.6.b F*ixed Day Static Services in Sterilisation at facility level*:

- Operationalization of FDS has following objectives:
  - o To make a conscious shift from camp approach to a regular routine services;
  - o To make health facilities self-sufficient in provision of sterilization services and
  - o To enable clients to avail sterilization services on any given day at their designated health facility.

FDS Guidelines for sterilization services

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

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

9.3.6.c *Camp approach for sterilization services* is continued in those States where operation of regular fixed day static services in sterilization takes longer time duration.

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

Actions taken and achievements:

- In year 2013-14 all the States have shown their commitment to strengthen fixed day family planning services for both IUCD and sterilisation and it has been included under quarterly review mechanism to assess progress made by the States:-

Fixed Day FP Services: 2013-14

S.No.	State	Fixed Day Services for IUCD	Fixed Day Services for Sterilisation
1	Bihar	Twice weekly at PHC-534 & RH-149. HSC-534	FS:PHC-534, RH-149 MS: DH-25, SDH-20, PHC-50
2	Chhattisgarh	124 Sites	FS: 15 DH twice a week, 106 CHC fortnightly
3	Himachal Pradesh	All DHs	All DHs
4	Jammu & Kashmir	480 Facilities Twice/week in CHC'S and FRU'S	Daily at All DHs & CHC-138 Facilities
5	Jharkhand	21 DH, 120 CHC, 113 PHC, 678 HSC	All DHs
6	Madhya Pradesh	3 days a week in DH & CH, 2 days a week in CHC, once a week in SHC	Daily at DH, 6 days at CH, 2 days a week in CHC & PHC
7	Odisha	All DPs upto CHC level + 15% of PHC(N)s & SCs (1187 institutions)	DPs - 128 Other DPs - 146
8	Rajasthan	Every Tuesday & Friday at Sub Centre (12701) & PHC (1612)+50(City)	Both FS & MS on every Wednesday at 249 block level CHCs (including DH, SDH & SH)

9	Uttar Pradesh	Once a week in PHC & SHC	Daily in DH and Twice a week in CHC
10	Uttarkhand	SHC (once/week) - 1765 PHC (twice/week) - 239	27 (12 DH, 10 SDH, 5 FRU)
North East States			
1	Arunachal Pradesh	75 PHCs & 49 CHCs and 14 DH/GH	FS: 35 DPs MS: 13 FRUs
2	Assam	SC-2356; DH-21; SDCH-10; CHC-50; PHC-30	21 DHs- FS; 21 DH+15 FRUs- MS
3	Manipur	40 HSC, 16 CHC, 9 DH, 30 PHC	FS & MS : PPS Churchaderpur, RIMS Imphal, Imphal West, SD kakchin
4	Meghalaya	100SC + Daily at 8 DH, Weekly at PHCs + 20 CHCs	FS: Daily at 6 DH + 1 MCH Tura & 3 CHCs MS: 2 (Jeldupara PHC & Civil Hospital Shillong)
5	Mizoram	SDH-2, CHC-9, PHC-40, at least 2 days per week	DH, CHC, PHC-1 per week
6	Nagaland	3 time a week at DH, once a week at CHC & 24x7 PHC (PHC 125; CHC 21; DH 11)	FS-All DHs MS- 4 DH
7	Sikkim	Daily at SHC	All DHs
8	Tripura	2 days In a week CHCs and once weekly in PHC & once in a week in 8 HSC	For Both FS & MS at 2SHs & 3 DHs
Non High Focus Large States			
1	Andhra Pradesh	SHC - 301; ; PHC - 29; CHC - 25	FRU - 13 (MS & FS); 24x7 - 29 (FS)
2	Goa	Not Available	FS: Every Friday at 2 DHs, 1SDH, 4 CHCs MS: No FDS
3	Gujarat	PHC - 104 SHC - 688	FS (104-PHCs & 136-DH/ FRUs) MS (45-DH / SDH)
4	Haryana	Daily at all DH, SDH and CHC. Weekly at PHC Twice weekly at 2360 SC	All DH+All FRU+ 50% PHC per district
5	Karnataka	Twice weekly at SC & PHC	DH & FRUs
6	Kerala	Weekly @ PHC + CHC	DH + 1 SDH/ FRU per dist
7	Maharashtra	8211 SC & 1578 PHC	23 DH, 11 WH, 4 GH, 81 SDH, 368 RH, 1811 PHC
8	Punjab	23 DH, 35 SDH and 114 CHCs	170 facilities
9	Tamilnadu	Weekly once at 8706 HSC & Daily PHCs (1614), PPCs(110) & UFWCs (108)	FS- Daily-225 (Med College, DH & SDH), Weekly twice - 70 (SDH-Non Taluk), Weekly once-360 (Upgraded PHC & Block PHC), Once in 15 days - 48 H Facilities, Once in a month - 106 H Facilities. MS: 195 (DH, SDH & MCH)
10	West Bengal	7820 Centres	All DHs
Union Territories			
1	A&N Islands	All SCs	FS& MS: All DHs
2	Chandigarh	Daily in GMSH-16 & GMCH-32	FS: Daily in GMSH-16 & GMCH-32, CHC-22(wed & sat) MS: Tue & Thurs in GMSH-16 & GMCH-32

3	D&N Haveli	Twice weekly at all SC and Daily at DH	FS: Daily at DH MS: As & when client comes
4	Daman & Diu	All SC	All DH
5	Delhi	MH, SDH & DH provide 6 days/week Dispensaries,Seed PUHC & M&CW centres 5 days/week	FS & MS: Daily at 9 DHs & 49 SDH
6	Lakshadweep	To provide services in all 10 Island Facilities	To provide services in all 10 Island Facilities
7	Puducherry		All DH

- Recent field visits and review missions to the States reveal that most of the facilities at the level of CHC and above have been operationalised for providing FP services on fixed day basis.
- Analysis of the data available from HMIS for 2013-14 reveals that:
  - o Around 67% of NSVs are conducted at PHC and CHC level.
  - o Majority of minilap sterilisations (32.7%) are conducted at PHC level followed by 28.2% at CHC level.
  - o Majority of laparoscopic sterilisation (42%) is conducted at CHC level.
  - o As anticipated around 39% of the PPS is reported at DH/SDH level since majority of institutional deliveries are conducted at these facilities; however, this needs to increase at PHC and CHC level as well.

9.3.7 Quality assurance in Family Planning

Quality assurance in family planning services is the decisive factor in acceptance and continuation of contraceptive methods and services. The Hon'ble Supreme Court of India in its Order dated 1.3.2005 in Civil Writ Petition No. 209/2003 (Ramakant Rai V/s Union of India) has, inter alia, directed the Union of India and States/UTs for ensuring enforcement of Union Government's Guidelines for conducting sterilization procedures and norms for bringing out uniformity with regard to sterilization procedures by:

- Creation of panel of Doctors/health facilities for conducting sterilization procedures and laying down of criteria for empanelment of doctors for conducting sterilization procedures.
- Laying down of checklist to be followed by every doctor before carrying out sterilization procedure.
- Laying down of uniform proforma for obtaining of consent of person undergoing sterilization.
- Setting up of Quality Assurance Committee for ensuring enforcement of pre and postoperative guidelines regarding sterilization procedures.
- Bringing into effect an insurance policy uniformly in all States for acceptors of sterilizations etc.

Actions taken and achievements:

The Ministry of Health & Family Welfare developed various standards/manuals/guidelines and directed the States to adhere to the same to ensure quality of service provision, which are as follows:

- **Standards for Female and Male Sterilisation Services (2006):**
  - o It sets out the criteria for eligibility, physical requirements, counselling, informed consent, preoperative, postoperative, and follow-up procedures and procedures for management of complications and side effects.
- **Quality Assurance Manual for Sterilization Services (2006):**
  - o It sets out modalities for formation of Quality Assurance Committees (QACs) at State and District whose main functions include:

- Empanelment of doctors for sterilization procedures
- Accreditation of private/NGO facilities
- Review/report post sterilization deaths/ complications/failures

- **Standard Operating Procedure (SOP) for Sterilisation Services in camps (2008)**
- **Fixed Day Static approach for Sterilization Services (2008)**
- **IUCD Reference Manual:** Comprehensive manual for the interval IUCD and PPIUCD insertion
- **Comprehensive manual on female sterilization**
- **Comprehensive manual on male sterilization**
- **Family Planning Indemnity Scheme:**
  - o For the acceptors of Sterilization for treatment of post-operative complications, failure or death attributable to the procedure of sterilization. The manual has been revised in 2013.
- Ministry of Health & Family Welfare, Family Planning Division has recruited technical experts to support states in improving delivery of quality services

9.3.8 Other promotional schemes:

9.3.8.a Revised compensation scheme for acceptors of sterilization:

- Government has been implementing a Centrally Sponsored Scheme since 1981 to compensate the acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization. This compensation scheme for acceptors of sterilization services was revised with effect from 31.10.2006 and has been further improved with effect from 07.09.2007. Breakup of compensation scheme provided below:

For Public (Govt.) facilities:

	Breakup of the Compensation package	Acceptor	Motivator	Drugs & dressing	Surgeon charges	Anaes thetist	Staff nurse	OT technician/ helper	Refresh ment	Camp manage ment	Total
High focus States	VAS-ALL TUB-ALL	1100 600	200 150	50 100	100 75	- 25	15 15	15 15	10 10	10 10	1500 1000
Non High focus States	VAS-ALL TUB (BPL + SC/ ST only)	1100 600	200 150	50 100	100 75	-- 25	15 15	15 15	10 10	10 10	1500 1000
	TUB (APL)	**250**	**150**	**100**	**75**	**25**	**15**	**15**	**10**	**10**	**650**

For Private Facilities:

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

9.3.8.b National Family Planning Indemnity Scheme (NFPIS):

With effect from, 01.04.2013, it has been decided that States/UTs would process and make payment of claims to accepters of sterilization in the event of death/failures/ complications /Indemnity cover to doctors/health facilities performing sterilization procedure. The States/UTs would make suitable budget provisions for implementation of the scheme through their respective State/UT Programme Implementation Plans (PIPs) under the National Rural Health Mission (NRHM) and the scheme is renamed as "Family Planning Indemnity Scheme".

9.3.8.c Public Private Partnership (PPPs):

- PPP in family planning services are intended to utilize the reach of private sector in increasing the access to family planning services. In order to promote PPP in family planning services, accredited private facilities and empanelled private healthcare providers are covered under revised compensation scheme for sterilization and NFPIS.
- Accreditation and empanelment of private health facilities/healthcare providers is decentralized to District Quality Assurance Committees (DQAC).
- Top five and bottom five States in terms of sterilisation services at private facilities:

S. No.	State	Sterilisation at private facilities (%)		
		2012-13	2013-14	Change (% point)
Top five States				
1	Kerala	48.44	48.08	-0.4
2	Tamil Nadu	36.87	36.26	-0.6
3	Daman & Diu	32.35	34.55	2.2
4	Gujarat	20.83	33.99	13.2
5	Dadra & Nagar Haveli	13.88	29.14	15.3
Bottom five States				
1	Himachal Pradesh	0.60	0.40	-0.2
2	Odisha	0.30	0.86	0.6
3	Uttar Pradesh	9.43	1.05	-8.4
4	Jammu & Kashmir	0.24	2.11	1.9
5	Madhya Pradesh	8.24	3.66	-4.6
	INDIA	**20.80**	**16.80**	**-4.00**

9.3.8.d Scheme of Home delivery of contraceptives by ASHAs at doorstep of beneficiaries:

- Community based distribution of contraceptives by involving ASHAs and focused IEC/BCC efforts are undertaken for enhancing demand and creating awareness on family planning. To improve access to contraceptives by the eligible couples, services of ASHA are utilised to deliver contraceptives at the doorstep of beneficiaries. The scheme has been rolled out in all the districts of the country.
- 3 independent agencies evaluated the scheme and following points emerged out of it:
  - Majority (62%) respondents have heard of the scheme from ASHA. In other words, ASHA has been communicating on the scheme to the community;
  - Nearly, 78 % of those she visited, said that ASHA was able to explain and counsel on the use of contraceptives;
  - 95% of the women beneficiaries (interviewed) were completely satisfied with the Scheme;
  - 65 % of those who procured from ASHA cited easy access as the reason. In other words, ASHA is emerging as an important source on account of her easy access;
  - Of the respondents who were provided contraceptives by ASHA, 53 % were willing to pay;
  - 86% ASHAs believed that the Scheme including payments will be successful in the longer term;
  - 50% of the ASHAs indicated positive community response and
  - ASHAs feel empowered and have expressed confidence in distributing contraceptives to beneficiaries, irrespective of receiving any payment by beneficiaries.

9.3.9 Celebration of World Population Day & fortnight (July 11-24, 2013)

- For the first time, the World Population Day (WPD) was celebrated in the country in all States (except Assam) in 6348 blocks of 649 districts in all the States.

- The event was observed over a month long period, split into an initial fortnight of mobilization/ sensitization followed by a fortnight of assured family planning service delivery.
  - o **June 27 to July 10, 2013 "Dampati Sampark Pakhwada"** or "Mobilisation Fortnight" was organised.
  - o **July 11 to July 24, 2013 "Jansankhya Sthirtha Pakhwada"** or "Population Stabilisation Fortnight" was organised.

Key findings:

- Overall performance during the fortnight (11th to 24th July 2013) is placed below:

S.No.	Method	2012	2013
1	Female Sterilisation	201715	157431
2	Male Sterilisation	16873	8130
	Total Sterilisation	**218588**	**165561**
3	IUCD Insertion	435986	350642

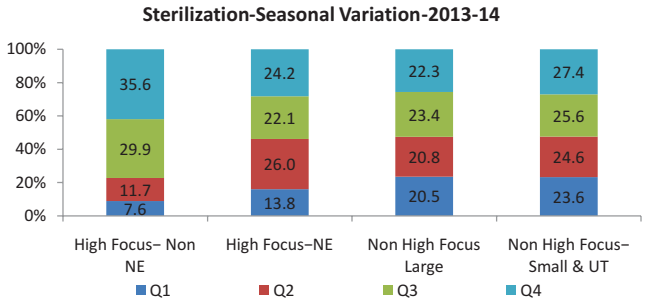
The total sterilization which took place during the WPD was 1.66 lakhs (1.6 lakhs female sterilizations and 8130 Male Sterilizations). Bihar was the highest performing State with total female sterilizations at 35,314 followed by Andhra Pradesh (22,101) and Odisha (20,661). The total Male sterilizations was highest in Chhattisgarh at 2389 followed by Uttar Pradesh (1070) and West Bengal (815). The total IUCD inserted were 3.5 lakhs. The highest was in Uttar Pradesh (61,466) followed by Bihar (49,375) and Rajasthan (45581).

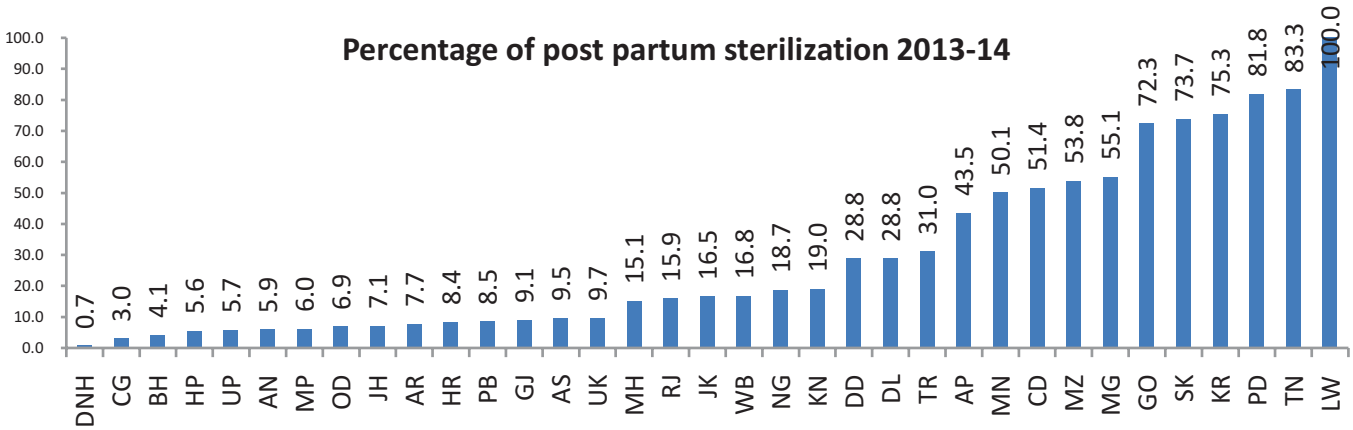
- In the past 3 years, with intensive advocacy/ awareness campaign during the WPD and linked with assured service delivery has resulted in breaking the seasonal phenomenon of conducting sterilisations only in the winter months, in the country.
- The awareness campaigns have highlighted the positive impact of Family Planning on maternal and child health in addition to population stabilisation.

9.4 KEY CHALLENGES & OPPORTUNITIES

9.4.1 Unavailability of regular sterilization services:

- The access to sterilization services at sub-district level is restricted due to poor implementation of FDS approach, especially so in high focus States with high TFR and high unmet need due to:
  - o lack of trained service providers specially in minilap & NSV at the CHCs and PHCs
  - o Lack of willingness to plan for provision of services across the year
  - o poor facility readiness.





- Above chart clearly reflects that majority of sterilisations in high focus States (65.5%) are conducted in last 2 quarters.
- NE States are relatively better; however, sterilisation services are not equally distributed across year.
- Southern States provide uniform services around the year which also reflects on their outcomes.

9.4.2 Increased institutional delivery vs PPFP:

- The huge potential for postpartum contraception offered by the increasing number of institutional deliveries has not been tapped adequately due to lack of planning, lack of trained postpartum family planning service providers and lack of infrastructure in most of the high focus States.
- This is evident from following figure, which shows that in high focus States postpartum sterilization is very low (2-20%) as compared to 70-80% in non-high focus States like Kerala and Tamil Nadu:

9.4.3 Inadequate attention to spacing methods

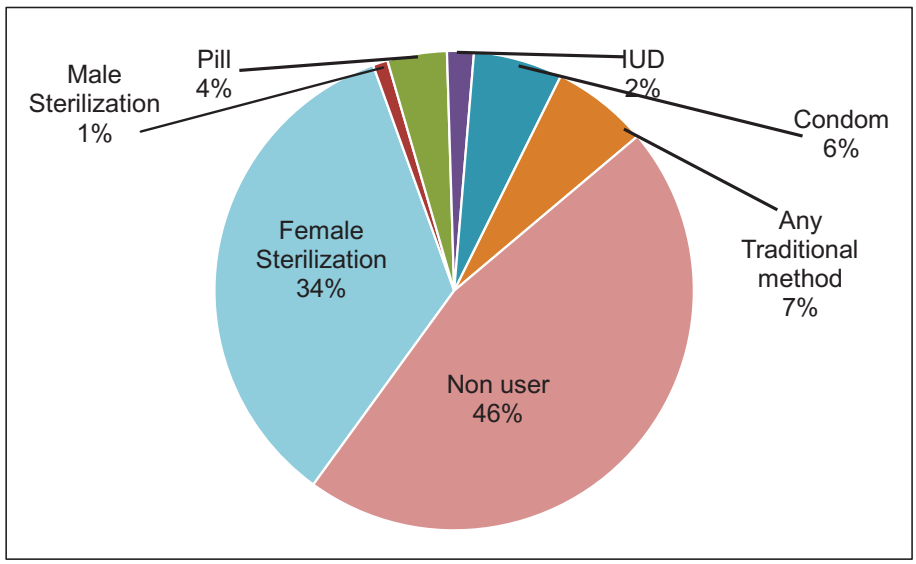
- Low use of spacing methods is evident by most States of India, despite high unmet need in spacing. According to DLHS 3, all the spacing methods together account for just around 25.5% of the current contraceptive use compared to 74.5% by female & male sterilizations put together as evidenced in adjoining pie chart.
- Latest survey data of AHS 2011 reflects that the Districts/States with very good CPR for modern methods have not focused on IUCD and it is highly skewed towards female sterilization.

The demand from the States for contraceptives and survey findings on contraceptive use are in variance. To address this issue, the logistics of procurement and supply of contraceptives has to be rationalized to reflect the actual requirement and usage.

9.4.4 Public Private Partnership (PPP) in family planning has not been adequately promoted across most States in India and there is a reluctance to accredit private providers at State/District level, which is adversely affecting the widest possible access of family planning services to clients.

9.5 FUTURE STRATEGIES

- Greater emphasis on spacing methods:
  - o Interval and Post-partum IUCD training
  - o Strengthening fixed day IUCD services
- Focus on revitalising Post-partum FP delivery system through strengthening district hospitals in focused States to provide PPFP services along with good counselling.
- Strengthening management systems at National, State, District and Block levels by infusing public health management professionals at these levels.
- Addressing social determinants such as education, delay age at marriage etc. through communication.
- Strengthening contraceptive supply and availability at every level.



Appendix 1: State wise Survey Data

S. No.	States	Total Fertility Rate (TFR) (SRS)		Infant Mortality Rate (IMR) (SRS)	Maternal Mortality Ratio (MMR) (SRS)	Crude Birth Rate (CBR) (SRS)	% of currently married women (15 - 49) using contraception				Total Unmet Need for Family Planning (%)	
		SRS 2012	AHS 2011	SRS 2012	SRS 2010-12	SRS 2012	Any Method (%)		Modern Method (%)		2007-08 (DLHS III)	AHS 2011
							DLHS III	AHS 2011	DLHS III	AHS 2011		
	ALL INDIA	**2.4**		**42**	**178**	**21.2**	**54**		**47.1**		**21.3**	
1	A&N Islands	1.6*		24	..	..	..		..		..	
2	Andhra Pr	1.8		41	110	20.6	65.3		65.1		8.5	
3	Arunachal Pr	2.3*		33	..	..	52		49		14.3	
4	Assam	2.4	2.4	55	328	21.4	49.7	65.1	31.2	37.9	24.3	15.9
5	Bihar	3.5	3.6	43	219	20.8	32.4	43	28.4	38.2	37.2	33.5
6	Chandigarh	1.7*		20	..	..	75.6		70.7		8.3	
7	Chhattisgarh	2.7	2.8	47	230	20.6	49.7	58.6	47.1	55.4	20.9	24.8
8	DNH	2.9*		33	..	..	..		..		..	
9	Daman & Diu	2.0*		22	..	..	..		..		..	
10	Delhi	1.8		25	..	22.9	66.1		55.5		13.9	
11	Goa	1.4*		10	..	..	45		35.9		28.8	
12	Gujarat	2.3		38	122	21.4	61.6		54.3		16.5	
13	Haryana	2.3		42	146	21.1	62		54.5		16	
14	HP	1.8		36	..	22.4	70.2		68.1		14.9	
15	J & K	1.9		39	..	24.6	54.1		41.2		21.6	
16	Jharkhand	2.8	2.9	38	219	20.2	34.9	56.5	30.8	43.9	34.7	22.6
17	Karnataka	1.9		32	144	21.4	61.8		60.8		15.8	
18	Kerala	1.8		12	66	22.9	62.3		53.1		16.8	
19	Lakshadweep	1.6*		24	..	..	..		..		..	
20	Madhya Pr.	2.9	3.1	56	230	20.8	56.2	63.4	53.1	59.3	19.3	21.6
21	Maharashtra	1.8		25	87	20.7	63.8		62.6		14.2	
22	Manipur	1.5*		10	..	..	..		..		..	
23	Meghalaya	2.9*		49	..	..	22.9		16.8		32.7	
24	Mizoram	1.7*		35	..	..	53.9		53.5		16.7	
25	Nagaland	1.8*		18	..	..	..		..		..	
26	Odisha	2.1	2.3	53	235	21.2	47	59.4	37.8	46.8	24	19.1
27	Puducherry	1.8*		17	..	..	59.4		57.5		19.8	
28	Punjab	1.7		28	155	22.6	69.3		62.9		11.9	
29	Rajasthan	2.9	3.1	49	255	20.6	57	66.4	54	59.4	17.9	12.6
30	Sikkim	1.7*		24	..	..	71.1		61.1		16.1	
31	Tamil Nadu	1.7		21	90	22.4	59.9		57.8		19.4	
32	Tripura	1.4*		28	..	..	68.5		40.8		12.8	
33	UP	3.3	3.4	53	292	21.3	38.4	58.6	26.7	37.3	33.8	24.1
34	UK	2.1*	2.1	34	292	..	72.7	61.7	53.3	54.1	11.6	18.1
35	West Bengal	1.7		32	117	20.5	72.7		53.3		11.6	

Source: *TFR, IMR, MMR, CBR, CDR - SRS estimates, RGI; Rest - District Level Household Surveys, 2007-08*
**SRS 2010 Estimates*

Appendix 2: Number Sterilisations and IUCDs by States: 2013-14

States	Female Sterilisation	Male Sterilisation	Total Sterilisation	IUCD Insertions
Bihar	400,294	2,443	402,737	361,109
Chhattisgarh	121,887	4,344	126,231	88,783
Himachal Pradesh	19,139	2,106	21,245	20,687
Jammu & Kashmir	15,560	638	16,198	18,640
Jharkhand	97,117	5,358	102,475	92,241
Madhya Pradesh	343,442	6,378	349,820	370,168
Odisha	134,356	1,878	136,234	138,696
Rajasthan	285,767	3,481	289,248	366,198
Uttar Pradesh	256,591	16,243	272,834	1,081,381
Uttarakhand	22,626	1,224	23,850	88,170
Arunachal Pradesh	1,201	2	1,203	2,952
Assam	48,585	4,066	52,651	84,541
Manipur	739	130	869	4,837
Meghalaya	2,493	14	2,507	4,437
Mizoram	1,732	0	1,732	2,818
Nagaland	1,771	15	1,786	3,803
Sikkim	167	49	216	1,441
Tripura	5,389	23	5,412	984
Andhra Pradesh	300,042	8,867	308,909	192,433
Goa	2,676	14	2,690	1,399
Gujarat	242,368	1,792	244,160	531,583
Haryana	68,909	4,158	73,067	184,559
Karnataka	300,620	1,813	302,433	179,508
Kerala	96,173	1,803	97,976	56,619
Maharashtra	525,187	17,862	543,049	398,519
Punjab	60,038	3,986	64,024	215,619
Tamil Nadu	253,516	1,182	254,698	325,942
West Bengal	202,739	5,871	208,610	110,764
A &N Islands	1,050	1	1,051	621
Chandigarh	2,088	74	2,162	3,940
Dadra & Nagar Haveli	1,494	2	1,496	504
Daman & Diu	382	3	385	252
Delhi	17,421	1,364	18,785	57,676
Lakshadweep	37	0	37	49
Puducherry	8,415	2	8,417	5,198
MO Railways	1314	92	1,406	933
TOTAL	**3,843,325**	**97,278**	**3,940,603**	**49,98,004**

9.6 NATIONAL FAMILY WELFARE PROGRAMME

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

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

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

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

The quantities given to the States under Free Supply Scheme during the last three years and the current year (upto September, 2013) along with the budget utilized are given in the following table.

Quantities supplied to States/UTs

Contraceptives	2010-11	2011-12	2012-13	2013-14 (Upto Sept. 2013)
Condoms (In million pieces)	290.137	295.000	367.866	234.271
Oral Pills (In lakh cycles)	237.998	298.135	226.793	205.573
IUDs (In lakh pieces)	90.000	73.500	87.508	34.005
Tubal Rings (In lakh pairs)	34.534	30.359	31.22	18.274
ECP (in lakh packs)	21.540	18.300	75.919	14.098
Pregnancy Test Kits (in lakhs)	211.74	21174	222.186	0.00

Budget Utilization

(Rs. in crore)

Contraceptives	2010-11	2011-12	2012-13	2013-14 (Upto Sept. 2013)
Condoms	44.420	53.327	66.499	42.349
Oral Pills	7.973	9.697	8.4140	7.627
IUDs	17.721	15.986	18.630	7.206
Tubal Rings	4.403	4.372	4.4962	2.631
ECP	1.723	0.485	1.898	0.374
Pregnancy Test Kits	22.89	22.890	21.05	NIL

9.6.1 Social Marketing Scheme

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

The SMOs are given Deluxe Nirodh condom at Rs. 2.00 per packet of 5 pieces and this is sold @ Rs. 3/- per packet of 5 pieces to the consumer. One cycle of Oral Pills, which is required for one month, is given to the SMOs @ Re. 1.60/- and it is sold to the consumer @ Rs. 3/- per strip (cycle) under the brand name-"Mala -D". Under the Social Marketing programme, currently Government brands and different SMO brands of condoms and OCPs are sold in the market. Based on the recommendation of the Working Group on Social Marketing of Contraceptives, SMOs have the flexibility to fix the price of branded condoms and OCPs within the range fixed by the Government.

9.6.1.a Sale of Condoms (Quantity in Mcps)

S. No.	Social Marketing Organisation	2010-11	2011-12	2012-13	2013-14 (Upto Sept. 2013)*
1.	HLL Lifecare Ltd., Thiruvananthapuram	253.81	225.03	308.76	217.79
2.	Population Services International, Delhi	154.02	164.65	164.49	63.56
3.	Parivar Seva Sanstha, Delhi	40.46	67.56	46.03	25.40
4.	World Pharma, Indore	0.00	0.00	0.00	0.00
5.	DKT, India, Mumbai	71.36	89.84	54.68	Not SMO
6.	Eskag Pharma(Pvt.) Ltd., Kolkata	0.00	0.00	0.00	4.267
7.	Janani, Patna	11.24	46.81	3.66	3.38
8.	Population Health services, Hyderabad	50.51	69.20	65.47	Not SMO
9.	Sanskar Shiksha Samiti, Bhopal	0.04	0.04	0.00	Not reported
10.	PCPL, Kolkata	0.00	14.51	3.56	0.00
11.	World Health Partner, New Delhi	0.00	0.27	1.53	0.70
	Total	**581.44**	**677.91**	**648.18**	**315.19**

**Figures are provisional*

9.6.1.b Sale of Oral Contraceptive Pills (Quantity in lakh Cycles)

S. No.	Social Marketing Organisation	2010-11	2011-12	2012-13	2013-14 (Upto Sept. 2013)*
1.	HLL Lifecare Ltd., Thiruvananthapuram	77.20	139.52	115.73	2.46
2.	Population Services International, Delhi	110.55	69.37	139.43	103.34
3.	Parivar Seva Sanstha, Delhi	0.00	19.355	15.52	9.19
4.	World Pharma, Indore	0.00	0.00	0.00	0.00
5.	DKT, India, Mumbai	107.89	184.33	28.88	0.00
7.	Janani, Patna	17.54	24.87	7.40	8.8
8.	Population Health services, Hyderabad	41.90	34.53	65.24	Not reported
9.	Sanskar Shiksha Samiti, Bhopal	0.04	0.04	0.00	0.00
10.	PCPL, Kolkata	3.00	0.00	4.00	Not reported
11.	World Health Partner, New Delhi	0.00	0.00	0.62	1.00
	TOTAL	**358.08**	**471.975**	**376.82**	**124.79**

**Figures are provisional*

9.6.1.c Centchroman (Oral pills)

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

9.6.2. Performance of Social Marketing Programme in the sale of contraceptive

Contraceptives	2010-11	2011-12	2012-13	2013-14 (Upto Sept. 2013)
Condoms (Million pieces)	581.44	677.91	618.18	315.19
Oral Pills (Social Marketing) (lakh cycles)	358.08	471.975	376.82	124.79
SAHELI Weekly Oral Pill (in lakh tablet)	234.31904	244.56	270.76	0.042*

**Figures are provisional*

9.6.3. Emergency Contraceptive Pills [ECP]

Department of Health & Family Welfare introduced 'Emergency Contraceptive Pills' (E- pills) in the National Family Welfare Programme during the year 2002-03. This contraceptive is used within 72 hours of un-protected sex. The following quantities of E-pills were procured during the years 2010-11, 2011-12, 2012-13 and 2013-14 (upto Sept. 2013).

(in lakh packs)

Quantity procured				
Item	2010-11	2011-12	2012-13	2013-14 (Upto Sept. 2013)*
ECP	21.54	18.30	75.919	14.098

**Figures are provisional*

9.6.4 Pregnancy Test Kits

These kits are being supplied free of cost. Orders have been placed on HLL Lifecare Ltd, (a PSU under the Ministry), for procurement of 2,17,48,200 Pregnancy Test kits each during the year 2010-11 and 2011-12. 2,22,18,600 Kits were procured during the year 2012-13 and 1,22,40,195 kits will be procured during 2013-14.

9.6.5 Copper-T

Under the National Family Welfare Programme, Cu-T-200B was being supplied to the States/UTs. From 2003-04, advanced version of Intra Uterine Device i.e.Cu-T-380-A has been introduced in the Programme. This Cu-T has longer life of placement in the body and thus provides protection from pregnancy for a period of about 10 years. Now the advanced version of IUDs i.e.Cu-T-380A is being procured and supplied to the States/UTs. Orders have been placed for a quantity of 88.756 lakh Copper-T-380A, out of which nearly 87.508 lakhs Copper-T-380-A have been supplied during 2012-13. In the current year 2013-14 another advanced version of IUD-375 has been introduced in the programme which is also being procured by the Government for supplying to the States. Orders have been placed for 15.529 lakh pieces of IUD-375 out of which 4.252 have been supplied upto September 2013-14.

Chapter 10

TRAINING PROGRAMME

10.1 INTRODUCTION

The National Rural Health Mission envisioned universal access to health, with a strong focus on community involvement. This was to enhance the people's participation in health and enable action on its various social determinants. ASHA and Village Health Sanitation and Nutrition Committees have been the key instruments for achieving this goal. Today 8.8 lakh ASHAs have been selected across the country and the number of Village Health Sanitation and Nutrition Committees exceeds 5.5 lakhs.

10.2 ASHA PROGRAMME

In the last eight years ASHA programme has evolved and made progress in significant ways. A mechanism of systematic training built within the programme design, is intended to ensure continuous learning, enhancement of skills and strengthens the ASHA as a community level facilitators, activist and a care provider. As a result, ASHAs are undertaking a wide range of activities which include- counselling on improved health practices, motivating married couples to ensure birth spacing, prevention of illness and complications and appropriate curative care or referrals in pregnant women, new born, young children as also for malaria, tuberculosis and other conditions. New roles for ASHA have been visualized this year in programmes like Rashtriya Bal Swasthya Karyakram and National Iron-plus initiative and in other areas such as non-communicable diseases and addressing violence against women at the community level. To enable ASHAs perform these roles effectively most states have established the institutional structures required for training and support at the state, district and block levels.

The key ASHA programme developments of the year 2013-14 have been:

- Dissemination of revised guidelines for Community Processes (comprising of guidelines for ASHA, VHSNC and the common support structure for these programmes).
- Implementation of Performance Monitoring system for ASHAs.
- Setting up of Grievance Redressal mechanism in districts across the states.
- Introduction of Induction Module for newly selected ASHAs- A consolidated Module comprising of Modules One to Five.
- Approval of the process of ASHA Certification by NIOS.
- Training of ASHAs in Uttarakhand in disaster preparedness.

10.3 ASHA SELECTION

ASHAs are in place, in all states except in Goa, Puducherry, Himachal Pradesh the non-tribal areas of Tamil Nadu and the Union Territory of Chandigarh. During this year, the Himachal Pradesh has also started the process of selection of ASHAs. Selection is around 90% of the total required based on a normative population coverage of one per 1000. During the last year, states have streamlined the mechanisms for performance monitoring of ASHAs, maintenance of ASHA data base and regular programme reviews and update which has enabled them to identify the drop out and non-functional ASHAs.

Table: 1 ASHA Selection:

State	Proposed Number of ASHAs	ASHAs selected	% Selection
High Focus States	525357	469311	89.33
North Eastern States	55788	54498	97.69
Non High Focus States	357671	310307	86.76
Union Territories	870	806	92.64
Total	**939686**	**834922**	**88.85**

10.4 ASHA TRAINING

The trainer pool for ASHA training has been effectively strengthened. Training of State trainers in Round 1 and Round 2 for Modules 6 and 7 is complete in almost all states. All states completed Round 1 TOT (Training of Trainers) for ASHA Trainers this year. The total Number of qualified state trainers in Round 1 is 407 and for Round 2 it is 283. Overall, 13403 District/ASHA trainers have undergone training in Round 1 TOT and 7162 in Round 2 TOT. The states are right now in various stages of completing different rounds of Modules 6 and 7 and the number of ASHAs Trained in the first two rounds of Modules 6 and 7 shows a substantial increase. (See Table 2 for details of ASHA Training). To reinforce the skills acquired in Module 6 and 7 a refresher training for ASHAs is also underway in the state of Uttarakhand. The state also trained 2283 ASHAs and 154 ASHA Facilitators in the four disaster affected districts of Rudraprayag, Chamoili, Uttarakashi and Pithoragarh in disaster response.

Table 2: ASHA Training:

Training Status						
Percentage of ASHAs trained against selected						
State Name	ASHA Selected	Up to Module 4	Module 5	Module 6 and 7		
				Round 1	Round 2	Round 3
Table 1A: High Focus States						
Bihar	83826	63.06	87.37	87.37	66.24	19.44
Chhattisgarh*	66179	87.31	87.31	84.06	81.75	87.19
Jharkhand	39380	90.59	104.02	93.24	94.58	53.26
Madhya Pradesh	50571	90.52	90.73	95.77	77.75	12.36
Odisha	43363	99.20	100.02	97.96	88.68	52.49
Rajasthan	46773	96.44	90.08	61.94	16.80	0.00
Uttar Pradesh	128611	100.42	94.58	16.49	8.17	0.00
Uttrakhand	10608	104.51	84.63	97.22	94.87	96.24
Total-1A	**469311**	**89.59**	**92.47**	**67.54**	**53.93**	**28.59**

Table 1B: North Eastern States						
Assam	29694	95.97	95.72	98.05	89.81	20.62
Arunachal Pradesh	3761	95.88	96.86	96.49	87.82	83.09
Manipur	3878	100.00	100.00	98.09	98.09	98.09
Meghalaya	6258	99.87	89.29	94.14	93.85	81.83
Mizoram	987	100.00	100.00	100.00	100.00	100.00
Nagaland	1887	90.09	68.68	73.56	74.56	86.06
Sikkim	666	100.00	100.00	100.00	100.00	100.00
Tripura	7367	100.00	100.00	97.12	95.14	95.30
Total 1B	**54498**	**97.16**	**95.14**	**96.58**	**91.23**	**52.24**
Table 1C: Non High Focus States						
Andhra Pradesh	64827	100	100.00	88.92	70.11	0.00
Delhi	4044	84.72	111.40	69.14	45.18	0.00
Gujarat	33117	83.72	84.75	91.35	86.16	70.73
Haryana*	16841	99.47	65.98	75.52	13.76	0.00
Jammu and Kashmir	10683	84.25	77.69	64.79	0.00	0.00
Karnataka	30175	100	100.00	98.36	98.36	88.68
Kerala	28242	102.84	102.84	87.00	0.00	0.00
Maharashtra	55975	101.12	93.34	61.36	28.12	10.14
Punjab	16812	97.40	97.57	96.62	96.62	0.00
Tamil Nadu**	6204	88.86	88.86	26.71	26.71	25.32
West Bengal	43387	90.26	86.61	95.47	82.33	44.90
Total 1C	**310307**	**96.23**	**92.74**	**83.22**	**57.09**	**24.79**
Table 1D: Union Territories						
Andaman and Nicobar Island	407	100.00	100.00	66.83	66.83	0.00
Dadra and Nagar Haveli	208	41.83	41.83	32.69	21.63	0.00
Lakshadweep	110	0.00	0.00	0.00	0.00	0.00
Daman & Diu	81	77.78	77.78	0.00	0.00	0.00
Total 1D	**806**	**69.11**	**69.11**	**42.18**	**39.33**	**0.00**

* Haryana has trained its ASHAs in NIPI's Home Based Post natal and New born Care Model in two rounds.

** Tamil Nadu has trained ASHAs in a state specific adaptation of module 6 and 7.

10.5 ASHA SUPPORT

Status of support structures showed substantial improvement and four levels of support structures have been set up in Assam, Haryana, Maharashtra and all high focus states except UP and Odisha. Three levels of programme specific support structures exist in six North Eastern states, two High Focus and two Non-High Focus States.

ASHA facilitators provide on the job supervision and mentoring and one facilitator has been selected for a cluster of 10-40 ASHAs in all high focus states and all north east states except Nagaland. In all non-high focus states on the job mentoring is provided to ASHAs by ANMs except in Haryana, Gujarat, Maharashtra and Punjab which have selected facilitators.

This year about 150 personnel from the High Focus, North Eastern and Non High Focus States (except Kerala, Tamil Nadu and Jammu and Kashmir) were trained in-Performance Monitoring of ASHAs, ASHA data base management and on all the aspects of supportive supervision. Subsequently training of ASHA Facilitators has been completed in all North Eastern States, four High Focus states such as- Bihar, Chhattisgarh, Jharkhand and Uttarakhand and the non-high focus states of Punjab and Haryana. It is underway in the remaining states. Performance Monitoring reports for ASHA functionality are now being received from all North Eastern States, Jharkhand, Uttarakhand, Madhya Pradesh, Delhi, Karnataka and Punjab.

10.6 ASHA PAYMENTS

Payment mechanisms have been streamlined and almost all states have started making payments either in cheque or bank transfer mode. More than 90% ASHAs have bank accounts across all high focus and non- high focus states. To address the issue of delayed payments MoHFW is planning to introduce a system of PFMS linked single window payment of ASHAs across all the states. In addition to the performance based incentives a number of non-monetary incentives in the form of welfare packages for ASHAs, supporting enrolment in National Open School, ASHA help desks etc. are also being offered by MoHFW. The first Mission Steering Group (MSG) meeting of the National Health Mission approved several new incentives for the ASHA programme including an incentive amount of Rs. 1000 for a set of routine and recurrent activities regardless of population coverage. Thus an ASHA can receive Rs. 1000 for conducting a VHSNC meeting, organizing the VHND, attending monthly review meetings at the PHC, and undertaking routine tasks such as maintaining and updating population registers etc.

10.7 VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES (VHSNC)

To strengthen VHSNC and enable both ASHA and VHSNC to function in a coordinated manner, a revised set of guidelines were released by the Ministry of Health and Family Welfare this year. These guidelines provide a comprehensive framework for establishing a common support structure for both ASHA and VHSNCs and also include set of principles to strengthen community processes. In addition training strategy and manuals for training VHSNC members is also being finalized by the MoHFW.

10.8 COMMUNITY ACTION FOR HEALTH

The Advisory Group for Community Action (AGCA) is an advisory body set up under National Rural Health Mission (NRHM) in 2005. The body consists of civil society experts working at the community level in the field of public health. The mandate given to the AGCA is to advise on developing community partnership and ownership for the Mission, provide feedback based on ground realities, to inform policy decisions and develop new models of Community Action and recommend for further adoption/extension to the national/state governments. With the launch of National Health Mission encompassing the NRHM and the National Urban Health Mission (NUHM) as its Sub-Missions, the mandate of AGCA has been extended to provide technical and policy inputs to NUHM also.

10.9 CENTRALLY SPONSORED SCHEME OF "BASIC TRAINING OF ANM/LHV"

Availability of qualitative services to the community depends largely upon the efficacy with which health functionaries discharge their responsibilities, which in turn would depend mainly upon their education and training. Department of Family Welfare had recognized the crucial role of training of health personnel in providing effective and efficient health care to the rural

community from the very beginning of the Five Year Plans. The pre-service and in-service training for different categories of health personnel are imported through the following schemes/activities:

- ANMs/LHVs play a vital role in MCH and Family Welfare Service in the rural areas. It is therefore, essential that the proper training to be given to them so that quality services be provided to the rural population.
- For this purpose 333 ANM/MPHW (Female) schools with an admission capacity of approximately 13,000 and 34 promotional training schools for LHV/ Health Assistant (Female) with an admission capacity of 2600 are imparting pre-service training to prepare required number of manpower to man the sub centers, PHC, CHC, Rural Family Welfare Centers and Health posts in the country. The duration of training programme of ANM is 1 & 1/2 years and minimum qualification required for this course is 10+2 pass. Senior ANM with five years of experience is given six months promotional training to become LHV/Health Assistant (Female). The role of Health Assistant (Female) is to provide supportive supervision and technical guidance to the ANMs in sub-centres. Curriculam of these training courses are provided by the Indian Nursing Council. Assistance will be limited to the salary for the regular staff in the training schools funded by Government of India as per orders dated 25.5.2012.
- Funds under the scheme are replenished by Family Welfare Budget Section on the basis of audited accounts submitted by States. Rs. 1385.38 lakhs has been released till March, 2014.

10.10 CENTRALLY SPONSORED SCHEME OF "BASIC TRAINING FOR MULTI-PURPOSE HEALTH WORKER (MPHW) (MALE)"

The Basic Training of MPHW (Male) scheme was approved during 6th Five-Year Plan and taken up by Govt. of India in 1984, as a 100% centrally sponsored scheme. There are 49 basic training schools of MPHW (Male). Duration of course is 1 year and on successful completion of the training, the candidate is posted as Multi-Purpose Health Worker (Male) at the sub-centre. Assistance will be limited to the salary for the regular staff in the training schools funded by Government of India as per orders dated 25.5.2012.

Funds under the scheme are replenished by Family Welfare Budget Section on the basis of audited accounts submitted by States. Rs. 1385.38 lakhs has been released till March, 2014.

10.11 MAINTENANCE OF HEALTH AND FAMILY WELFARE TRAINING CENTRE (HFWTC)

49 HFWTCs were established in the country in order to improve the quality and efficiency of the Family Planning Programmes and to bring the change in the attitude of the personnel engaged in the delivery of health services through in service training programmes. These training centres are supported under Centrally Sponsored Scheme of "Maintenance of HFWTCs".

Key role of these training centres is to conduct various in-service training programmes of Department of Family Welfare. Apart from in-service education some of the selected centres has an additional responsibility of conducting the basic training of MPHW's course where MPW training centers are not available. Assistance will be limited to the salary for the regular staff in the training schools funded by Government of India as per orders dated 25.5.2012

Funds under the scheme are replenished by Family Welfare Budget Section on the basis of audited accounts submitted by States. Rs. 2085.68 lakhs has been released till March, 2014.

10.12 REPRODUCTIVE AND CHILD HEALTH TRAINING

National Institute of Health and Family Welfare (NIHFW) - Report of Training activities under NRHM for the Year 2013-14: National Institute of Health & Family Welfare (NIHFW) has been identified as the Nodal Institute for training under NRHM and RCH-II, till 31st March 2015. NIHFW has pursued responsibilities of organizing National Level Training Courses and coordination of the NRHM/RCH training

activities with the help of 22 Collaborating Training Institutions (CTIs) in various parts of the country. Four more institutions i.e. RHFWTC at Srinagar, Jammu & Kashmir, RIHFW at Haldwani, Uttarakhand, Regional Institute of Paramedical and Nursing Sciences (RIPANS) at Aizawl and Institute of Public Health (IPH) at Ranchi, Jharkhand have been approved to function as CTIs. The activities conducted by NIHFW during the year 2013-14 are as follows:

- Reviewed and prepared comments on training component of the first draft and revised draft PIPs of all 35 States for finalization of SPIPs.
- On behalf of NIHFW, consultants from RCH Unit attended NPCC meetings for all the 35 States/UTs conducted at Nirman Bhawan for finalizing approval of States/UTs' PIPs for the year 2013-14.
- Central Training Plan (CTP) for training under NRHM for the entire country was developed for 2013-14 based on approved budget and was uploaded on NIHFW's website.
- **Monitoring Visits:** Monitoring visits were under taken to validate the Comprehensive Training Plan (CTP) by the state, monitor training progress, ensure quality of training being maintained and utilization of trained persons at different health facilities in States. Monitoring quality of training was done using structured checklists through visits to districts and various peripheral facilities. Different trainings including Integrated EmOC training, SBA Integrated training, BEmOC, SBA, SBA TOT, MTP/MVA, RMNCH, NSSK, F-IMNCI, IMNCI, IYCF, RTI/STI, ARSH, Minilap, IUCD Immunization and for various categories of health personnel were observed in a number of States. Feedback based on those observations was sent to each State for improvement and shared with MoHFW.
- Consultants visited State headquarters and training centres. During this period Consultants at NIHFW visited 22 States/UTs including 17 headquarters visits & 28 districts and 55 districts of 14 States were covered by Consultants at CTIs. Some of these districts were visited number of times for observation of different trainings.
- Professional Development Course (PDC) in Management, Public Health & Health Sector Reforms for District Level Medical Officers (DMOs) 175 Medical Officers were trained during 2012-13 & 109 were trained during 2013-14.

Consolidated thematic area-wise total achievement are given in the table placed below:

Consolidated Thematic area wise total Training achievements in the Country RCH-II/NRHM (2013-14)

Thematic Areas	Annual Training Load 2013-14	Training Achievement (Apr.-Sep. 2013)	GAP	% of Achievement
Maternal Health	97677	37268	60409	38.15
Child Health	349400	82977	266423	23.74
Family Planning	60714	19638	41076	32.34
ARSH	364930	57041	307889	15.63
National Disease Control Programme	72523	29069	43454	40.08
Other Trainings	195064	71386	123678	36.60

Chapter 11

OTHER NATIONAL HEALTH PROGRAMMES

11.1 NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIO VASCULAR DISEASES AND STROKE (NPCDCS)

In the 12th five year plan, NPCDCS is being implemented in the 35 States / UTs from 2013-14. NPCDCS has now been brought under the umbrella of NHM in PIP mode. Interventions upto District level and below have been integrated under the Mission and funds provided through NCD Flexipool.

- **Functional Status of NCD Cells/ Clinics**
  - ➢ State NCD Cell functional in 21 states.
  - ➢ District NCD Cell functional in 96 districts.
  - ➢ District NCD Clinic functional in 95 districts.
  - ➢ 204 CHC Clinics functional in 7 states.
  - ➢ **Cardiac Care Unit:** Cardiac Care Units have been fully established in 61 districts.

- **Screening for Diabetes and Hypertension**

29,000 Glucometers, 5.8 crore Glucostrips and 6.67 crore Lancets have been supplied to 21 States for Diabetes screening under NPCDCS, Urban Health Checkup (4 cities) and Pilot Phase of School Health Programme (4 Districts).

As on 31st March, 2014, as per the data received from States, total 5,5,39,571 persons have been screened for Diabetes and Hypertension under various health facilities, schools, work place and urban slums.

An average of 6.15% were found suspected to be Diabetes (above 140mg/dl, random) and an average of 5.12% were found to be either pre hypertensive or hypertensive. For confirmation, diagnosis and management, the patients are referred to the higher treatment centers as per the management protocols.

- **Cancer**
  - ➢ Chemotherapy services initiated in 38 districts.
  - ➢ Cancer Screening Guidelines prepared and sent to the States.

- **Training**
  - ➢ 95 trainers have been trained in 3 programme sessions of Training of Trainers conducted by NIHFW from 22nd November 2011 onwards till date.
  - ➢ 693 MOs have been trained by States (batch size of 20 /course) in 32 training sessions.

- **Funds:** Fund released under NCD Flexi-pool during the financial year 2013-14.
  - ➢ Allocation of funds made by NRHM — 300 crores
  - ➢ 75% of Allocation — 225 crores
  - ➢ Unspent Balance available with the States — 175.38 crores
  - ➢ Release to States — 75.67 crore

- **Health Education Text Books**

Text Book on Health Education for schools from class IIIrd to Xth is being developed in collaboration with NIHFW.

Infrastructure Details under NPCDCS

Sl. No.	State	State NCD Cell	District NCD Cell	District NCD Clinics	CCU	Chemotherapy Centres	CHC NCD Clinics
1.	Andhra Pradesh	1	8	8	8	0	--
2.	Assam	1	5	5	2	2	22
3.	Bihar	1	6	6	1	0	0
4.	Chhattisgarh	1	3	3	0	0	--
5.	Gujarat	1	6	6	4	1	68
6.	Haryana	1	4	4	4	4	2
7.	Himachal Pradesh	1	3	3	1	0	12
8.	Jammu	1	2	2	2	2	--
	Kashmir		3	3	3	3	2
9.	Jharkhand	1	3	3	0	3	--
10.	Karnataka	1	5	5	5	5	--
11.	Kerala	1	5	5	4	4	--
12.	Madhya Pradesh	1	5	5	5	0	--
13.	Maharashtra	1	6	6	6	5	65
14.	Sikkim	1	2	2	2	2	--
15.	Odisha	1	5	5	5	1	--
16.	Punjab	1	3	3	1	2	33
17.	Rajasthan	1	7	7	0	0	--
18.	Uttarakhand	1	2	2	0	2	--
19.	Tamil Nadu	1	5	5	5	5	--
20.	Uttar Pradesh	1	5	4	0	0	0
21.	West Bengal	1	3	3	3	0	--
	Total	**21**	**96**	**95**	**61**	**38**	**204**
29,000 sub centres were taken up for diabetes screening of population above 30 years by using glucometer kits.							

11.2 NATIONAL TOBACCO CONTROL PROGRAMME

Tobacco is the foremost preventable cause of death and disease in the world today, killing half of the people who use it. As per report of the Tobacco Control in India (2004), more than 8 lakh people die due to tobacco consumption every year in India.

India is the second largest consumer (after China) of tobacco products in the world. As per Global Adult Tobacco Survey, India (GATS), 2009-10, conducted in

the age group of 15 years and above, 47.8% men and 20.3% women consume tobacco in some form or the other, translating to more than 27.5 crores in absolute numbers. The Global Youth Tobacco Survey (GYTS), 2009 indicates that nearly 15% children in the age group of 13-15 years are consuming tobacco in some form. There is also evidence that each day 5,500 new youth are getting addicted to tobacco use.

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

1. Prohibition of smoking in a public place (section 4);
2. Prohibition of direct and indirect advertisement, promotion and sponsorship of cigarette and other tobacco products (section 5);
3. Prohibition of sale of cigarette and other tobacco products to a person below the age of eighteen years [section 6(a)];
4. Prohibition of sale of tobacco products near the educational institutions. [Section 6(b)] and
5. Mandatory depiction of statutory warnings (including pictorial warnings) on tobacco packs (section 7).

The Food Safety & Standards Authority of India (under Ministry of Health & Family Welfare) issued a regulation in August 2011 under the Food Safety & Standards Act 2006, laying down that tobacco and nicotine cannot be used as an ingredient in any food product.

11.2.1 Major Achievements during 2013-14

Ministry of Health and Family Welfare has up-scaled the coverage of National Tobacco Control Programme (NTCP) from existing 42 districts of 21 states to 53 districts of 29 states in 2013, subsumed under the National Health Mission (NHM) Flexi-pool for Non-Communicable Disease (NCD's).

33 States/UT's have issued orders for implementation of the Central Food Safety Regulations prohibiting manufacture, sale and storage of Gutka and Pan Masala containing tobacco and nicotine. The States/UTs are- Madhya Pradesh, Kerala, Bihar, Himachal Pradesh, Rajasthan, Maharashtra, Mizoram, Chandigarh, Chhattisgarh, Jharkhand, Haryana, Punjab, Delhi, Gujarat, Uttar Pradesh, Nagaland, Andaman & Nicobar, Daman & Diu, Dadra and Nagar Haveli, Uttarakhand, Odisha, Andhra Pradesh, Goa, Sikkim, Manipur, Arunachal Pradesh, J&K, Assam, West Bengal, Tripura, Tamil Nadu, Karnataka and Puducherry.

The Ministry launched a campaign for The Tobacco Free North-East at Guwahati on 27th February 2013, which was flagged off by the Hon'ble Chief Minister of Assam. During this campaign, it was decided that each of the individual States in the North-East would continue the campaign in their respective states. Accordingly, campaign for Tobacco Free North-East was launched in Meghalaya on 3rd June 2013 which was a first of its kind. The Chief Guest, Sri A. L. Hek, Hon'ble Minister of Health & Family Welfare, Government of Meghalaya, delivered a motivating speech wherein he urged the youth to abstain from tobacco use so as to make a change over of the present image of the state. He also administered the pledge 'Pledge to Save Lives from tobacco'.

3 more regional campaigns have been approved and planned to sensitize the State Tobacco Control Officials towards enforcement of Cigarette & Other Tobacco Products Act (COTPA, 2003) as well as implementation of National Tobacco Control Programme (NTCP).

A South East Asia regional conference on implementation of the WHO Framework Convention on Tobacco Control was organized during 23-26 July, 2013 at New Delhi.

This regional conference was attended by all the 11 countries in the South East Asia Region. The main objective of the meeting was to discuss and promote implementation of the Convention in the region and to promote the signature and ratification of the Protocol to eliminate Illicit Trade in Tobacco Products adopted by the fifth session of the Conference of the Parties in November 2012. Among inter-governmental development partners, the International Agency for Research on Cancer (IARC), United Nation's Development Programme (UNDP), United Nations Office on Drugs and Crime (UNODC), World Bank and World Customs Organization (WCO) participated. The meeting deliberated upon challenges related to use of tobacco, including smokeless tobacco, as well as other priority areas, such as electronic cigarettes and hookah. The conference adopted an outcome document on challenges and policy options, effective responses and way forward to tackle the important tobacco control issues in the Region.

Hon'ble Supreme Court vide order dated 22.07.2013 set aside the stay granted by Hon'ble High Court of Bombay on the Rules related to regulation of advertisement of tobacco products at Points of Sale (POS) and issued directions to the Central and State Government to rigorously implement COTPA, 2003 and the 2004 Rules therein with its amendments. The Hon'ble Supreme Court's order removed the impediments to an effective implementation of the Rules related to regulation of advertisement at Points of Sale.

The Ministry co-hosted 'The International Conference on Public Health Priorities in the 21st Century: The Endgame for Tobacco' in New Delhi from September 10-12, 2013. Tobacco conference provided an opportunity for experts to deliberate, discuss, debate and agree on an endgame vision, definition and endgame strategies. Multiple sessions were held to evaluate novel, radical and bold endgame strategies, weigh their outcomes and the political, legal, ethical, economic, regulatory and social barriers to jointly develop an action plan to reach this aspirational goal of a tobacco-free world. The conference also reiterated the commitment of the Governments to protect the health of its citizens.

National level public awareness campaign was launched as a key activity under the National Tobacco Control

Programme. A variety of media have been used to reach a wider audience. Dedicated spots were developed as well as adapted from global best practices. The Ministry also launched a mega outdoor campaign focusing on the harmful effects of Tobacco Use (both smoking and chewing forms) and Second hand Smoke, using two outdoor media, i.e. (1) exterior train wrap-up and (2) bus panels in selected states.

Ministry of Health and Family Welfare released a half page coloured advertisement on 2nd October, 2013 in leading newspapers at national and regional level to mark one year of implementation of the Rules relating to regulation of tobacco products or their use in Films and TV Programmes, also known as the 'Tobacco-free Movie Rules'.

The implementation of 'Tobacco-free Movie Rules' has, for the first time, made available a huge quantum of statutory free airtime for airing anti-tobacco health spots and disclaimers/messages through films and TV programmes.

The Department of Personnel (DoP), Government of Rajasthan has issued a circular making it mandatory that no prospective applicant who wishes to apply for government jobs in the state should be a tobacco user. The Government of Rajasthan has become the first state in India to issue such order discouraging tobacco use.

Uttar Pradesh State Transport Corporation (UPSRTC) passed an order declaring all the bus stations and allied

premises in the state of Uttar Pradesh under UPSRTC's jurisdiction as 'smoke-free'. Compliance with various provisions especially related to prohibition of advertisements has been included in the terms and conditions, thereby prohibiting the use of bus panels for advertising tobacco products.

The Government of Karnataka has issued an advisory to the 'alcohol de-addiction centres' in the state to provide tobacco cessation facilities for those desiring to quit tobacco use.

The Government of Delhi has launched the concept of DRY DAY for tobacco on the last day of each month. On this day an appeal is made to all the tobacco vendors to close the shops voluntarily. Likewise an appeal is made to the general public to refrain from using tobacco on that day.

The Government of Assam has instituted an annual award for the educational institutes showing best compliance with the tobacco-free rules. The award ceremony for the same shall be held on the occasion of 'Independence Day' every year.

Munger became the first district in Bihar to be declared 'smoke-free'. The declaration was made by the District Magistrate on 3rd August 2013.

11.3 NATIONAL MENTAL HEALTH PROGRAMME

11.3.1 Burden of mental health disorders

Prevalence of mental disorders as per World Health Report (2001) is around 10% and it is predicted that burden of disorders is likely to increase by 15% by 2020.

According to various community based surveys, prevalence of mental disorders in India is 6-7% for common mental disorders and 1-2% for severe mental disorders. With such a magnitude of mental disorders it becomes necessary to promote mental health services for the well-being of general population, in addition to provide treatment for mental illnesses. Treatment gap for severe mental disorders is approximately 50% and in case of Common Mental Disorders it is over 90%.

National Mental Health Programme (NMHP) was started in 1982 with the objectives to ensure availability and accessibility of minimum mental health care for all, to encourage mental health knowledge and skills and to promote community participation in mental health service development and to stimulate self-help in the community.

Gradually the approach of mental health care services has shifted from hospital based care (institutional) to community based mental healthcare, as majority of mental disorders do not require hospitalization and can be managed at community level.

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

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

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

11.3.2 District Mental Health Programme

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

now incorporated promotive and preventive activities for positive mental health which includes:

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

11.3.3 Manpower Development Schemes

A. Establishment of Centre of Excellence in Mental Health:- Centre of excellence in the field of mental health are being established by upgrading and strengthening identified existing mental health hospitals/institutes for addressing acute manpower gap and provision of state of the art mental health care facilities in the long run. Eleven such Centres of Excellence were envisaged. Total budgetary support of up to Rs. 338 crore (Rs. 30 crore per center) was to be provided for undertaking capital work, equipment, library, faculty induction and retention for the plan period. As of now 11 Mental Health Institutes have been funded for developing as Centers of Excellence in Mental Health. Also, the Academic Sessions in 8 of the 11 Centres of Excellence have commenced from this year and process to start the academic sessions in rest of the Institutes has already been initiated.

B. Establishment/up-gradation of Post Graduate Training Departments:- To provide an impetus to development of Manpower in Mental Health, other training centers (Government Medical Colleges/ Government General Hospitals/ State run Mental Health Institutes) were also to be supported for starting PG courses or increasing the intake capacity for PG training in Mental Health. Support was to be provided for setting up/strengthening 30 units of Psychiatry, 30 Departments of Clinical Psychology, 30 Departments of PSW and 30 Departments of Psychiatric Nursing. Total budget allocated for this scheme was Rs. 70 crores during plan period with a limit of Rs. 51 lacs to Rs. 1 crore per PG Department. As of now, 27 PG Departments in 11 Institutes have been taken up upto 2012-13.

11.3.4 Research and Training

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

11.3.5 Information, Education & Communication (IEC)

It has been observed that there is low awareness regarding mental illness and availability of treatment. There is also lot of stigma attached to mental illness leading to poor utilization of available Mental Health resources in the country. The awareness of Mental Health under provisions of Mental Health Act, 1987 is also very low among the public and implementing authorities. These issues are addressed through IEC activities at the District level by the District Mental Health Programme. In addition to the district level activities, National Mental Health Programme Division conducts nationwide mass media campaign through audio-video and print media. Awareness activities were also conducted during World Suicide Prevention Day, 10th September, 2013 and the World Mental Health Day, 10th October, 2013.

An intensive national level mass media campaign on awareness generation regarding mental health problems and reduction of stigma attached to mental disorders was undertaken under NMHP. In sync with the theme of World Mental Health Day, 2012 "Mental Health and Older Adults", a series of activities were conducted in close collaboration with the three National Mental Health Institutes and District Mental Health Programme in selected districts of the country.

11.3.6 Support for Central and State Mental Health Authorities

As per Mental Health Act, 1987, there is provision for constitution of Central Mental Health Authority (CMHA) at Central level and State Mental Health Authority (SMHA) at State level. These statutory bodies are entrusted with the task of development, regulation and coordination of mental health services in a State/UT and are also responsible for the implementation of Mental Health Act, 1987 in their respective states and union territories. States are required to have functional SMHAs to operationalize the mental health programme activities.

However, in most of the states, there is no financial support for these bodies and as such they function in an ad-hoc manner and are unable to do justice to their statutory role of implementation of Mental Health Act, 1987 and development of Mental Health Services. Support under NMHP has been approved for SMHAs during the 11th Plan period. Till date, funds have been provided to 32 State Mental Health Authorities in 32 States/UTs.

11.3.7 Monitoring & Evaluation

In order to strengthen the monitoring and improve implementation of existing NMHP schemes in States support has been approved under the programme during XI plan period. A survey to ascertain the number of mentally ill patients and availability of mental health resources in the country has been commissioned through NIMHANS, Bangaluru.

11.3.8 Mainstreaming NMHP into NHM

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

11.3.9 Expenditure statement under National Mental Health Programme

Rs. 623.445 crore was approved as XI plan outlay for the National Mental Health Programme. In the first year of the 12th Plan Rs. 130 crores was allocated. Year wise financial allocation for the NMHP and expenditure incurred is as given in the table :-

Financial Year	Allocation (Rs. in crore)	Expenditure (Rs. in crore)
2007-08	38	14.57
2008-09	70	23.45
2009-10	55	52.27
2010-11	101	90.90
2011-12	130	113.66
2012-13	130	54.72 (including Rs. 45.18 crore of Grant in aid)

11.4 NUTRITION

The Nutrition Cell in the Directorate General of Health Services provides technical advice in all matters related to policy making, programme implementation, monitoring & evaluation, training content for different levels of medical and para medical workers. Besides, the Nutrition Cell is involved in providing technical inputs for issues such as, fortification of foods, nutrition related proposals, project evaluation etc.

The Nutrition Cell coordinates, monitors all administrative and technical matters in the implementation of new health initiative "National Programme for Prevention & Control of Fluorosis (NPPCF)" which was launched in the year 2008-09 in order to address fluoride related health problems. The programme is being implemented in 100 districts of 17 states of the country. During the 12th Five Year Plan, it will be extended to another 95 districts.

The cell has been making efforts in creating awareness regarding nutrition and prevention of diet related chronic non-communicable disorders. Posters and pamphlets on these issues, video spots on IDD have been developed. Video films on National Iodine Deficiency Disorders Control Programme, Diet related Chronic Non-Communicable Diseases and Promotion of Healthy Life Styles in Hindi were also developed. A publication entitled "Current Nutritional Therapy Guidelines in Clinical Practices - A hand book for Physicians, Dieticians and Nurses" has been published and circulated to Institutions/ Hospitals, Doctors/Health professionals concerned.

11.5 ASSISTANCE TO STATES FOR CAPACITY BUILDING FOR DEVELOPING TRAUMA CARE FACILITIES IN GOVERNMENT HOSPITALS ON NATIONAL HIGHWAYS

Magnitude of the problem:

- Accidental trauma is one of the leading causes of mortality and morbidity all over the world. India has the highest number of deaths due to road accidents. Our country has just 1% of total motor vehicle population in the world, but accounts for nearly 6% of the total road accidents. The accidents rate of 35 per 10000 vehicles in India is the highest in the world as compared to 10 accidents per 10000 vehicles in the developed countries. Every 4 minutes one Indian dies on the road and the number of injured persons is five times more than this. Among the injured, 30% become disabled for the whole life either partially or totally. The vehicular population is expected to increase rapidly in the coming years, which will accelerate the accident rate leading to more deaths and disability in case no preventive measures are undertaken to tackle the menace.
- The incidence of deaths on Indian roads is increasing constantly. In 2012 total number of deaths was 1.38 lakhs as compared to 86000 in 2003. World Health Organization has projected that by the year 2020, road traffic accidents in India would be a major killer accounting for 5,46,000 deaths and 1,53,14,000 disability adjusted life years (DALY) lost.
- Thus, accidental trauma is a major public health problem needing immediate attention towards development of trauma care facilities in a systematic and planned manner as a national priority.

11th Five Year Plan:

- During 11th Plan a Trauma scheme with an outlay of Rs.732.75 crore was approved for developing a network of 140 trauma care facilities in the Govt. Hospitals along the Golden Quadrilateral highway corridor covering 5,846 Kms connecting Delhi-Kolkata-Chennai-Mumbai-Delhi as well as North-South & East-West Corridors covering 7,716 Kms connecting Kashmir to Kanyakumari and Silchar to Porbandhar respectively. Through the scheme, the designated hospitals were to be upgraded for providing trauma care facilities. It was envisaged that the network of trauma care facilities along the corridors will bring down the morbidity and mortality on account of accidental trauma on the roads in India by providing trauma care within the ambit of golden hour concept.
- Out of the identified 140 hospitals, the trauma centres in 118 hospitals were to be funded under the trauma scheme. 20 hospitals were to be funded under PMSSY scheme and rest 2 trauma centres were developed with their own funds.
- The trauma care network is so designed that no trauma victim has to be transported for more than 50 kms to a designated hospital having trauma care facilities. For this purpose an equipped basic life support ambulance is to be deployed by NHAI (Ministry of Road Transport and Highways) at a distance of 50 KMs on the designated National Highways.

Progress made during 11th plan:

- Out of the 118 identified hospitals under the trauma scheme, funds were released to 116 hospitals during the 11th plan.
- Out of these 116 hospitals, construction work has been completed in 89 hospitals.
- Trauma centres in 37 hospitals have started functioning as on date.
- In 12 places construction is in progress.
- However, in 15 places construction has not yet been initiated due to various reasons.

Coordination with Ministry of Road Transport & Highways:

- Pre-hospitals first aid including transportation of accident victims to the nearby identified hospital is the responsibility of Ministry of Road Transport

and Highways through NHAI. For this NHAI will provide ambulances provided at a distance of 50 Km. on the identified National Highways.

- A high level coordination committee has been constituted in consultation with Ministry of Road Transport and Highways for proper synchronization between pre-hospital and hospital components.

Proposal for 12th Five Year Plan

The scheme is being extended to the 12th plan period and the proposal for extension of scheme during 12th plan has already been approved by CCEA. There is proposal for development of another 85 new Trauma Care Centres on the same pattern with minor variations. Rs. 900 crore is the proposed outlay for the 12th plan.

The criteria for identification of State Govt. hospitals on the national highways will be as follows:-

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

The identification of the hospitals for development of 85 trauma centres will be done in consultation with all the stake holders in due course of time. Preference will be given to states which are not covered during 11th plan. Hilly and North Eastern States will also be given priority.

Unlike 11th plan, the scheme will no more be a 100% centrally sponsored scheme. The proposed amount of assistance will be shared between central and State Governments in a ratio of 70:30. The ration of sharing for North Eastern States and hilly states of Himachal Pradesh, Uttarakhand and Jammu & Kashmir this ratio will be 90:10.

The scheme has been merged within the ambit of "Human Resource in Health and Medical Education Scheme". Hence, 12th plan component of the scheme will be governed according to the norms set under this umbrella scheme. However, the old components of 11th plan will be as per the original plan of 11th plan.

11.6 NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF DEAFNESS (NPPCD)

Hearing loss is the most common sensory deficit in humans today. As per NSSO survey (2002), currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss. The estimates burden of disease in the school going age group in India is about 26.4 million. Such large number of hearing impaired young Indians lead to severe loss of productivity both physical and economic. About 50% hearing loss cases are caused by infections of the ear (Acute Suppurative Otitis Media, Chronic Suppurative Otitis Media), Secretory Otitis Media, Trauma, Rubella, Noise Induced Hearing loss and Ototoxicity, further 30% cases of deafness, though not preventable, are treatable. Thus a total of 80% of all deafness cases are avoidable by medical or surgical methods and the rest can be rehabilitated with the use of hearing aid, speech and hearing therapy.

In view of the above, the National Programme for Prevention and Control of Deafness (NPPCD) was initiated on pilot basis in the year 2006-07 (January 2007) covering 25 districts of 10 States and 1 UT which has been expanded to 192 districts of 17 States and 3 UTs in a phased manner till now.

Objectives of NPPCD

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

Strategies of NPPCD: In the 12th Five Year Plan, it is proposed to implement the Programme in 200 new districts in addition to the existing 192 districts in a

phased manner, with the following components.

a. Prevention through Behaviour Change Communication (BCC)

Majority of causes of deafness may be prevented by raising awareness among the health care providers and the community. For such awareness generation, various categories of mass media, community education and interpersonal communication approaches will be used.

b. Capacity building which will include:

1. **Training:** Seven types of training are proposed for various categories of health professional at different levels of health care facilities including training/sensitization of ENT doctors, Audiologists, Obstetricians and Paediatricians, Medical officers, MPWs, PHNs, AWWS, Anganwadi workers and their supervisors, teachers, ASHA and parents of disabled children.
2. **Manpower support:** Ear care services shall be strengthened by providing ENT Surgeon, Audiologist, Audiometric Assistant and Instructor for hearing impaired in each district on contractual basis.
3. **Equipments:** To strengthen the early detection and management of hearing impaired, health care facilities will be provided financial support to procure the equipments.
4. **Rehabilitation and Hearing Aid provision:** The hearing aids will be issued under ADIP Scheme implemented by Ministry of Social Justice & Empowerment as per criteria developed for implementation of the programme (ADIP).
5. **Screening for Hearing Impairment:** The activity of screening of all the School Children of the district to ascertain the magnitude of Hearing Impairment among the School Children and Screening in the Urban Slums shall be conducted in Public Private Partnership (PPP) mode.
6. **Referral services:** Effective linkages would be developed from peripheral level to district level with the help of functionaries and personnel from grass root level to the District level officers.

c) Monitoring and Supervision is being done closely at Central and State level.

d) Public Private Partnership

e) Operational Research & Evaluation

➢ The Components at D & E has been added in the current Plan.

➢ There is no hearing aid for Hearing Impaired children. However the Ministry of Social Justice will be involved for provision of Hearing Aids under their ADIP scheme and Screening Camps would be organized in convergence with the Rashtriya Bal Swasth Karyakram.

The Programme is a 100% Centrally Sponsored Scheme. Various Programme activities are implemented at Central, State and District level.

11.7 NATIONAL PROGRAMME FOR PREVENTION & CONTROL OF FLUOROSIS (NPPCF)

Fluorosis, a public health problem is caused by excess intake of fluoride through drinking water/food products/ industrial pollutants over a long period. It results in major health disorders like dental fluorosis, skeletal fluorosis and non-skeletal fluorosis. These harmful effects being permanent and irreversible in nature are detrimental to the health of an individual and the community which in turn has an impact on growth development & economy of the country.

The Government of India started the National Programme for Prevention and Control of Fluorosis as a new health initiative in the 11th Five Year Plan (2008-09) with the aim to prevent and control fluorosis in the country. 100 districts of 17 States have been covered under the programme in a phased manner during the 11th Plan with additional 5 districts during 2013-14. The objectives of the programme are (i) assess and use the baseline survey data of fluorosis of Ministry of Drinking water & Sanitation; (ii) Comprehensive management of fluorosis in the selected areas; (iii) Capacity building for prevention, diagnosis and management of fluorosis cases.

The strategy followed under the programme is surveillance of fluorosis in the community; capacity building (Human Resource) in the form of training and manpower support; establishment of diagnostic facilities

in the medical hospitals; management of fluorosis cases including treatment surgery, rehabilitation and health education for prevention and control of fluorosis cases.

During the year 2013-14, a two-day Training of Trainers (TOT) programme was conducted for District Consultants, District Nodal Officers and State Nodal Officers and two training programmes were conducted for Laboratory Technicians by National Institute of Nutrition, Hyderabad.

A Review meeting with the State Nodal Officers and the District Consultants as well as the Meeting of Technical Advisory Committee to review the existing policy in combating fluorosis were held on 21st March 2014 along with States representatives and Experts respectively.

In the 12th Five Year Plan it is proposed to implement the programme under the National Health Mission (NHM). Accordingly the States have been provided with the guidelines and requested to submit their Programme Implementation Plans (PIPs). It is proposed to extend the programme in 95 new districts in a phased manner in addition to the 100 districts covered during the 11th Plan.

The Budget Allocation for the 12th Five Year Plan is Rs. 135.00 crores and for the year 2013-14 is Rs. 3.73 crores.

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

Government of India has launched the "National Programme for Health Care of the Elderly" (NPHCE) to address health related problems of elderly people, in 100 identified districts of 21 States during the 11th Plan period. Eight Regional Geriatrics Centres as referral units have also been developed in different regions of the country under the programme.

The basic aim of the NPHCE Programme is to provide separate, specialized and comprehensive health care to the senior citizens at various level of state health care delivery system including outreach services. Preventive and promotive care, management of illness, health manpower development for geriatric services, medical rehabilitation and therapeutic intervention and IEC are some of the strategies envisaged in the NPHCE.

It is expected to cover 225 more districts during the 12th Five Year Plan in a phased manner. 12 more Regional Geriatric Centres in selected Medical Colleges of the country are also expected to be developed under the programme. In addition, two National Institute of Ageing (NIA) are also being established at AIIMS, New Delhi and Madras Medical College, Chennai, the core functions of which are training of health professionals, research activity and health care delivery in the field of geriatrics.

The details of the geriatric setup and activities undertaken so far under the programme at various health care levels are as below:

- **Department of Geriatric at 8 Super Specialized Institutions:** Geriatric Department are being developed at 8 identified medical institution located in various regions of the country with 30 bedded in patient facility. Apart from providing referral treatment, research and manpower development, these institutions are involved in developing and updating training materials for various levels of health functionaries, developing IEC material, guidelines, etc. Funds have been provided for manpower, equipments, medicines, construction of building, training etc.
- **Geriatric unit at 100 District Hospitals:** The programme is being implemented in 100 districts, covering 21 States. There is provision for establishing 10 bedded geriatric ward and dedicated OPD services exclusively for geriatric patients. The grant-in-aid has been provided for contractual manpower, equipments, medicines, construction of building, training etc. During the year 2013-14, the programme will be implemented in more districts.
- **Rehabilitation units at CHCs:** There is provision for dedicated health clinics for the elderly persons twice a week. A rehabilitation unit is being set up at all the CHCs falling under indentified districts. The grant-in-aid has been provided for manpower, equipments, training. The Rehabilitation Worker is supposed to provide physiotherapy to the needy elderly persons.

- **Activity at PHCs:** Weekly geriatric clinics are arranged at the identified PHCs by a trained Medical Officer. For diseases needing further investigation and treatment, persons will be referred to the first referral unit i.e. the Community Health Centre or District Hospital as per need. One-time grant will be given to PHCs for procurement of equipment.
- **Activity at Sub-Centre:** The ANMs/Male Health Workers posted in sub-centre will make domiciliary visits to the elderly persons in areas under their jurisdiction. She/he will arrange suitable calipers and supportive devices from the PHC and provide the same to the elderly disabled persons to make them ambulatory. There will also be provision for treatment of minor ailments and rehabilitation equipments at the identified sub centers. Grant-in-aid will be provided to SCs for purchase of aids and appliances.

The programme was approved with an outlay or Rs. 288 crore for the remaining period of the 11th Plan. The expenditure was shared by Central and the State Government on 80:20 basis. Total amount of Rs. 112.86 crore was released to the States/8 regional Geriatric Centres during the 11th plan period and an amount of Rs. 68.55 was released during the 2012-13. In 12th Five Year Plan, a total amount of Rs. 1710.13 crore has been approved. Out of this, an amount of Rs. 1147.56 crore is earmarked for activities proposed to be undertaken up to district level. The fund sharing ratio between the Centre and the State is 75:25 during the 12th Five Year Plan. An amount of Rs. 562.57 crore has been earmarked for tertiary level activities. The funds earmarked for the year 2013-14 is Rs. 150/- crore.

The following are the achievements made so far under the programme

Geriatric OPDs have been opened in all 8 Regional Geriatric Centres viz: (1) All India Institute of Medical Sciences, New Delhi; (2) Madras Medical College, Chennai; (3) Grants Medical college & JJ Hospital, Mumbai; (4) Sher-I-Kashmir Institute of Sciences (SKIMS), Jammu & Kashmir; (5) Govt. Medical College, Thiruvananthapuram; (6) Guwahati Medical College, Assam; (7) Dr. S.N. Medical College, Jodhpur, Rajasthan; and (8) Banaras Hindu University, U.P.

Indoor services have been established in 6 Regional Geriatric Centres viz: All India Institute of Medical Sciences, New Delhi; Madras Medical College, Chennai; Grants Medical Collage & JJ Hospital, Mumbai; Sher-I-Kashmir Institute of Medical Sciences (SKIMS), Jammu & Kashmir; Govt. Medical College, Thiruvananthapuram; Dr. S.N. Medical College, Jodhpur, Rajasthan.

Among the states, Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Sikkim, Uttar Pradesh, Uttarakhand and West Bengal have reported opening of 65 Geriatric OPD/Ward and various district Hospitals. Physiotherapy daily geriatric clinics have also been started at 28 District Hospital in 10 States.

Bi-weekly Geriatric Clinic started at CHCs of 29 Districts viz. Dibrugarh, Jorhat, Kamrup, Lakhimpur, Sivasagar (Assam); Bilaspur, Jashpur Nagar, Raipur (Chhatishagrh); Gandhi Nagar, Surendranagar, Rajkot, Jam Nagar, Porbandar, Junagarh (Gujarat); Mewat, Yamuna Nagar (Haryana); Leh, Kupwara, Kargil, Doda, Udhampur (J&K); Bokaro, Dhanbad, Ranchi (Jharkanand); Shimoga, Kolar (Karnataka); East Sikkim, South Sikkim (Sikkim); and Batinda (Punjab).

Weekly Geriatric Clinics at PHCs have been started at Gandhi Nagar, Jamnagar (Gujarat); Mewat (Haryana), Leh, Kupwara, Kargil, Doda, Udhampur (J&K); Ranchi, Dhanbad, Bokaro (Jharkahand); Shimoga & Kolar (Karnataka); and East Sikkim, South Sikkim (Sikkim).

11.9 UP-GRADATION OF FACILITIES IN THE DEPARTMENT OF PHYSICAL MEDICINE & REHABILITATION (PMR) IN GOVERNMENT MEDICAL COLLEGES

During the Xth Five Year Plan period, the scheme "Up-gradation of facilities in the Department of PMR in State Government Medical Colleges" amounting to Rs. 5.2 crores was approved in 2004 by the SFC with the aim of creating an independent Department of PMR within the six existing Medical College set-up and augmenting/strengthening the Department through acquisition of essential equipment and manpower for comprehensive rehabilitative services.

The scheme was extended in 11th Plan with the target of setting an independent PMR Department in total 30 State Govt. Medical Colleges with the following objectives:

- Set-up an independent PMR Department in identified Medical Colleges.
- Develop Medical rehabilitation services in one district, CHC & PHC under each PMR Department.
- Training of Medical and Paramedical Staff for providing secondary & tertiary rehabilitation services.
- Developing 2 apex PMR Departments in the country as model training centers with comprehensive service delivery system.

29 Medical Colleges were inspected and the scheme was proposed to be implemented in 28 Medical Colleges. However, financial support for establishing PMR Department was provided to 21 Medical Colleges only (6 medical colleges in the 10th Plan and additional 15 in the 11th Plan). Since MoU was not received from remaining 7 Medical Colleges, funds could not be released to them. The scheme was withdrawn from GTB Hospital, New Delhi in 2011 due to non-performance. Hence, currently the scheme is being implemented in 20 government medical colleges of the country.

Under the scheme, funds are provided under 4 components:

i) Recruitment of manpower

ii) Procurement of equipment

iii) Material & supplies

iv) Maintenance & office equipment

The Scheme is proposed to continue in 12th Five Year Plan with an outlay of Rs. 71.3 crores. It is expected that the scheme will be completed by end of 12th FY Period (31.03.2017). It has the following objectives and Sub-objectives:

General Objective

To build capacity in the Government Medical Colleges for providing comprehensive rehabilitation services and to train adequate manpower required at all levels of Health Care Delivery System.

Sub Objectives:

- To support and strengthen independent Department of Physical Medicine and Rehabilitation in existing 20 State Government medical colleges and to take up six new Medical Colleges in the 12th Five Year Plan. It is also proposed to keep provision for two more Medical Colleges in case a request is received for the same during the Plan period.
- To conduct training programme for Under Graduate medical professionals on Disability Prevention, Detection and Early Intervention.
- To train the District level Medical officer and Health Professionals in disability assessment computation, prevention and rehabilitation through Community Based Rehabilitation.
- Setting up of rehabilitation services in a comprehensive manner so that all clinical Departments are involved and thereby to evolve a strategy of continuation of care even in the domiciliary and community set up.

11.10 NATIONAL ORAL HEALTH PROGRAMME (NOHP)

India has a high prevalence of oral-dental disease & it is well established that oral diseases have a great impact

Expenditure in 11th FYP *(Rs. in crores)*

Year	2007-08	2008-09	2009-10	2010-11	2011-12	Total
No. of Medical Colleges	2	3	2	8	-	15
Budget Estimate	1.00	1.00	11.95	13.90	8.00	35.85
Expenditure	1.0434	0.9859	1.94	4.821	0.7615	9.5518

on systemic health. Poor oral health can cause poor aesthetics, affects mastication adversely, causes agonizing pain and can lead to loss of productivity due to loss of man-hours. To address these issues, a comprehensive oral health programme was envisaged.

The Planning Commission had sanctioned Rs. 25.00 crore for the Pilot Project on Oral Health Programme during 11th Five year Plan period. However, the same could not be included because of the instructions issued by M/o Finance on Expenditure Management wherein it was indicated that no new scheme or programme, except for those that are part of the budget announcement 2008-09, should be introduced in the financial year 2008-09.

This programme is a new initiative by Government of India and has been included in the 12th Plan Proposal. It is proposed to implement the programme in 200 districts (@ 50 districts per year) across the country during the remaining period of 12th Plan with a tentative budget provision of Rs. 100.00 crore. The allocation of budget for the year 2013-14 stands at Rs. 15.73 crore. The main objectives of the programme are as under:-

i. Improvement in the determinants of oral health e.g. healthy diet, oral hygiene improvement etc. and to reduce disparity in oral health accessibility in rural & urban population.

ii. Reduce morbidity from oral diseases upto primary and secondary level.

iii. Strengthening of existing healthcare delivery system at primary and secondary level.

iv. Integrate oral health promotion and preventive services with general health care system and other sectors that influence oral health.

Chapter 12

INTERNATIONAL CO-OPERATION FOR HEALTH & FAMILY WELFARE

12.1 INTRODUCTION

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

12.2 WORLD HEALTH ORGANIZATION (WHO)

World Health Organization (WHO) is one of the main UN agencies collaborating in the Health Sector with the Ministry of Health & Family Welfare, Government of India. WHO provides technical support in the major areas of Health & Family Welfare programmes and health care facilities in the country. Activities under WHO are funded through two sources.

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

12.2.1 Nodal Functions of WHO

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

The 66th WHA was held in May, 2013 at Geneva and a high level delegation comprising of officials of this Ministry under the leadership of Hon'ble Minister of Health and Family Welfare attended. The 66th WHA, inter-alia, discussed the following agenda items and the resolutions were adopted on some of the agenda items:-

- WHO reform
- *Programme and Budget:* Implementation of Programme Budget 2012-13, Draft Twelfth General Programme of Work, Proposed Programme Budget 2014-15
- *Non-communicable Diseases:* Draft comprehensive Global Monitoring framework and targets for the prevention and control of non-communicable diseases 2013-20, Draft Comprehensive Mental Health Action Plan 2013-20, Draft Action Plan for the Prevention of avoidable blindness and visual impairment 2014-19, Disability etc.
- *Promoting Health through the Life Course:* Monitoring the achievement of the Health-related Millennium Development Goals, Health in the Post 2015 Development agenda, follow-up actions to the recommendations of the high-level commission convened to advance women's and children's health, Social determinants of health.
- *Preparedness, Surveillance and Response:* Implementation of the International Health Regulations (2005), Pandemic Influenza Preparedness: Sharing of Influenza viruses and access to vaccines and other benefits, Poliomyelitis: intensification of the Global Eradication initiative.

- *Communicable Diseases:* Global Vaccine Action Plan, Neglected Tropical Diseases, Malaria.
- *Health System:* Substandard / spurious / falsely-labeled / falsified / counterfeit medical products, follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, Universal Health Coverage, The health workforce: advances in responding to shortage and migration, and in preparing for emerging needs, e-Health and health Internet domain names.

ii. Meeting of Ministers of Health and Regional Committee of WHO South East Asia Regional Countries: The Health Ministers' Meeting (HMM) and the Regional Committee (RC) Meeting of WHO-SEAR countries are held annually. HMM provides a forum for Health Ministers to discuss important health issues in the region as well as for forging bilateral arrangements. The Regional Committee is a forum to review progress made on health issues and to lay down the roadmap for future action.

The 31st WHO-SEAR Health Ministers Meeting (HMM) was held in New Delhi on 10th September 2013, followed by the Sixty-sixth Session of the WHO Regional Committee (RC) for South-East Asia during 11th-13th September, 2013 at New Delhi.

Various agenda items were discussed during the 31st WHO-SEAR Health Ministers Meeting (HMM) and the 66th Session of the WHO Regional Committee (RC) for South-East Asia and resolutions were adopted on some of these agenda items. Some of the important agenda items discussed during these Sessions are:

31st WHO-SEAR Health Ministers Meeting (HMM):

- Review of Yogyakarta Declaration on Ageing and Health and all other previous HMM declaration/ follow-up actions on the decision and recommendation of the Thirteenth Meeting of Ministers of Health.
- New Delhi Declaration on High Blood Pressure.
- Health in the Post 2015 Development agenda.

66th Session of the WHO Regional Committee (RC):

- Implementation of Programme Budget 2012-13
- 12th General Programme of Work (GPW) and Proposed Programme Budget 2014 - 2015
- WHO-Reform: financing dialogue and development of Programme Budget 2016 - 2017
- Technical Discussions on Universal Health Coverage
- Selection of a subject for the technical discussions to be held prior to the Sixty-Seventh Session of the Regional Committee
- Implementation of the International Health Regulations (2005)
- Measles elimination and rubella control in SEA Region
- Regional Action Plan and Targets for Prevention and Control of Non-communicable Diseases (2013-2020).
- Reports of WHO Global working/advisory groups: Pandemic Influenza Preparedness Framework: (PIPFW), Progress Report on Malaria
- Challenges in Polio Eradication
- 2012: Year of Intensification of Routine Immunization in the South-East Asia Region: Framework for Increasing and Sustaining Coverage
- National Essential Drug Policy Including rational use of Medicines
- Consultative Expert Working Group on Research and Development: Financing & Coordination
- Nomination of Regional Director
- Revision to the Rules of Procedure of the WHO Regional Committee of SEA
- Important issues arising out of the Sixty-sixth World Health Assembly and the 132nd and 133rd Sessions of the WHO Executive Board
- UNICEF / UNDP / World bank / WHO Special Programme for Research and Training in Tropical Diseases: Joint Coordinating Board (JCB) - Report on attendance at JCB in 2013

- UNDCP / UNFPA / UNICEF / WHO / World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP): Policy and a Coordination Committee (PCC) - Report on attendance at PCC in 2013 and nomination of a member in place of Bhutan whose term was expiring on 31st December, 2013
- Election to the post of Regional Director, WHO-SEARO.

iii. **Session of the Executive Board of WHO:** The Executive Board is a Governing Body of WHO, composed of 34 individuals technically qualified in the field of health, each one designated by a Member State elected to do so by the World Health Assembly. Member States are elected for three-year term. The main functions of the Executive Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work. The Board meets at least twice a year; the main meeting is normally held in January, with a second shorter meeting in May, immediately after the Health Assembly.

The 132nd Session of the Executive Board of WHO was held in January, 2013 at Geneva and Indian delegation comprising of Shri Keshav Desiraju, then Special Secretary (Health) and Shri Amal Pusp, Director (IH) attended the Session.

The 133rd Session of the Executive Board of WHO was held in May, 2013 at Geneva immediately after the World Health Assembly and PMI, Geneva represented on behalf of the Ministry of Health & Family Welfare.

The 134th Session of the Executive Board of WHO was held in January, 2014 at Geneva and Indian delegation comprising of Shri C. K. Mishra, Additional Secretary (Health) and Dr. Poonam Khetrapal Singh, the then Adviser (IH) attended the session.

Various important agenda items were discussed during the meeting and resolutions were adopted on some of these agenda items. Most importantly, the EB ratified the nomination of Dr. Poonam Khetrapal Singh, the Indian candidate elected to the post of Regional Director (RD), WHO South East Asia Region (SEAR) during 66th session of Regional Committee of WHO SEAR in September, 2013.

iv. The Regional Meeting on implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) was held in New Delhi during 23 - 26 July, 2013. The focus of the WHO-FCTC Regional Meeting was on regional achievements and challenges, based on implementation experience of the parties and International Development Partners, such as, the UNDP, UNCTAD, UN-WOMEN and also the Civil Society organizations active in the Region, like the World Lung Foundation.

12.2.2 Government of India contribution to WHO

As a member country of WHO, India makes regular contribution to WHO for each biennium. A WHO biennium commences in January of the first year of the biennium and ends in December of the second year of the biennium.

The Assessed Contribution payable by Government of India to WHO is decided on the basis of UN Scale of Assessment. For the biennium 2014-2015, the scale of assessment for India has been revised from the existing scale of 0.5340 to 0.666. India's Assessed Contribution for the biennium 2014-2015 stands at USD 15,46,785 + CHF 14,50,884 and Voluntary Contribution of USD 55,000 and USD 35,000 towards the WHO / UNICEF / UNDP / World Bank's Special Programme for Research & Training in Tropical Diseases Research (TDR) and UNDP / UNFPO / WHO / World Bank Special.

Programme of Research, Development and Research Training in Human Reproduction (HRP) respectively. The first installment of Government of India's contribution to WHO for the biennium 2014 - 2015 amounting to USD 15,46,785 + CHF 14,50,884 (Assessed Contribution) and USD 90,000 (Voluntary Contribution) has been paid in February, 2014.

India has remitted Euro 7,56,570 towards membership fee to International Agency for Research on Cancer (IARC), Lyon, France for the year 2013 in March, 2014.

12.2.3 Government of India/World Health Organization collaborative Activities

WHO funding is available for taking services of the experts on contractual basis on specific terms and

references; training within and outside the country; holding of workshops, seminars and meetings for raising awareness or exchange of information and supplies of medical equipment, viz: (i) Technical Services Agreement; (ii) Fellowship; (iii) Agreement for Performance of Work (APW); (iv) Direct Financial Cooperation (DFC) and (v) Supplies and Equipment etc.

12.3 SPECIAL ACHIEVEMENTS

I. The election for the post of Regional Director, WHO-SEAR Office was held on 12th September, 2013 at the 66th Regional Committee Meeting of WHO-SEAR. India had nominated Dr. Poonam Khetrapal Singh as a candidate from India for election to the post of Regional Director. There were three candidates in the election to the post of Regional Director, WHO-SEARO viz. Dr. Poonam Khetrapal Singh from India, Dr. Syed Modasser Ali from Bangladesh and Dr. Myint Htwe from Myanmar. India's candidate Dr. Poonam Khetrapal has been elected as the Regional Director of the South-East Asia Regional Office of the WHO in New Delhi for the next 5 years. Her appointment was ratified on 1st February, 2014. India had not held this position since 1967. This is indeed a major achievement for India.

II. India hosted the 31st WHO - South East Asia Region (SEAR) Health Ministers Meeting on 10th September, 2013 in New Delhi. The Hon'ble President of India, Shri Pranab Mukherjee inaugurated the meeting. Important agenda items on Health issues concerning SEAR countries were discussed during the meeting. New Delhi declaration on High Blood Pressure was adopted.

III. India hosted the 2nd BRICS Health Ministers Meeting (HMM) during 10th - 11th January, 2013 at New Delhi. During the BRICS Health Ministers Meeting, the Action Plan i.r.o. 5 Thematic Areas viz. (i) Strengthening health surveillance system (ii) Strategic Health Technologies, with a focus on Communicable and Non-communicable Disease (iii) Medical Technologies (iv) Drug Discovery and Development (v) Reducing NCD Risk factors, prevention and health promotion and Universal Health Coverage were finalized and adopted. Health Ministers also adopted the Delhi Communique calling for increased collaboration amongst BRICS countries in the sphere of health and for renewed efforts to combat the threats posed by various diseases.

IV. The Ministry of Health & Family Welfare released an additional US $ 50,000 in March 2013 towards the pooled fund of WHO Reforms as a special one-time measure.

12.4 AIRPORT HEALTH ORGANIZATIONS / PORT HEALTH ORGANIZATIONS

Airport Health Organization, Port Health Organizations and Airport and Border Quarantine Center (APHOs/ PHOs/ ABQC) are subordinate offices of the Directorate General of Health Services. At present, there are 9 PHOs and 5 APHOs, established at all major International Airports and Ports and one Border Quarantine Centre at Attari Border, Amritsar. In addition to these, the Health Offices at Bangalore and Hyderabad Airports and Tuticorin Port have also been established and started functioning in full swing and action has been taken to set up health offices (APHOs) at Ahmedabad, Lucknow and Trivandrum Airports. The recruitment of contractual staff at these 3 APHOs is in advanced stage. An EFC proposal for strengthening 21 existing (10 APHOs, 10 PHOs and 1 ABQC) and to establish health offices at 23 POEs (15 Airports, 2 Ports and 6 Airport and Border Crossings), is under consideration.

These are statutory organizations and are discharging their regulatory functions, as delineated under the Indian Aircraft (Public Health) Rules, 1954 and Port Health Rules, 1955, respectively. Apart from this India is also signatory to the International Health Regulations, framed by WHO and therefore, it is obligatory on our part to implement these regulations. Accordingly, both Indian Aircraft Public Health Rules as well as Indian Port Health Rules have been framed in agreement with the International Health Regulations.

Main objective of the APHO/PHOs is to prevent the spread of infectious diseases of epidemic proportions from one country to another, with minimum interference to the world traffic. Some of the important functions of these organizations are Health Screening of International Passengers, Quarantine, Clearance of

Dead Bodies, Supervision of Airport Sanitation, Vaccination to International Passengers, Vector Control, etc. Apart from this, issuance of Ship Sanitation Certificate is another major responsibility at International Ports.

WHO has notified a list of Yellow Fever Endemic Countries, under IHR and any person coming to India from these notified endemic countries is required to possess valid Yellow Fever Vaccination Certificate, failing which, such passengers are quarantined for a maximum period of six days. In the light of changing global health scenario, existing IHR have been revised by WHO (IHR 2005) and these new IHR have come into effect from June, 2007. In order to revise our own rules, in tune with IHR, a number of workshops have been organized by Directorate General of Health Services and finally, the amended draft Rules are under final stage of approval from Law Ministry.

For development of core capacities at all the Points Of Entry (POEs) for dealing with Public Health Emergency of International Concern (PHEIC), task force meeting of all the stakeholders from all the disciplines, including Radio Nuclear, Chemical, Atomic and Zoonosis have been held and the process of development of Contingency Plans and Capacity Building at all the POEs has been initiated. Contingency Plans of POEs have been shared with the stakeholders. After implementation of Food Safety & Standards Act 2006, the VIP Food related function has been authorized and is being performed by POEs. Designated Points of Entry (POEs) Health Officers have been notified as designated offices for the purpose of food safety and licensing at POEs.

Port Health Organizations for the Period 1 January 2013 - 31 March 2014

Sl. No.		PHO, Marmagoa	PHO, Chennai	PHO, Vishakha-patnam	PHO, Kolkata	PHO, JNPT Sheva	PHO, Mumbai	PHO, Tuticorin	PHO, Cochin	PHO, Kandla
1	No. of Ships Arrived	310	2323	1782		1709	1872	1260	1304	414 KP 332 MP 82
2	No. of Ships given health clearance	310	1571	1782	2589	1709	1872	1260	1304	414 KP 332 MP 82
3	No. of Ships given free Pratique	210	1571	1496	River Pilot, KoPT is authorised	NA	105	1111	1258	102
4	No.of Ships Given Radio Free Pratique	210	NA		NA	NA	NA	NA	46	220
5	No. of Ships quarantined	1	NA	NIL	0	16	NIL	0	NIL	NIL
6	No. of Ships disinsected	NIL	NA	86	0	NA	15	17	NIL	82
7	No. of Ships issued Sanitary Control Certificate	1	NA	NA	0	85	NIL	0	NIL	12
8	No. of Ships issued Sanitary Control Exemption Certificate	58	91	NA	179	NA	660	175	122	152
9	No. of Yellow Fever Vaccinations Given	1067	4287	1888	3327	NA	21304	0	5851	220
10	No. of Sanitary Inspections	310	NA	NA	NIL	NA	NIL	0	1034	414
11	No. of Imported food samples lifted	25	NA	NIL	Now under jurisdiction of FSSAI	NA	NIL	0	852	1

12	No. of Water samples lifted	1	12	NA	8	NA	53	144	8	NIL
13	No. of Imported Edible Oil samples lifted	1	NA	NA	NA	NA	NA	NA	5	57
14	No. of Dead Bodies given clearance	1	NIL	2	0	NA	4(death on board)	0	2	NIL
15	No. of entomological surveys undertaken	4	3	NA	3	NA	NIL	0	NIL	3
16	No. of Medical Chests Inspected	13	48	106	81	NA	133	43	48	21
17	No. of passengers medically Examined	19200	31699	31747	16319	NA	NIL	0	354783	NIL
18	No. of crew medically examined	15794	NA	NA	56256	NA	NIL	374	41181	9305
19	No. of medical emergencies attended	NIL	NA	NA	0	NA	NIL	0	12	7
20	No.of Rodent Screening of Ships from Plague Endemic Areas	NIL	NA	182	NA	NA	NA	NA	NIL	138

Data Highlights in Yellow is only for the period 1 January 2013 - 31 December, 2013
NA-Data not Available NIL- Data is NIL

Airport Health Organizations for the Period 1 January 2013 - 31 March 2014

S. No.		APHO, Delhi	APHO, Thiruchirapally	APHO, Kolkata	APHO, Mumbai	APHO, Chennai
1	Flights Arrived/Inspected	31955	3142/730	8769	23141	
2	Aircrafts Disinsected	Aircraft Disinsection in case of Death on Board, on demand of airlines & if GD is not there or conveyance not disinsected by Airlines	3142	7189	13550	
3	Surveillance of International Passengers and Crew for YF	Done by Immigration Department	Yes	Done by Immigration	4139111	
4	Quarantine of Passengers	283	NIL	NIL	11	
5	Yellow Fever Vaccinations	5166	NIL	1127	14678	
6	Clearance of Dead Bodies	937	228	87	441	
7	VVIP Food Surveillance	44	NIL	17	NIL	
8	Medical and Flight Emergencies	1 Mock Drill	12	20	9	
9	Vector Surveillance	Pre-Monsoon & Post-Monsoon + Supervision	For Aedes Aegypti Done	1296	Pre and Post Monsoon	
10	Sanitary Inspection	Only Supervision	24	1260	Yes	
11	Food Establishments Inspected	Not being done after August 2011	12	360	NIL	

NA- Data Not Available NIL- Data is NIL

12.5 CUSTOM DUTY EXEMPTION CERTIFICATE

During 2013-14, this Ministry has issued one time Customs Duty Exemption Certificates in favour of -

i. North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS), Mawdiangdiang, Shillong (Meghalaya);

ii. Two ESI Medical College / Hospitals: (i) ESIC Medical College and Post Graduate Institute of Medical Science & Research, Rajajinagar, Bengaluru, Karnataka & (ii) ESI Hospital, Peenya, Bengaluru, Karnataka;

iii. Kalawati Saran Children's Hospital, New Delhi;

iv. Lady Hardinge Medical College & Smt. S.K. Hospital, New Delhi;

v. All India Institute of Medical Sciences (AIIMS), Sijua, Post-Dumduma, Bhubaneswar (Odisha);

vi. All India Institute of Medical Sciences (AIIMS), Jodhpur (Rajasthan);

vii. All India Institute of Medical Sciences (AIIMS), Rishikesh (Uttarakhand);

viii. All India Institute of Medical Sciences (AIIMS), Bhopal-462 024 (Madhya Pradesh);

ix. All India Institute of Medical Sciences (AIIMS), Patna (Bihar); and

x. All India Institute of Medical Sciences (AIIMS), Raipur (Chhattisgarh).

12.6 FOREIGN TRAVEL BY SENIOR OFFICERS

For the year 2013-14, a provision of Rs. 3,10,50,000/- (after 10% austerity cut) was made against Foreign Travel Expenses (Revised Estimate) under Non-Plan. Out of this, the expenditure till 31st March, 2014 is Rs. 1,57,00,000/- (approx.).

12.7 VISIT ON FELLOWSHIP / CONFERENCE ABROAD

During the period under report, 159 medical personnel were permitted to participate in International conference / symposia etc. abroad, including 18 medical personnel from CHS cadre who were granted financial assistance subject to a maximum of Rs. One (1) lakh each under CHS Assistance Scheme to attend seminars / conferences abroad in order to acquaint themselves with the latest developments in the field of medicine and surgery in other countries and to exchange views with their counterparts.

12.8 AGREEMENTS / MOUs

i. An MoU between the Government of India and the Government of Bangladesh on cooperation in the field of health sector was signed on 12th February, 2013;

ii. An MoU between the Government of India and the Government of the United Kingdom of Great Britain & Northern Ireland on cooperation in the field of health sector was signed on 19th May, 2013;

iii. An MoU between the Government of India and the Government of Yemen on cooperation in the field of health and medicine was signed on 09th June, 2013;

iv. An MoU between the Government of India and the Government of Indonesia on cooperation in the field of health and medicine was signed on 11th October, 2013;

v. An Agreement between the Directorate General of Health Services (DGHS), Ministry of Health & Family Welfare, Government of India and the National Trauma Research Institute (NTRI), Government of Victoria, Australia on collaboration in Road Traffic Injury Prevention & Control, Management of Trauma, Trauma System Development and Emergency (Trauma Care) Medical Services was signed on 16th November, 2013;

vi. An MoU between the Government of India and the Government of Maldives on cooperation in the field of health was signed on 02nd January, 2014;

vii. An MoU between the Government of India and the Government of The Netherlands on cooperation in the field of healthcare and public health was signed on 30th January, 2014 and

viii. A Statement of Intent (SoI) between the Government of India and the Government of USA on cooperation in the field of medical products was signed on 10th February, 2014.

12.9 MEETINGS / CONFERENCES

i. 4th meeting of the India-Brazil-South Africa (IBSA) Trilateral Joint Working Group (JWG) to discuss various trilateral health issues was held in New Delhi on 11th January, 2013;

ii. A meeting between Ms. Anna Soubry, Parliamentary Under Secretary of State, United Kingdom and Hon'ble Minister of Health & Family Welfare to discuss various issues associated with India-UK MoU / Agreement on health, primary healthcare and infectious disease control was held in New Delhi on 14th January, 2013;

iii. A meeting between Hon. LormusBundhoo, Minister of Health and Quality of Life, Republic of Mauritius and Hon'ble Minister of Health & Family Welfare to discuss issues related to health sector was held in New Delhi on 14th January, 2013;

iv. 1st South Asian Autism Network (SAAN) Conference inaugurated by Smt. Sonia Gandhi, Chairperson, National Advisory Council was hosted by India to discuss issues associated with Autism and developmental disorders in New Delhi on 11th February, 2013;

v. 1st India - United Kingdom Health Policy Forum Workshop for continuation of cooperation and enhancement of partnership across the health space between the two countries was held in New Delhi on 21-22 February, 2013;

vi. A meeting between Dr. Sergio G.C. Lobo, Hon'ble Minister of Health of Timor-Leste and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 06th March, 2013;

vii. A meeting between Mr. Alexandre Manguale, Hon'ble Minister of Health, Mozambique and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 18th March, 2013;

viii. A meeting between H.E. Mr. Tonio Borg, European Commissioner (Minister) for Health and Consumer Policy, European Commission and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 11th April, 2013;

ix. A meeting between Mr. Daniel Bahr, Federal Minister for Health, Germany and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 29th April, 2013;

x. A meeting between H.E. Alain Berset, Minister of Health, Switzerland and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in Geneva, Switzerland on the sidelines of the World Health Assembly on 20th May, 2013;

xi. A meeting between Ms. Kathlean Sebelius, Secretary of State for Health & Human Services, USA and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in Geneva, Switzerland on the sidelines of the World Health Assembly on 21st May, 2013;

xii. Separate bilateral meetings between Hon'ble HFM and the respective Health Ministers of China and Afghanistan were held on the sidelines of World Health Assembly to discuss bilateral health issues at Geneva, Switzerland on 21st May, 2013;

xiii. A meeting between H.E. Dr. Neil Sharma, Minister for Health, Fiji and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 31st May, 2013;

xiv. A meeting between H.E. Dr. Ahmed Qasim Al-Anisi, Minister for Health, Yemen and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 04th July, 2013;

xv. Separate bilateral meetings between Hon'ble HFM and his counterparts from Indonesia, Nepal & Maldives were held to discuss bilateral health issues at Nirman Bhawan on 11th September, 2013;

xvi. A meeting between H.E. Lyonpo Tandin Wangchuk, Minister for Health, Bhutan and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 13th September, 2013;

xvii. 6th meeting of the Joint Working Group (JWG) constituted under the MoU signed between India and Sweden on Health was held in New Delhi on 04th October, 2013;

xviii. 4th meeting of the South Asian Association for Regional Cooperation (SAARC) Technical Committee on Health and Population Activities was hosted by India for two days in New Delhi on 09th and 10th October, 2013;

xix. 1st meeting of the Joint Working Group (JWG) constituted under the MoU signed between India and Mozambique on Health was held in New Delhi on 25th October, 2013;

xx. 1st meeting of the Joint Working Group (JWG) constituted under the MoU signed between India and Kuwait on Medical Cooperation was held in Kuwait on 10-11 November, 2013.

xxi. A meeting between H.E. Ms. Nguyen Thi Kim Tien, Minister for Health, Vietnam and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 12th December, 2013.

xxii. A meeting between H.E. Ms. Edith I. Schippers, Minister for Health, Welfare & Sport of The Netherlands and Hon'ble Minister of Health & Family Welfare to discuss bilateral issues related to health sector was held in New Delhi on 30th January, 2014. This was followed by signing of a MoU between the Government of India and the Government of The Netherlands on cooperation in the field of healthcare and public health.

xxiii. A meeting between H.E. Ms. Margaret Hamburg, Commissioner of US Food & Drug Administration, USA and Hon'ble Minister of Health & Family Welfare to discuss various issues related to drug regulatory matters was held in New Delhi on 10th February, 2014.

xxiv. A meeting between H.E. Ms. Una O'Brien, Health Secretary of the United Kingdom and Secretary (H&FW) to discuss various issues associated with the identified areas of cooperation in the health sector was held in New Delhi on 24th February, 2014.

xxv. 1st meeting of the Joint Working Group (JWG) constituted under the MoU signed between India and Bangladesh on cooperation in the fields of Health & Medical Sciences was held in New Delhi on 26th February, 2014.

xxvi. Ministerial/Official bilateral meeting between India and Sri Lanka, Guinea, Congo, Japan & Venezuela were also held with a view to enhancing bilateral cooperation in the Health Sector during the year 2013-14.

12.10 PERMISSION FOR INTERNATIONAL CONFERENCES

In the year 2013-14, permissions were granted to 146 Organizations/Institutions for holding health related International Conferences in India.

Chapter 13

MEDICAL RELIEF AND SUPPLIES

13.1 CENTRAL GOVERNMENT HEALTH SCHEME (CGHS)

The Government of India (Allocation of Business) Rules, 1961 has entrusted the responsibility of providing medical care to the Central Government Servants, to the Department of Health and Family Welfare, Ministry of Health and Family Welfare. At Sr. No. 14 of the list of business allocated to the Department of Health and Family Welfare, it provides as under:-

"Concession of medical attendance and treatment for Central Government Servants other than (i) those in Railway Services (ii) those paid from Defence Service Estimates (iii) officers governed by the All India Services (Medical Attendance) Rules, 1954 and (iv) officers governed by the Medical Attendance Rules, 1956"

CGHS was constituted vide Ministry of Health's OM dated 1.5.1954. In accordance with para 6 of the said Office Memorandum, CGHS facilities are admissible to all the Central Government servants who are paid their salary/pension from the Civil Estimates of the Central Government.

Central Government Health Scheme (CGHS) is a health scheme for serving/retired Central Government employees and their families. The scheme was started in 1954 in Delhi. The scheme was intended to be only for serving Central Government employees who had difficulty in getting reimbursement on account of OPD medicines (today CGHS dispensaries are giving OPD medicines). The fact that there were not many private hospitals at that point of time was also one of the reasons for starting the scheme. This was not envisaged to be an all India scheme. In fact, the stretch of this scheme to 25 cities over the years has put a heavy strain on limited resources available for the purpose. The scheme was extended to Mumbai in 1963, Allahabad in 1969, Kanpur, Kolkata and Ranchi in 1972, Nagpur in 1973, Chennai in 1975, Patna, Bangaluru and Hyderabad in 1976, Meerut in 1977, Jaipur, Lucknow and Pune in 1978, Ahmedabad in 1979, Bhubaneshwar in 1988, Jabalpur in 1991, Guwahati & Thiruvananthapuram in 1996, Bhopal, Chandigarh and Shillong in 2002, Dehradun in 2005 and Jammu in 2007.

13.1.1 Facilities available under CGHS:

- OPD Treatment including issue of medicines,
- Specialist Consultation at Govt. Hospitals,
- Hospitalization at Government and Empanelled hospitals,
- Investigations at Government and Empanelled Diagnostic centres,
- Pensioners and other identified beneficiaries have facility for cashless treatment in empanelled hospitals and diagnostic centres,
- Reimbursement of expenses for treatment under emergency in Private unrecognized hospitals under emergency,
- Reimbursement of expenses incurred for purchase of hearing aid, artificial limbs, appliances etc.,
- Family Welfare & MCH Services and
- Medical consultation and dispensing of medicines in Ayurveda, Homeopathy, Unani and Siddha systems of medicine (AYUSH).

13.1.2 Eligibility for joining CGHS:

- All Central Govt. employees drawing their salary from Central Civil Estimates and their dependant family members residing in CGHS covered areas,
- Central Govt. Pensioners receiving pension from Central Civil Estimates and their eligible family members,
- Sitting and Ex-Members of Parliament,
- Ex-Governors & Lt. Governors,

- Freedom Fighters,
- Ex-Vice Presidents,
- Sitting and Retired judges of Supreme Court,
- Retired judges of High Courts,
- Employees and pensioners of certain autonomous /statutory bodies which have been extended CGHS facilities in Delhi,
- Journalists accredited with PIB (in Delhi),
- Delhi Police Personnel in Delhi only,
- Railway Board employees and
- Central Government servants who (through proper channel) got absorbed in Central Public Sector Undertakings/Statutory Bodies/Autonomous Bodies and are in receipt of pro-rata pension from Central Civil Estimates.

13.1.3 CGHS - Categories of Beneficiaries

CGHS has 11.12 lakh card holders with a beneficiary base of 35.88 lakh members. Detailed break-up of the current membership profile is given in the table below:

Category	Total Number in the Country (approx.)	Covered under CGHS	
		Card Holders	Beneficiaries (Card holders and their eligible dependants)
Serving	17 lakh	6,62,513	26,20,177
Pensioners	10 lakh	4,28,236	9,25,691
Freedom Fighters		12,286	19,051
MPs		784	2,437
Ex-MPs		2,232	6,143
Others (includes journalists, autonomous bodies and Family Permit cards)		5,598	14,465
Total	**27 lakh**	**11,11,649**	**35,87,964**

13.1.4 Subscription rates for CGHS membership

Revised monthly Contributions for availing CGHS facility (w.e.f. 01.06.2009): (After implementation of the Sixth Pay Commission's Report)

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

13.1.5 Entitlement of CGHS beneficiaries

CGHS beneficiaries access the same services from CGHS dispensaries irrespective of the subscription rates paid by them. However, for in-patient treatment, entitlement for ward accommodation is linked to their Basic pay in the Pay Band, as explained below:

[A] Entitlement of wards in private hospitals empanelled under CGHS:

S.N.	Ward Entitlement	Pay Drawn in Pay Band
1.	General Ward	Up to Rs. 13,950/-
2.	Semi Private Ward	Rs. 13,960/- to 19,530/-
3.	Private Ward	Rs. 19,540/- and above

[B] Pay Slab for determining the entitlement of accommodation in AIIMS, New Delhi

S.N.	Ward Entitlement	Pay (in the Pay Band) / Pension / family Pension drawn per month
1.	General Ward	Up to Rs. 19,540/-
2.	Private Ward	Rs. 19,540/- and above

13.1.6 Details of CGHS Hospitals/Wellness Centres according to different systems of medicine

CGHS has a large network of 254 Allopathic, 85 AYUSH dispensaries, 19 polyclinics, 73 labs, 19 dental clinics, 2 geriatric clinics and 4 hospitals. The details may be seen at **Appendix-I**.

In addition, CGHS has also taken over 19 Postal dispensaries w.e.f. 1st August, 2013 in 12 cities, where CGHS is in operation.

13.1.7 Empanelment of private hospitals and diagnostic centres under CGHS

As CGHS does not have adequate facilities to offer medical treatment to its beneficiaries in Government hospitals, it empanels private hospitals and diagnostic centers in all CGHS covered cities. For this purpose, tenders were floated calling for private hospitals and diagnostic centers interested in being empanelled under CGHS to offer their rates for various procedures/ tests, etc. Based on the rates quoted by the private hospitals and diagnostic centers, the lowest rates in respect of each procedure/test were offered to the private hospitals and diagnostic centers and the private hospitals and diagnostic/imaging centers which accepted the rates have been empanelled under CGHS in Delhi and all other CGHS cities in 2010. However, the numbers of private hospitals on the panel of CGHS were not found to be adequate at some places so with a view to empanel more hospitals under CGHS, Continuous Empanelment Scheme was introduced in some cities in 2010-11. The Scheme was revived on 14th February 2013 for empanelment of more hospitals in all CGHS cities. A large number of new hospitals have since joined CGHS under this Scheme. Details about the number of private hospitals and diagnostic centres empanelled under CGHS in different cities may be seen at **Appendix- II**.

13.1.8 Expenditure on CGHS

The details of year wise expenditure on CGHS since 2007-08 are as:

(Rs. in crore)

S. No.	Year	PORB	CGHS	Total Expenditure
1.	2007-08	438.45	464.86	903.31
2.	2008-09	500.00	533.20	1033.20
3.	2009-10	449.74	666.90	1116.64
4.	2010-11	645.49	669.05	1314.54
5.	2011-12	837.93	731.45	1569.38
6.	2012-13	865.87	752.23	1618.10

13.1.9 Medical facilities for the central government employees and pensioners not covered under the CGHS

The medical needs of serving central government employees living in non-CGHS areas are presently met under Central Services (Medical Attendance) Rules [CS(MA) Rules]. Under this scheme, such serving employees receive both OPD treatment and IPD treatment through government (State/Central Government) doctors and government hospitals and also through private doctors appointed as Authorized Medical Attendants (AMAs) and private hospitals empanelled under CS(MA) Rules and also those empanelled under CGHS in cities wherever available. There are about 160 such private hospitals empanelled under CS (MA) Rules throughout the country. CS (MA) Rules are applicable to all serving employees except in the 25 cities where CGHS is in operation.

Pensioners are not covered under CS (MA) Rules. Pensioners staying in non-CGHS areas are entitled to a fixed medical allowance (FMA) of Rs. 300 per month. Such pensioners, however, have the option to become a member of the CGHS in the nearest CGHS covered city of his choice.

13.1.10 Facilities to CGHS beneficiaries residing in Non-CGHS covered areas

Pensioners, who are eligible for availing CGHS benefits and living in Non-CGHS covered areas have the option to obtain a CGHS card from a nearby CGHS covered city.

In view of the difficulties faced by such CGHS beneficiaries living in non-CGHS covered areas, they

have been permitted to obtain in-patient /hospitalization treatment and follow up treatment from CS(MA) approved hospitals and ECHS (Ex-Servicemen Contributory Health Scheme) empanelled hospitals (in addition to the government hospitals) and claim the reimbursement at CGHS rates from the AD/JD of CGHS city, where his CGHS card is registered.

13.1.11 Issue of medicines prescribed by specialists

CGHS maintains a formulary of drugs. If the dispensary has in its stock medicines prescribed by the specialist, then the same is issued to the beneficiary. If, however, the medicine with the same active salt ingredient but of different firm is available in the stock, then that medicine is issued to the beneficiary. If, however, the medicine prescribed by the beneficiary is not available in the dispensary then the dispensary places an indent on the authorized local chemist for the supply of the same and on receipt of the medicines from the chemist, the same is issued to the beneficiary.

13.1.12 Filling up of vacancies of Medical Officers on contract basis

CGHS was finding it difficult to fill up the vacancies of medical officers as the majority of the doctors recommended by the Union Public Service Commission did not assume charge in the CGHS for various reasons. To overcome the problem of unfilled vacancies, it has been decided to appoint, on contract basis, doctors who had retired from Government service. As a result of this decision, many retired allopathic doctors, Ayurvedic doctors and Homeopathic doctors are serving CGHS on short term contract basis. To further expedite the process, Powers have also been delegated to field level Committees headed by Additional Director, CGHS of the concerned cities to engage retired Govt. PSU doctors on short term contract basis on lump sum monthly remuneration. Necessary steps have also been taken to fill up the vacant posts of doctors on regular basis through UPSC.

13.1.13 Provision for Cancer treatment

For providing better cancer treatment facilities to CGHS beneficiaries, 20 private hospitals have been empanelled under CGHS exclusively for Cancer treatment as per the rates of Tata Memorial Hospital for Cancer Surgery.

In addition, provision already exists (since September 2009) that CGHS beneficiaries can avail cancer treatment at approved rates from any hospital, where facilities for cancer treatment are available. Cancer treatment can also be obtained from any Government/Regional Cancer Hospital.

13.1.14 Steps taken to improve the functioning of CGHS

a) Taking over of Postal Dispensaries by CGHS in 12 cities

In pursuance of the recommendation of 6th CPC, CGHS has taken over the 19 dispensaries of Department of Posts in the 12 cities where CGHS is in operation w.e.f. 01.08.2013. These cities are Ahmadabad, Bhopal, Bhubaneswar, Dehradun, Guwahati, Jammu, Jabalpur, Jaipur, Lucknow, Pune, Ranchi and Shillong.

b) Change in timings of CGHS Wellness Centres

With a view to further improve the services of CGHS dispensaries and ensure optimum utilisation of scarce manpower resources, the working hours of the CGHS dispensaries have been revised across the country. The new timings are 8.00 AM to 3.00 PM with 30 minutes of lunch break from 1:00 to 1:30 PM.

c) Installation of Biometric devices in CGHS Wellness Centres

With a view to enforce punctuality in attendance of the doctors and staff in the CGHS Wellness Centres and other administrative offices of CGHS, it has been decided to install biometric attendance recorder devices to record their attendance. Biometric devices have already been installed in 74 Wellness Centres in Delhi NCR. Instructions have been issued to install such devices at the remaining places also.

d) Inspection of Hospitals and Diagnostic Centres

With a view to ensure quality healthcare service delivery to the CGHS beneficiaries and also to check unfair trade practices by CGHS empanelled private hospitals and diagnostic centres, inspection of hospitals and diagnostic centres are carried out by an Inspection team constituted under Additional Director (HQ), CGHS, Delhi. Instructions have also been issued to Additional Directors

of other cities for undertaking similar exercise to ensure proper service delivery by the empanelled private hospitals to the CGHS beneficiaries.

e) FAQ, Helpdesk and Helpline

FAQs on CGHS have been updated and improved with additional FAQs. A CGHS Helpdesk has been set up in Delhi from 8.00 AM to 8.00 PM and it has been receiving queries from beneficiaries on various subjects mainly regarding facilities under CGHS. A 'Flying Squad' has recently been set up for surprise visits of Wellness Centres.

In addition, CGHS Help Line (No. 155224) is in operation between 9.30 A.M. to 5.30 P.M. There is also an E-Mail Help Line- cghs@nic.in to provide the desired information to beneficiaries.

f) Guidelines & ceiling rates for Liver Transplantation surgery of beneficiaries under CGHS and CS (MA) Rules, 1944

In view of the growing number of cases, this Ministry has issued fresh guidelines and ceiling rates for granting permission and reimbursement for Liver Transplant Surgery. Now, liver transplant surgery shall be allowed only in Government Hospitals/Pvt. Hospitals, which are registered under the Transplantation of Human Organs Act, 1994, as amended from time to time. Prior permission has to be obtained to undergo the Liver Transplantation surgery. In case of emergency/ex-post facto approval cases, it will be referred to a Standing Committee.

g) Permanently disabled dependent brother of CGHS beneficiary now eligible for CGHS facilities as dependent family member

Earlier, dependent brother(s) of a Central Government employee were entitled for CGHS coverage upto the age of becoming a major. Now, on receipt of several requests from CGHS beneficiaries to relax the upper age-limit in the case of a disabled dependent brother, it has been decided to extend the CGHS facilities to a permanently disabled dependent brother, without any age-limit. Provided he suffers from any one or more of the disabilities as defined in Section 2(i) of "The persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (No.1 of 1996 and as per Clause (j) of Section 2 of National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental retardation and Multiple Disabilities Act, 1999 (No.44 of 1999). 'Permanent disability' means a person with 40% or more of one or more disabilities.

h) Bariatric surgery procedures under CGHS/CS (MA) Rules, 1944

Earlier, beneficiaries' requests for 'Bariatric Surgery' procedures were considered on merits of each case as no guidelines were in place for this procedure. Keeping in view the increasing number of such cases, guidelines for examining such cases and ceiling rates for Bariatric Surgery in respect of CGHS/CS(MA), Rules 1944 beneficiaries/patients with 'morbid obesity' have been notified.

13.1.15 Other major initiatives taken in CGHS

a) Requirement of prior permission for diagnostic tests - dispensed with

The Ministry had been receiving suggestions from various quarters for doing away with the requirement of prior permission from the CMO in charge of the dispensary in case of pensioner beneficiary and the Department in case of serving beneficiaries of CGHS in view of hardship being faced by them in obtaining the same. Accordingly, with a view to facilitate the CGHS beneficiaries in getting the prescribed tests carried out timely and start the medical treatment early, the Ministry decided to dispense with the requirement of prior permission for undertaking the listed diagnostic tests on the prescription of a CGHS doctor/Government specialist. This decision to liberalise the procedures has helped the beneficiaries in getting the requisite treatment timely and conveniently. It has also reduced the workload of dispensary and the doctors can now serve the beneficiaries more efficiently. It has come into effect from 1st January, 2013.

b) Introduction of 'SMS-Alert' system to check misuse of CGHS cards and pilferage of medicines

With a view to exercise an effective check on misuse of CGHS cards and pilferage of medicines from the CGHS

Wellness Centres, an 'SMS-Alert' system has been introduced. Under this system, whenever a CGHS card is used for issue of medicines from the CGHS dispensary, a system generated message is sent to the CGHS beneficiary indicating that he has been issued medicines from the CGHS dispensary. It alerts a CGHS beneficiary and provides a check on unauthorised use of a CGHS card by any other person and helps in checking pilferage of medicines.

c) Opening of new dispensaries

CGHS has since opened new dispensaries at SaritaVihar, Vasant Kunj, Greater Noida, Rohini Sector-16, Gurgaon, Noida Sector 82 and Sahibabad on 23rd November 2012, 30th November 2012, 12th December 2012, 14th December 2012, 14th December 2012, 26th March 2013 and 8th April 2013 respectively. All the newly opened CGHS Wellness Centres have since become functional. In addition, Ashok Vihar CGHS Wellness Centre has moved to its own newly constructed dispensary building. Construction activities at two other places namely, Yamuna Vihar and Mayur Vihar-I has also commenced. For other places in Delhi NCR where CGHS has its own land, actions are underway to get the necessary approval so that construction work can begin early.

d) Issue of CGHS Cards

The system of preparation of CGHS cards and its delivery to the beneficiaries concerned has since been reviewed and CGHS has taken the responsibility of sending the cards to beneficiaries either by post or through courier. The situation has improved significantly and the pendency has been brought to zero. The beneficiaries are now getting timely delivery of CGHS cards at their home by Speed Post. This, also in a way, acts as a verification of the address of beneficiaries. Complaints of delay in card making have come down drastically. Beneficiaries are now getting their CGHS cards within two weeks, which earlier used to take few months. CGHS plastic cards are now being issued in all other CGHS cites also.

e) Promoting generic medicines

Instructions have been issued to promote use of generic medicines in CGHS. The Government doctors and specialists have been instructed to prescribe medicines from CGHS formulary and only in rare cases they should prescribe branded medicines with adequate justification for the same.

f) Distribution of Life Saving drugs from the CGHS Wellness Centres in the NCR locations of Noida, Gurgaon, and Faridabad.

The patients suffering from chronic diseases like cancer etc. require costlier medicines for treatment. These were supplied against indents placed through MSD, Gole Market and the medicines were to be collected from the MSD, the following day by the patient or his family member. Arrangements have now been made for distribution of the Life Saving drugs/MSD items at the dispensary level in NCR locations outside Delhi. The system has since become functional in Noida, Gurgaon and Faridabad.

g) Cashless Facility for the pensioner beneficiaries at AIIMS and other Central Government Hospitals namely, Dr. RML Hospital, Safdarjung Hospital and Lady Harding Hospital in New Delhi.

For the benefit of the CGHS pensioner beneficiaries, it has been decided to provide cashless facility to them and their eligible family members in the above mentioned Central Government Hospitals in New Delhi.

h) Delegation of Power for appointing retired Govt. doctors

CGHS has been facing shortage of doctors at several places. To provide its services to the beneficiaries, CGHS has been appointing retired Government doctors on contract basis to bridge the gap between the requirement and availability of regular doctors. The powers for appointing retired Government doctors have now been delegated to the Additional Directors, CGHS of the cities to expedite the process of appointment.

i) Computerization: To keep pace with the modern times, computerisation of CGHS has been completed in all allopathic dispensaries in collaboration with the National Informatics Centre. Computerisation has brought about the following improvements in functioning of CGHS:

- CGHS Wellness Centers have become more user friendly;
- Indented medicines are available next day as against 3-4 days earlier. Penalties are imposed for late supply of medicines by authorised local chemists;
- Better inventory management at WCs and CGHS(MSD);
- Online indents to CGHS(MSD);
- Procurement in bulk of commonly prescribed medicines at competitive rates based on data of consumption of medicines, resulting in ready availably of medicines to beneficiaries at dispensaries and lesser dependence on local purchase;
- Access to collect medicines from any Wellness Centre;
- Easy access to medical records of beneficiaries;
- Computerization of AYUSH Wellness Centres/ Units/Medical Store in Delhi & NCR have also been completed to a large extent and
- **Option to avail CGHS facilities from any CGHS wellness centre:** As a result of computerization and online connectivity of all CGHS Wellness Centres in India, CGHS beneficiaries are now able to avail CGHS benefits from any Wellness Centre across the country.

j) Health Check-up of CGHS Beneficiaries above 40 years in Delhi

A pilot project was introduced in 2 Wellness Centres, namely, Sector 8 and Sector 12 in Ramakrishna Puram, New Delhi for the Preventive Health Check-up of the beneficiaries above the age of 40 years in Delhi. The same has been extended to eight dispensaries in Delhi & NCR (two in each zone).

30 beneficiaries per day are registered in advance - online and undergo a list of identified investigations. Beneficiaries undergo a clinical check up on the date of appointment along with investigation report and the doctor prescribes the required medication wherever required alongside counseling about healthy lifestyle to keep himself/herself fit and healthy. The health check is proposed to identify risk factors including lifestyle related diseases for prevention/early identification for further follow-up and treatment, if required.

k) Out Sourcing of Dental Services

Dental services in 13 dispensaries in Delhi have so far been outsourced to a private service provider.

l) Outsourcing of sanitation services in dispensaries

In view of a shortage of Class IV Staff in a large number of dispensaries in Delhi, cleaning work with mechanised system has been outsourced to a private agency. This has improved the sanitation in the CGHS Wellness Centres.

m) Appointment of Authorized Local Chemists (ALC)

To facilitate easy and faster availability of medicines which do not figure in the Formulary, Authorised Local Chemists have been appointed, through tender system for procurement of non-formulary medicines prescribed by specialists requiring to be indented.

All dispensaries in Delhi and ALCs have been linked in the network and all indents are raised online, where ALCs are required to supply indented medicines the next day.

n) Minor Children of Widowed /Separated / Divorced daughters now eligible for the purpose of CGHS facilities as dependent member of family

Based on the recommendation of the 6th Central Pay Commission, the definition of 'family' has been expanded under Central Government Health Scheme (CGHS) to include minor children of widowed/separated daughters who are dependent upon the CGHS beneficiary. The upper-age limit of the dependents for the purpose of being eligible for CGHS medical facilities will be 18 years, the age of their becoming major and they should be normally residing with the Government servant/ pensioner.

Appendix-I

Statement showing the details of CGHS Hospitals / Wellness Centres according to different Systems of Medicine

Sr. No.	City	State	CGHS Hospitals	CGHS Wellness Centres						
				Allopathy	Ayurvedic	Homeopathy	Unani	Siddha	Yoga	Total
1	Ahmadabad	Gujrat		5	1	1	0	0	0	7
2	Allahabad	Uttar Pradesh		7	1	1	0	0	0	9
3	Banglore	Karnataka		10	2	1	1	0	0	14
4	Bhopal	Madhya Pradesh		1	0	0	0	0	0	1
5	Bhubaneswar	Odisha		2	1	0	0	0	0	3
6	Chandigarh			1	0	0	0	0	0	1
7	Chennai	Tamil Nadu		14	1	1	0	2	0	18
8	Dehradun	Uttarakhand		1	0	0	0	0	0	1
9	Delhi		4	94	13	13	5	1	4	128
10	Guwahati	Assam		3	0	1	0	0	0	4
11	Hyderabad	Andhra Pradesh		13	2	2	2	0	0	19
12	Jabalpur	Madhya Pradesh		3	0	0	0	0	0	3
13	Jaipur	Rajasthan		5	1	1	0	0	0	7
14	Jammu	Jammu & Kashmir		1	0	0	0	0	0	1
15	Kanpur	Uttar Pradesh		9	1	2	0	0	0	12
16	Kolkata	West Bengal		18	1	2	1	0	0	22
17	Lucknow	Uttar Pradesh		6	1	1	1	0	0	9
18	Meerut			6	1	1	0	0	0	8
19	Mumbai	Maharashtra		26	2	3	0	0	0	31
20	Nagpur			11	2	1	0	0	0	14
21	Patna	Bihar		5	1	1	0	0	0	7
22	Pune	Maharashtra		7	1	2	0	0	0	10
23	Ranchi	Jharkhand		2	0	0	0	0	0	2
24	Shillong	Meghalaya		1	0	0	0	0	0	1
25	Thiruvanthpuram	Kerala		3	1	1	0	0	0	5
	Total		**4**	**254**	**33**	**35**	**10**	**3**	**4**	**339**

Note: In addition, CGHS has also taken over 19 Postal dispensaries w.e.f. 1st August, 2013 in 12 cities, where CGHS is in operation.

Appendix-II

Number of CGHS empanelled private hospitals and diagnostic centres - Citywise									
Sr. No.	Name of the CGHS city	Hospitals			Total	Eye Care Centre	Dental Clinics	Diagnostic Centres	Exclusive Cancer Hospitals
		Super-Specialty	General Purpose	Specialty Hospital					
1.	Ahmadabad	2	3	3	8	2	1	1	-
2.	Allahabad	-	5	5	10	1	1	3	
3.	Bangalore	4	6	3	13	5	6	1	
4.	Bhopal	-	6	1	7	2	-	2	2
5.	Bhubaneshwar	-	4	-	4	-	-	-	-
6.	Chandigarh	1	3	3	7	3	-	4	-
7.	Chennai	1	5	2	8	5	1	2	-
8.	Delhi	11	88	7	106	90	33	53	11
9.	Dehradun	-	3	-	3	3	-	3	-
10.	Guwahati	-	2	-	2	-	-	5	-
11.	Hyderabad	6	23	12	41	6	3	10	2
12.	Jaipur	1	9	7	17	6	4	4	1
13.	Jabalpur	-	14	4	18	5	7	6	1
14.	Jammu	-	-	-	-	-	-	-	-
15.	Kanpur	-	29	-	29	8	1	6	1
16.	Kolkata	1	3	5	9	3	2	5	-
17.	Lucknow	-	7	3	10	6	5	9	1
18.	Meerut	5	7	5	17	5	2	5	-
19.	Mumbai	-	12	3	15	8	2	5	-
20.	Nagpur	-	5	12	17	10	1	5	-
21.	Pune	-	18	16	34	7	1	4	-
22.	Patna	-	1	3	4	3	2	4	1
23.	Ranchi	-	1	1	2	-	-	-	-
24.	Shillong	-	-	-	-	-	-	-	-
25.	Trivandrum	-	1	-	1	1	-	-	-
	Total	**32**	**255**	**95**	**382**	**179**	**72**	**137**	**20**

13.2 HEALTH MINISTER'S DISCRETIONARY GRANT (HMDG)

Financial Assistance up to maximum of Rs. 1,00,000/- is available to the poor indigent patients from the Health Minister's Discretionary Grant to defray a part of the expenditure on Hospitalization/treatment in Government Hospitals in cases where free medical facilities are not available. The assistance is provided for treatment of life threatening diseases i.e. Heart, Cancer, Kidney, Brain-tumor etc. During the year 2013-14, financial assistance totaling Rs. 249.81 lakhs was given to 327 patients under Health Minister Discretionary Grant (HMDG).

13.3 RASHTRIYA AROGYA NIDHI (RAN)

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

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

In order to provide immediate financial assistance, to the extent of Rs. 1,00,000/- (Rs. One Lac) per case, to critically ill, poor patients who are living below poverty line (BPL) and undergoing treatment, the Medical Superintendent of Dr. Ram Manohar Lohia Hospital, New Delhi, Safdarjung Hospital, New Delhi, Lady Harding Medical College and Smt. Sucheta Kriplani Hospital, New Delhi, All India Institute of Medical Sciences, New Delhi, Post Graduate Institute Medical Education and Research (PGIMER), Chandigarh, Jawaharlal Institute of Post Graduate Medical Education & Research (JIPMER), Puducherry, National Institute of Mental Health and Neuro Sciences(NIMHANS), Bangalore, Chittaranjan National Cancer Institute (CNCI), Kolkata, Sanjay Gandhi Post Graduate Institute of Medical Sciences (SGPGIMS), Lucknow, Regional Institute of Medical Sciences (RIMS) , Imphal and North Eastern Indira Gandhi Regional Institute of Health & Medical Sciences (NEIGRIHMS), Shillong have been provided with a revolving fund of Rs. 10-40 lakhs. The financial assistance to the poor (BPL) patients up to Rs. 1.00 lakh is processed by the concerned Institute on whose disposal the revolving fund has been placed and all the institutes refer the cases to the RAN headquarter where the amount of financial assistance exceeds Rs. 1.00 lakh. The revolving fund is replenished after its utilization. For cases requiring financial assistance above the Rs. 1.00 lakh per case, the applications are processed in the Department of Health & Family Welfare through a Technical Committee headed by Special Director General, DGHS before being considered for approval by a duly constituted Managing Committee with Hon'ble Minister for Health & Family Welfare as the Chairman.

During the year 2013-14, financial assistance totaling Rs. 1263.71 lakh was given directly to 335 patients under Rashtriya Arogya Nidhi (Central fund) and further, the revolving fund of amount Rs. 330.00 lakh has also been given to the above hospitals/Institutes.

13.4 HEALTH MINISTER'S CANCER PATIENT FUND (HMCPF) WITHIN RASHTRIYA AROGYA NIDHI (RAN)

"Health Minister's Cancer Patient Fund "(HMCPF) within the Rashtriya Arogya Nidhi (RAN) has also been set up in 2009. In order to utilize the HMCPF, the revolving fund as under RAN, has been established in the various Regional Cancer Centres (RCCs). Such step would ensure and speed up financial assistance to needy cancer patients and would help to fulfil the objective of HMCPF. The financial assistance to the cancer patient up to Rs. 1.00 lakh would be processed by the concerned

Institutes/Hospitals at whose disposal; the revolving fund has been placed. Individual cases which require assistance more than Rs. 1.00 lakh but not exceeding Rs. 1.50 lakhis to be sent to the concerned State Illness Assistance Fund of the State/UT to which the applicant belongs or to this Ministry incase no such scheme is in existence in the respective State or the amount is more than Rs. 1.50 lakh. Initially 27 Regional Cancer Centres (RCCs) were proposed at whose disposal revolving fund of Rs. 10.00 lakh was placed (List of RCCs is at **Appendix-A**). An amount of Rs. 440 lakh was released to 16 Institutes during the year 2013-14.

Appendix-A

List of 27 Regional Cancer Centre and financial assistance provided to them from Health Minister's Cancer Patient Fund (HMCPF) within Rashtriya Arogya Nidhi (RAN)

Amount Released (Rs. in lakh)

Sl. No.	Name of Centres (27RCCs)	2013-14
1	Chittaranjan National Cancer Institute, Kolkata,	50
2	Kidwai Memorial Institute of Oncology, Bengaluru, Karnataka	40
3	Regional Cancer Institute (WIA), Adyar, Chennai, Tamil Nadu	30
4	Acharya Harihar Regional Cancer Centre, Cuttack, Odisha	--
5	Regional Cancer Control Society, Shimla, Himachal Pradesh	40
6	Cancer Hospital & Research Centre, Gwalior, Madhya Pradesh.	30
7	Indian Rotary Cancer Institute, (AIIMS), New Delhi.	--
8	RST Hospital & Research Centre, Nagpur, Maharashtra.	--
9	Pt.J N M Medical College, Raipur, Chhattisgarh	--
10	Post Graduate Institute of Medical Education & Research, Chandigarh	10
11	Sher-I Kashmir Institute of Medical Sciences, Soura, Srinagar.	10
12	Regional Institute of Medical Sciences, Manipur, Imphal.	--
13	Govt. Medical College & Associated Hospital, Bakshi Nagar, Jammu.	--
14	Regional Cancer Centre, Thiruvananthapuram Kerala	60
15	Gujarat Cancer Researach Institute, Ahmedabad, Gujarat	10
16	MNJ Institute of Oncology, Hyderabad, Andhra Pradesh.	--
17	Puducherry Regional Cancer Society, JIPMER, Puducherry	10
18	Dr. B.B. Cancer Institute, Guwahati, Assam.	30
19	Tata Memorial Hospital Mumbai, Maharashtra	20
20	Indira Gandhi Institute of Medical Sciences, Patna, Bihar	--
21	Acharya Tulsi Regional Cancer Trust & Research Institute Bikaner, Rajasthan	--
22	RCC, Pt. B.D.Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana.	10
23	Civl Hospital, Aizawl, Mizoram	20
24	Sanjay Gandhi Post Graduate Institute of Medical Science, Lucknow, Uttar Pradesh	--
25	Cancer Hospital Tripura, Agartala	40
26	Kamala Nehru Memorial Hospital, Allahabad, Uttar Pradesh.	30
27	Government Arignar Anna Memorial Cancer Hospital, Kancheepuram, Tamil Nadu	--
	Total	**440**

13.5 VARDHMAN MAHAVIR MEDICAL COLLEGE & SAFDARJANG HOSPITAL, NEW DELHI

Safdarjang Hospital was founded during the Second World War in 1942 as a base hospital for the allied forces. It was taken over by the Government of India Ministry of Health in 1954. Until the inception of All India Institute of Medical Science in 1956, Safdarjang Hospital was the only tertiary care hospital in South Delhi. Based on the needs and developments in medical care the hospital has been regularly upgrading its facilities from diagnostic and therapeutic angles in all the specialties. The hospital when started in 1942 had only 204 beds, which has now increased to 1531 beds. The hospital provides medical care to millions of citizens not only of Delhi but also the neighboring states free of cost. Safdarjang Hospital is a Central Government Hospital under the Ministry of Health & Family Welfare and is receives its budget from the Ministry. Safdarjang Hospital has a Medical College associated with it named Vardhman Mahavir Medical College.

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

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

Safdarjung Hospital, New Delhi

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

13.5.2 OPD Services: OPD Services are running in New OPD Building of VMMC & Safdarjang Hospital.

- Patients coming to OPD of Safdarjang Hospital find a congenial and helpful atmosphere. Various Public Friendly Facilities exist in the OPD Registration Area of the New OPD Building like the 'May I help You' Counter, Computerized Registration Counters, which are separately marked for Ladies, Gents, Senior Citizens and Physically Challenged. A special Counter for senior citizens, Physically handicapped patients and hospital staff was opened in Central Dispensary to avoid inconvenience to these patients and general hospital working. Additional Counter for Clinic patients was opened from the existing strength of Pharmacists in order to minimize waiting time of the patients.
- The hospital has an ever increasing attendance of 25,84,186 in the year 2012. To cater to this load and for convenience of the patients a new OPD Block was commissioned in August, 1992. All departments run their OPD in the new OPD block. There are several disciplines for which the OPD Services are provided daily. The OPD complex has a spacious registration hall with 18 registration windows. The OPD registration services have been computerized and the new system is functional since mid February 2005. The out-patient attendance for the last 6 years are as (Jan. to Dec.) :-

YEAR	OPD ATTENDANCE
2008	22,18,294
2009	23,13,585
2010	23,21,526
2011	23,22,152
2012	25,84,186
2013 till Oct.	20,62,648

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

The administrative requirements of the causality are taken care of by a Chief Medical Officer and Specialist (Nodal Officer) who are also posted in the causality from various departments by rotation. There is a 24 hour laboratory facility besides round the clock ECG, Ultrasound, X-ray & CT Scan services. The Department of Obst.& Gynecology and the burns have separate, independent causalities.

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

Department of Nephrology: The department of Nephrology offers an integrated and comprehensive service covering all aspects of renal disorders from the early phases of renal disease to patients presenting with end stage renal disease.

The various sub-specialty services include:

Clinical Nephrology:

- Diagnosis and treatment of glomerular diseases, hypertension, diabetic nephropathy, renal stone disease, urinary tract infections, acute kidney injury and chronic kidney disease.
- Nephrology ward has 13 beds for in-patient management of various renal diseases and more than 300 patients have been admitted for treatment since Junary 2013.
- Kidney biopsy are done free of cost for diagnosis and evaluation of renal diseases.
- Referral service for assisting in management of patients with renal dysfunction admitted in other specialties.

Hemodialysis facility:

- The dialysis unit is equipped with 11 dialysis machines and is providing hemodialysis facility for patients with AKI and CKD admitted to the hospital.
- Supportive therapy in patients admitted in other specialties for various diseases or interventions including SLED.
- More than 4000 dialysis have been done since January 2013.
- The department also provides facility for permacath insertion for patients requiring long term dialysis.

Plasmapheresis:

- Plasmapheresis is provided for indications for patients admitted in the hospital.
- Since January 2013, 32 patients have been taken up for plasmapheresis in our unit.
- Peritoneal Dialysis.
- The department is involved in placement of CAPD catheters, initiation of CAPD and follow up of patients on peritoneal dialysis.

Renal Transplantation Service:

- The department of nephrology and urology have initiated Renal Transplant programme at Safdarjang Hospital.

- The first transplant has been conducted successfully on 8th October 2013.
- Facilities are provided for investigation and treatment of patients with transplant rejection and complications.
- Dedicated transplant OT and separate isolation room for post-transplant care available.

Research & Academics:

- Teaching of post graduate students from medicine department.
- Supervision of theses and research in the field of nephrology.

Nuclear Medicine Department:

- Latest Gamma Camera (SPECT/CT) & Thyroid Uptake probe have been installed in the department of Nuclear Medicine. These provides functional imaging & data of various organs of human body.
- 131- Radioiodine (Low dose) Therapy.
- This department is duly approved by the Atomic Energy Regulatory Board (AERB), Department of Atomic Energy. Government of India to carry out Nuclear Medicine procedures.

Total no. of Operation Conducted

Total No. of In-Patients admitted and operations conducted in this hospital for the last 6 years is as under (**Jan. to Dec.**):

OPERATIONS

Years	Admission	Major	Minor	Total
2007	118923	19638	61874	81485
2008	129271	21604	69640	91244
2009	128175	23354	69091	92445
2010	125192	23096	70544	93650
2011	129349	24197	72469	96666
2012	140818	27882	91554	119436
2013	108023	17522	48254	65776

Delivery: The total number of deliveries conducted in the Department of Obst. & Gyane. during the year 2012 till September 25439.

Lab. Examination & X-ray

	2008	2009	2010	2011	2012	2013 (till Sept.)
Lab. Examination	3354439	3698191	4239160	3560900	5558335	4182667
X-ray Examination	230530	248211	256432	282865	299006	233396

13.5.4 HMIS

The server room has been coordinating with the C-DAC team for preparation of the DPR relating to implementation of HMIS to all sections of the hospital and medical college. There would also be an effort to include college activities i.e teaching & research and administrative sections in the HMIS to ensure rapid and smooth dissemination & retrieval of data relating to all aspects of patient care, administrative and teaching activities. Once the DPR is ready its implementation could taken up at the earliest.

13.5.5 Website

In order to make the hospital website friendlier for the differently abled persons (level A of WCAG 2.0) as per the current Govt. of India guidelines, the website is being redesigned. The process has been initiated and implemented with the guidance of NIC. The backend work and preparation of SRS is under process and the new website is expected to be launched in the next three months.

13.5.6 Tenders

As per the instructions of the ministry, tenders pertaining to procurement of items through the General & Medical stores which were uploaded on the hospital website in the past is being uploaded on the CPPP site (Central Public Procurement Portal: e-publish) www.eprocure.gov.in and display of tender id is uploaded on the hospital website-www.vmmc-sjh.nic.in. This was done with the intent for wider dissemination of the tender and greater transparency. Process to start (e-tender) where in all tendering process would be carried out online through

the CPPP portal has been started. The hospital is in constant touch with the NIC for early activation/ implementation of the e-procurement process.

13.5.7 Internet Services

It has been decided that the 1 GBPS internet connection from the National Knowledge Commission Network will be used for providing internet services for furthering research work at Departmental levels. This would also replace the current services being provided through fixed modems. It would also be used for providing internet services to the Central Government Heath Scheme Unit located in the hospital thereby connecting the unit to the CGHS headquarters and Dispensaries.

13.5.8 Digitization of MRD

The MRD has in co-ordination with the server room has initiated the process for digitization of old MRD records. The process once initiated would help in better record keeping (in digital format) and allow rapid retrieval of data as and when required. The data thus generated would subsequently be integrated with the hospital HMIS to enable safe keeping and retrieval for administrative and research purposes.

13.5.9 Training and Teaching

Teaching of Post-graduate Degree & Diploma to the students enrolled through GGSIP University are conducted in the Departments of Medicine, Surgery, Orthopedics, Obst. & Gynae., Pediatrics, Anesthesia, Radio-Diagnosis, Radiotherapy, Ophthalmology, ENT, Dermatology, PMR, Physiology, Anatomy, Community Medicine, Microbiology, Biochemistry, Pathology, Pharmacology is undertaken.

Compursary Hours Tranining to the Dietetics Degree/ Diploma holder, Pharmacy Diploma holder Pre-hospital trauma Technician course and Medical Record Technician Training course (MRT) and Medical Record Officer course O.T. Assistants training course and short term laboratory training programs for all MLT are being conducted regularly.

13.5.10 Research Activities

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

New works carried out by CPWD in Safdarjang Hospital in year 2013-14 (Completed or Ongoing)

- Renovation of Burns & Plastic surgery operation theatre.
- Creation a new Burns & Plastic OPD, to decongest the current one.
- Creation of New Seminar Room for Eye & ENT, in open area in front of Eye OPD.
- Renovation of Orthopedics OPD with false ceiling & central air conditioning.
- Renovation of office of Director CIO.
- Development of 6 Beded HDU in Orthopedics (Ward 27,28,29) Medicine (Ward 11,12,13)and Gynae (ward 3) Departments)
- Renovation of Laundary department
- Expansion of Emergency and Family Planning OT's in Obs. & Gynae. Dept.
- Renovation of ward 7 Gynae. block.
- Creation of new ART center in Old Admin. Block.
- Creation of new psychiatry ward in old Admin. Block.
- Installation of RO system in all Resident Doctors Duty Rooms.
- Central Air Conditioning in Ward 27, and Ward 17.
- Central Air Conditioning facilities at NOTTO (ICMR 4th & 5th floor).
- Augmentation of existing 11 KVA Substation & provision of DG sets for NOTTO (4th & 5th floor bldg.)
- Up gradation & additional wiring work in 1000 lines EPBAX at Safdarjang Hospital.
- Provided energy efficient fixtures in various locations like blood bank, MRD, MRTC, Streets, etc.
- New Parking facilities for Residents Doctors.
- Renovation of Medical Record Department.

- Organ Retrieval O.T. adjacent casualty, completed.
- Renovation in Radiology, Doctor Hostel Cafeteria, Urology etc.
- Miscellaneous repair work at incinerator plant at SJH, New Delhi.
- P/F False ceiling making A.H.U & other misc work in Ortho OPD at SJH, New Delhi.
- Replacement of existing defective centrifugal chiller with 220 TR capacity screw type chiller in burn ward.
- Replacement of existing outlived control panel of main OT AC plant at SJH.
- Repairing/Replacement of defective fire alarm accessories i/c panel in OPD Phase-III MBBS Boys Hostel & H Block Extn. At SJH.

New Initiatives

- Additional floor for PMR department with augmentation of facilities at the cost of Rs. 4.5 crores.
- Starting of Super Specialty Block (with 430+125 ICU beds), state of art private block (20+26 ICU Beds), Emergency Block (500 Beds) by project consultant HSCC (I) Ltd. with ground breaking in Nov. 2013.

Expenditure Statement in Respect of Safdarjang Hospital, VMMC & SIC

Rs. in crores

Component with Head		B.E. 2013-14	EXPR.	% w.r.t. B.E. 2013-14	Balance Budget	Remarks
Capital	4210SJH* MACH & Equip	40.00	16.34	40.85	23.66	L.C. Opened Rs. 7.08 crore, mach. & Equip. Expr. Rs. 8.48 crore, 10% L.C. Rs. 0.78 crore.
Capital	4210SJH* MAJOR WORKS	100.00	18.64	18.64	81.36	Placement to CPWD Elect. Rs.11.14 crore & Civil Rs. 2.24 crore Advance Payment for HSCC Rs. 5.25 crore.
Capital	4216 HOUSING	10.00	1.53	15.30	8.47	Placement to CPWD Civil Rs. 0.98 crore & H.S.C.C. Advance Rs. 0.55 crore.
Revenue	2210 SJH	180.00	80.23	44.57	99.77	Placement to CPWD Elect. Rs. 0.65 crore.
Revenue	2210 VMMC	9.50	6.24	65.68	3.26	
	Grand Total	**339.50**	**122.98**	**37.01**	**216.52**	

Non Plan

Rs. in crores

Component with Head		B.E. 2013-14	Expr.	% w.r.t. B.E. 2013-14	BALANCE BUDGET	Remarks
Revenue	2210SJH	235.64	177.48	75.32	58.16	

SPORTS INJURY CENTER (PLAN 2413) PLAN

Rs. in crores

Component with Head		B.E. 2013-14	Expr.	% w.r.t. B.E. 2013-14	BALANCE BUDGET	Remarks
Revenue	SIC 2413	10.00	6.73	67.30	3.27	

13.5.11 Library

The library of VMMC & Safdarjung Hospital is a three storied building having a total areas of 2700 sq. feet. The ground floor of the library building houses reading room which is open round the clock for the students & faculty of the college & hospital. On the 1st and 2nd floor is the main library which has a huge collection of approx 16654 books covering all subjects of medical education, nursing and laboratory technicians.

The library procures 126 journals (95 International and 31 Indian) and has collection of journals for more than 47 years. The study materials of the library are protected by tattle tape electromagnet strips. The library has 3 M's security system and has CCTV surveillance.

Library also provides the facility of photocopy, internet and computer lab. The computer lab has 21 thin clients and provides access to ERMED consortium which provides access to approximately 2000 International and Indian journals.The issue return of the books is computerized. The library also provides the facility of Book Bank to economically weak medical students.

13.5.12 Telephone Exchange

The Telephone department is located in a double storey building near Gate No. 1 next to Dental surgery department. Ground floor of the building has an Operator room with console of Exchange and Administrative office. On the first floor is the EPABX Electronic Exchange with other Machinery and Equipments. It interconnects the various depts. of SJ Hospital and also to the medical college through telephonic services. One hundred lines for VMMC are operational for the benefit of many departments of VMMC. One Mini Intercom Exchange with capacity of 100 lines was made operational in causality in previous year so as to avoid any interruption in emergency Services due to power failure or any other circumstance.

Staff Strength as at the end March 2013

Group	Sanctioned	In Position	Vacant
GroupA	457	361	96
Group B Gazatted	65	35	30
Group B Non Gazatted	1489	1335	154
Group C	2200	1811	389
Resident Doctors/PGs	1396	1079	317
Interns	200	187	13
Total	**5807**	**4808**	**999**

13.6 DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI

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

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

The hospital is one of the most prestigious Government Hospitals not only because locational advantage but also

because of availability of expertise and super specialties. The Government of India has chosen this Hospital for NABH accreditation, an International hallmark for health care service provider, through the Quality Council of India (QCI). The accreditation application has already been made to QCI for undertaking inspection to get the accreditation and to become the first NABH accredited Central Government Hospital.The hospital annually provided health care services to approx. 16 lacs outdoor patients and admitted around 57000 indoor patients during the period from January to November 2013. About 2.5 lac patients were attended in the Emergency and Casualty Department annually. The hospital has round-the-clock emergency services and does not refuse any patient requiring emergency treatment irrespective of the fact that beds are available or not. All the services in the hospital are free of cost except Nursing Home treatment and some nominal charges for specialized tests.

13.6.1 The Services Available

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

Clinical Services

- Accident & Emergency Services, Anaesthesia Services, Dermatology, STD & Leprasy, Eye, ENT, Family Welfare, General Medicine, General Surgery, Gynecology & Obstetrics, Orthopedics, Pediatrics, Psychiatry, Physiotherapy, Physical Medicine and Rehabilitation, Dental.

Super Specialty Departments / Units

- Neuro-Surgery, Burns & Plastic Surgery, Cardiology, Cardio Thoracic & Vascular Surgery, Gastroenterology, Neurology, Pediatrics Surgery, Urology, Nephrology, Endocrinology.

Departmental Special Clinics

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

Paediatrics & Neonatology Specialty Clinics

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

Gynaecology & Obstetrics: Antenatal Clinic, Infertility Clinic

Skin: Leprosy Clinic, Leukoderma

Eye: I.O.L, Glaucoma, Retina

Psychiatry: Child Guidance Clinic, Drug De-addiction Clinic, Marriage Counseling, Psycho-Sexual Clinic, Geriatric Psychiatry Clinic

Yoga Centre for cardiac and other patients Unani OPD (Daily).Ayurveda clinic and Homeopathy clinic has been planned.

Blood Bank Services

Dental: Dental Fracture

Diagnostic Services

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

Support Services

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

13.6.2 Emergency & Trauma Care Services

This hospital has well- established Emergency services including round- the-clock services in Medicine, Surgery, Orthopedic and Pediatrics while other specialties are also available on call basis. All services like laboratory, X-Ray, CT-Scan, Ultra-sound, Blood Bank and Ambulances are available round the clock. A well-established Coronary Care Unit (CCU) and an Intensive Care Unit (ICU) exist in the hospital for serious Cardiac and Non-Cardiac patients. The hospital has a well laid down disaster action plan & disaster beds, which are made operational in case of mass casualties and disasters.

A Disaster Management Unit is also functioning in the Casualty Department to attend the serious patients with the desired care.

The Hospital has comprehensive trauma care facility with 74 beds at the Trauma Care Centre in readiness to shoulder the added responsibility of providing comprehensive & timely emergency medical care to victims of trauma in the event of any accidents occurring in Delhi especially in Lutyen's Delhi.

13.6.3 Sanitation & Environmental Concern in Hospital Campus

The hospital has given high importance to the sanitation and beautification of entire campus to create a nature friendly ambience. Under a Special Drive, remodeling of Plants, landscaping of Central Park Lawns, relaying of grass, creation of Artificial Water Falls with colorful lights & fountains and a beautiful Herbal Garden in the Nursing Home Block have been under taken to give a refreshing look to the visitors and the patients alike. Special sanitation drives are undertaken at regular intervals to ensure proper cleanliness and hygienic atmosphere in the hospital. The Hospital has been adjudged by the FICCI as the best Hospital under the enviourrnental concern category in 2010.

13.6.4 Resident Hostels for Doctors & Nurses

The hospital has provided accommodation to Resident Doctors as well as Nurses/Nursing students to improve the Health Care Services by ensuring their availability on duty in the campus at the time of requirement. There are 143 rooms in the Doctors Hostel and 100 rooms in the Nurses Hostel.

13.6.5 Benefits/Activity for person with disability

The Hospital has facilitated for setting up ramps and wheel chair service through porters for the person with disability.

13.6.6 Recent Achievements of the Hospital

The following are the latest additions of the patient care facilities in the hospital;

1. **Renal Transplant:** Renal Transplant has been started on live related donors and January to 19th November 13 twenty two renal transplant surgeries have been done.

2. **General Maternity Ward and Neonatal Ward in the Hospital:** Apart from Maternity services available to nursing home entitled, the hospital has done 961 general maternity cases from January '2013 to 19th Nov. 2013.

3. **College of Nursing:** The Hospital's School of Nursing was set up in 1963 with 25 students per year has been upgraded into College of Nursing with intake capacity of 50 students per year. The Construction work of the new campus of college has been completed and the teaching classes have been started in the New Campus in the year 2010.

4. **Dharamshala:** A Dharamshala for attendants of patients is under construction on one acre of land allotted to hospital near the Birla Mandir to help the attendants/relatives of the out-patients coming from different parts of the country.

5. **Computerization:** The computerization of centralized OPD Registration was started from 2005 to facilitate the outdoor patients to get their Registration done from any of the 20 Counters in the OPD Block. There are separate Registration Counters opened for Senior Citizens, physically handicapped persons and the staff. The computerization of Administration & Accounts and cash handling work has also been started for easy retrieval of information/record. NIC has undertaken the comprehensive e-Hospital Project with approved cost of 3.50 crores to cover all the activities under its umbrella. OPD registration & repeat visits, IPD registration & ward allotment, casualty registration, transfer and discharges under E-Hospital software have been implemented. e-Hospital implementation covers all aspects of patient care, Labs, Human Resources of the Hospital, Inventory Control System for the Hospital and IT induction. The online monitoring of lab tests has since been made operational.

6. **Construction of New Casualty Building:** In Order to provide state of the art Emergency Medical Care, a new Casualty Building is under construction with a provision of 280 beds. The estimated cost of the project is about Rs. 26 crores. It is likely to be commissioned shortly.

7. **Improvements in the Super Specialty Services:** The hospital has focused attention towards the

patient care and improved services. Many new and sophisticated types of equipments have been procured in the hospital to update the hospital services. In order to strengthen the super specialty services to the patients, the Hospital has planned to construct a new Multi-story Super Specialty Block on the land available at G- point, adjacent to Trauma Center which has been handed over to the Hospital by the Land and Development Office. This will considerably improve the patient care services and also reduce the waiting time for the patients. Several new disciplines are also planned to be aided in proposed new Super Specialty Block.

8. **Citizen Charter & Public Grievance Redressal:** The Hospital has adopted a Citizen Charter since 1998 and as per the directives of Hon'ble High Court of Delhi, Public Grievance Redressal Machinery has also been set up to inform the patients about the facilities available and also for redressal of their grievances, if any. There are 19 Complaint & Grievance Boxes placed at various strategic locations which are opened periodically and put up before a High Powered Committee headed by a Consultant & HOD & reviewed by a Designated Addl MS and also by the Medical Superintendent. The complainants are given an opportunity to speak in person to the CMO in charge and a written reply of the outcome of the complaint is also sent to the complainant. The Hospital is revising the Citizen Charter under the scheme "Sarvotam".

9. **Advance Trauma Life Support (ATLS) Training:** The Hospital started an intensive ATLS Training Programme for the Senior Doctors to train them on latest advancement in the Trauma life support systems. Ten batches, each with 16 trainees have since been conducted in the Hospital training centre equipped with latest equipments required for ATLS. In India this course is conducted only at Lok Nayak Jai Prakash Narayan, Apex Trauma Centre of AIIMS and at Trauma Care Centre of Dr. Ram Manohar Lohia Hospital.

10. **Distance Education Learning Programme:** The Hospital has started e-diploma course DHLS (Diploma in Hearing and Learning Speech) in association with All India Institute of Speech and Hearing (AIISH) Mysore in which 20 students are trained each year. Till now, the Hospital has conducted three courses.The Hospital has also started a PG Diploma in Hospital Administration (PGDHA) in collaboration with IGNOU on distance learning basis. This is one year diploma course in which 30 students are admitted. This is sixth (2013) course in a row.

11. **Super-specialty facilities at G-point:** Dr. Ram Manohar Lohia Hospital has been allotted an additional Land measuring 3.86 acres at G-point adjacent to the Hospital by L&DO. A plan has been drawn for creation of Super Specialty Building at this site. Detailed plan has been prepared in consultation with Central Design Bureau. The tentative cost of the project is Rs. 618 crore (Rs. 386 crores for civil work, Rs. 193 crores for equipments and Rs. 39 crores for project management consultancy). It is pertinent that this plan is an integral part of Redeveloped Plan of the Hospital.

12. **Post Graduate institute of Medical Research:** Post Graduate Institute of Medical Education and Research started functioning from the Academic year 2008-09 with an objective to provide post graduate teaching in the science of modern medicine and other allied sciences, including physical and biological sciences and also to facilitate research in the various branches of such Sciences. This Institute is presently affiliated to Guru Gobind Singh Indraprastha (GGSIP) University, Delhi. In the year 2008, the Government sanctioned a total of 28 PG Degree/ Diploma seats and 2 seats in Super-speciality courses. At present, it has 101 seats of PG Degree/ Diploma Courses and 28 seats for Super Speciality course. The number of seats have gradually enhanced on the recommendations of the High Powered Committee from the Directorate General of Health Services and in pursuance of the revised guidelines of Medical Council of India.

13. **Financial Allocations:-** The financial allocations made to the hospital during the last five financial years are given:

Year	Final Estimate (Figures in lakhs)	Expenditure (Figures in lakhs)
2008-2009		
Plan	8364.01	8400.26
Non Plan	9315.00	9313.47
2009-2010		
Plan	10030.00	10013.36
Non Plan	12741.00	12739.14
2010-2011		
Plan	11551.7	11557.35
Non Plan	12097.00	12081.95
2011-2012		
Plan	13508.00	13246.20
Non Plan	13248.60	13226.5
2012-2013		
Plan	18037.00	17224.42
Non Plan	14430.00	14429.74
2013-14		**Up to 12.11.2013**
Plan	24055	10183.82
Non Plan	16250	11345.08

13.7 INDIAN RED CROSS SOCIETY

The Indian Red Cross Society is the largest statutory, independent humanitarian organization in India. It has myriad activities aimed at assisting the needy and vulnerable. It has always been at the forefront to alleviate suffering at the time of any man made or natural disaster. A big family of 12 million volunteers and members and staff exceeding 3500, it reaches out to the community through 700 branches spread throughout the country to reduce vulnerability and empower the community for disaster response.

Annual General Meeting of the Indian Red Cross Society and St. John Ambulance (India) held on 3rd May 2013

The ceremonial session, held at Rashtrapati Bhavan Auditorium, New Delhi was presided over by Shri Pranab

Mukherjee, the Hon'ble President of India, (President of the Indian Red Cross Society and St John Ambulance, India).

The Hon'ble President presented awards to twenty six Indian Red Cross (IRCS) and St. John Association, India (SJA,I) members, volunteers, and branches in recognition of their committed services. Shri Pranab Mukherjee in his inspiring address called upon young men and women of the country to donate blood in a big way to ensure that not a single person in need of blood was left wanting.

13.7.1 Disaster Management

J&K Earthquake in Doda district: The Chairman of the Indian Red Cross Society, National Headquarters, Minister for Health & Family Welfare, flagged off relief supplies for the victims who had shifted out of their damaged houses and were sleeping out in the open. The supplies consisted of 1000 family tents and 2000 blankets. The total value of the supplies was Rs 1.50 crores.

Uttarakhand Flash Floods, June 2013: IRCS dispatched three large Water Purification Machines (NORIT) (each having a capacity to provide about 2000 litres of potable water per hour) that were installed in Uttarkashi, Guptkashi and Rudraprayag. Purified water was distributed to about 8000 families in these districts. Further, three manpack units (these are carried by volunteers and can provide 80 liters of potable water per

hour) were made operational in Phata, Pithoragarh and Kedarnath. The NHQ also despatched Non-food items like tents, family packs, stoves and solar lanterns to Uttarakhand state branch.

The high point of the Uttarakhand operations was the deployment of First Medical Responders (FMRs) in these areas. The IRCS had trained in more than 4000 FMRs in Uttarakhand as a pilot project.

Cyclone Phailin Response (Odisha and Andhra Pradesh): Cyclone Phailin hit many coastal districts in Odisha and Andhra Pradesh. This was followed by severe flooding of these areas due to incessant rains in the following week. The cyclone triggered one of the largest evacuation operations in Indian history when over 90,00,000 people were moved to higher grounds in the coastal state of Odisha. 1,10,400 people took shelter in the 75 IRCS multipurpose cyclone shelters. Infrastructure in the area such as electricity, water supply, roads and communication were damaged substantially. There was extensive damage to kuccha houses and crops.

In response to the needs NHQ released non-food relief material to Odisha & Andhra Pradesh that consisted of 6000 mosquito nets, 19000 tarpaulins, 9000 kitchen sets, 10000 family packs and other items. NOMAD water Purification Units had been installed at Kanas block of Puri District. NORIT, water purification unit has been installed at Ganja block in Ganjam district. Approximately 150,000 liters of water was distributed among the affected population in addition to distribution of NFI to remote villages. Hygiene promotion activities were carried out in the affected villages. The IRCS deployed National Disaster WatSan Response Teams in Odisha. The approximate cost of the items was INR.3,38,03,500/- along with deployment of experts for installation & operation of WatSan units.

Apart from the above relief activities like release of non-food family pack items containing saris, gents dhotis, mosquito nets, plastic buckets, tarpaulin sheets, blankets, towels and kitchen sets were undertaken during 2013-14 in the events of flood in Bihar, Madhya Pradesh, West Bengal, Gujarat, Karnataka and fire incident in Bihar.

AmarnathYatra: In response to the state branch request 30 family tents, 3000 woolen blankets, 10 collapsible stretchers and 50 nos. First Aid kits were released for providing comfort to the AmarnathYatris with an approximate cost of INR. 11, 50,000/-

13.7.2 Disaster Management (DM) Programme 2013

The DM programme is being implemented in by the Red Cross branches of fourteen disaster prone states. This year the programme focussed on the training of FMRs in the districts where the programme is being implemented. 1400 FMRs will be trained at the end of 2013. The budget for the programme is approximately INR 1. 86 crores.

13.7.3 Health

Blood Services & Blood Distribution: In the year 2013 (April-Oct.2013), IRCS, Blood Bank collected 19180 units of blood from 177 Blood Donation Camps, out of which 11309 units were collected from voluntary blood donors in and around Delhi. 23029 Blood/Blood components were issued out of which 19980 (87%) units of blood were issued free of cost to the patients admitted in Government Hospitals, Thalassaemic and Haemophillic patients and 3049 (13%) units of blood issued against processing charges to the patients admitted in Private Hospitals / Nursing Homes.

The Valedictory function of the World Blood Donor Week was observed on 21st of June 2013 at the National Headquarters to facilitate the regular blood donors who have donated blood at IRCS more than 75 times. Hon'ble Minister of Health and Family Welfare, Chairman of the IRCS honoured twelve regular blood donors and eight blood donation camp organisers who have regularly contributed to supply large number of blood units to the IRCS (NHQ) blood bank.

NABH- The IRCS (NHQ), Blood Bank has received certificate of accreditation of NABH which is valid from 1.6.2013 to 31.5.2016. The certificate of NABH was released by Hon'ble Chairman (Hon'ble Minister for Health & Family Welfare, Govt. of India) on 21st June, 2013.

TB Control Programme: Initially started in 3 states of Punjab, Uttar Pradesh and Karnataka in 2009 and Gujarat in 2010, the programme was extended to 7 states in 2013 with the addition of Odisha, Bihar and Haryana. The objective of the programme is to bring back to DOTS

treatment Cat II patients i.e. those who have dropped out of the initial DOTS treatment after identification of the same from the DOTS centres in the identified districts and provide care and nutritional support to them till they are cured. This reduces the risk of such patients from being converted to the more dangerous Multi drug resistant TB (MDR TB) patients. In addition the volunteers spread awareness among the family and the community about the disease as well as to reduce stigma and discrimination against these patients.

In 2013, 1180 patients, 4400 family members and about 33000 community members are being targeted. The programme is being implemented with the support of the Ministry of Health & Family Welfare, Government of India, State and district TB Officers and the TB Association of India. The approximate budget is INR 1.10 crores. The adherence rate in 2013 is reported as 96%.

Measles Catch Up Programme: The IRCS supported the Ministry of Health & Family Welfare, Government of India Measles Catch Up Programme in 2012- 13 in two states of Madhya Pradesh and Uttar Pradesh. Six districts of Madhya Pradesh and fourteen districts of Uttar Pradesh were taken up by the respective state branches. In the state of Madhya Pradesh the programme reached 4,94,797 beneficiaries through door to door and community advocacy programmes and 48314 children were assisted in receiving the Measles vaccine. In Uttar Pradesh 5, 55, 193 beneficiaries were reached.

13.7.4 Post Graduate Diploma Course in Disaster Preparedness and Rehabilitation (PG DP&R)

Indian Red Cross Society is working towards having a cadre of qualified trainers through Post Graduate Diploma Course in Disaster Preparedness and Rehabilitation (PG DP&R) at its National Headquarters which is affiliated to the GGSIP University since September 2006.

Seven Batches have successfully completed the course till the end of August 2013.

The classes for the eighth batch have started on 23rd September, 2013. The course participants include professionals from Medical Services, Defence, Rajya Sabha, Lok Sabha, DMRC, NDRF, BSNL, DoPT, NIDM, NBCC, and other Govt.officials as well as NGOs.

13.8 EMERGENCY MEDICAL RELIEF (EMR)

13.8.1 Health Sector Disaster Management

Emergency Medical Relief Division (EMR) of Directorate General of Health Services, Ministry of Health & Family Welfare (MoHFW) is mandated for prevention, preparedness, mitigation and response to disasters pertaining to health sector. For such purpose, EMR Division coordinates with National Disaster Management Authority, concerned Central Ministries/ Departments and the State Governments/UT Administrations.

13.8.2 Preparedness and Response for Disasters

a. **Preparedness for disasters:** Crisis Management Plan for Biological Disasters and the Emergency Support Function Plan were reviewed in 2013 and circulated to all concerned in July, 2013. It contains the emergency support functions assigned to the MoHFW which includes details of nodal officers for coordination, quick response for crisis management at Hqrs. and field level, resource inventory etc. This plan also contained instructions regarding deployment of resources in the event of disasters.

b. **Response:** Ministry of Health and Family Welfare was represented in the central assessment teams of the Ministry of Home Affairs that visited Uttarakhand (Flash Floods) for damage assessment. Relief was recommended in terms of norms under National Disaster Response Fund.

13.8.3 Uttarakhand Flash Floods

Action Taken by MoHFW

1. The Ministry was in constant touch with the State Government and had provided assistance including trained doctors, Public Health Specialists, Commodity assistance (medicines, consumables, body bags etc.), and technical assistance. While the Director General of Health Services along with the Additional Secretary visited the State and discussed relevant issues with the State Health Minister, Chief Secretary and the Principal Secretary (Health), a team comprising Director,

National Centre for Disease Control and Director, Emergency Medical Relief was stationed at Dehradun. The said team facilitated coordination, visited affected areas to provide guidance/technical assistance to the district authorities on medical and public health issues and was also available for advice/technical assistance to the Health Department of the State.

2. MoHFW deputed 80 doctors (40 specialists and 40 General Duty Medical Officers) to help the State in meeting the severe shortage of doctors. This strength was maintained till August, 2013, thereafter scaled down to 40 doctors in September, 2013 and 20 doctors in October, 2013.

3. Disease surveillance was strengthened to check outbreaks of water borne, air borne or food borne diseases. Six public health teams were in position in affected districts. For the Vector Borne Diseases, a Senior Officer from the National Vector Borne Disease Control Programme was deputed to assist the State.

4. National Institute of Mental Health and Neurosciences (NIMHANS) did psycho-social need assessment. Four teams for counselling and psychological assistance were sent to the State. Currently 12 Psycho social counsellors are in Rudraprayag and Chamoli doing Psycho-social care and support activities. Two faculty members from NIMHANS are carrying out training for PHC medical officers on mental health and disaster mental health. A proposal submitted by NIMHANS for strengthening District Mental Health Programme in affected districts is under consideration of National Mental Health Programme (NMHP).

5. As per request received from the State Government, the drugs/consumables sought (immediate requirement) were supplied from Dr. RML Hospital and Safdarjung Hospital. The request made by the State for 3 lakh ORS sachets, 2 crore Chlorine tablets and 100 MT bleaching powder were also met. In addition, the Indian Red Cross Society was also mobilized to send relevant relief material to the State. This included 6 (3 large and 3 small) water purification units.

6. The State Government has submitted a plan for various Health/Public Health activities under the National Rural Health Mission amounting to Rs. 115.88 crores. This is in addition to the envelope of Rs. 228.29 crores already approved in the NRHM State PIP for the year 2013-14. The Ministry has approved proposals for Rs. 26.95 crores and proposal for the remaining amount is under consideration.

13.8.4 Influenza A H1N1

The Pandemic Influenza virus continued to circulate as seasonal influenza virus. From January 2013 to 27th October 2013 there had been 5200 laboratory confirmed cases with 684 deaths. The states which reported sporadic outbreaks with large number of cases and deaths are Gujarat, Maharashtra, Haryana, Karnataka, Punjab, Madhya Pradesh, Rajasthan, Tamil Nadu, Uttar Pradesh, Andhra Pradesh and Chandigarh.

Government of India is continuing its effort initiated from 2009 to mitigate the impact of Influenza A H1N1. Surveillance to detect clusters of influenza like illness is being done through Integrated Disease Surveillance Project. Laboratory network, strengthened for the Pandemic continued to test for influenza A H1N1 virus. The diagnostic reagents were provided free of cost to the 28 laboratories under this network. Sufficient stock of Oseltamivir, the drug to treat Influenza, is being maintained by Ministry of Health. The affected States were provided Oseltamivir as per their requirement. In addition personal protective equipments, N-95 masks and surgical masks were also provided as per requirement of States. Central multi-disciplinary team was deputed to Maharashtra to assist the State Government in instituting mitigation measures.

13.8.5 Avian Influenza

Ministry of Health and Family Welfare, Government of India took adequate measures to contain the human cases of Avian Influenza if it is to happen. The Joint Monitoring Group under the chairmanship of DGHS reviewed the situation and preparedness measures regularly. Avian Influenza outbreaks were notified by Department of Animal Husbandry in Regional Poultry Farm, Lanka Tola, Madhubani, Purnea, Bihar and in the Poultry

Production Unit, College of Veterinary Sciences and Animal Husbandary, Durg and Government Poultry farm, Jagdalpur, Chhatisgarh. The contingency plan for containment was implemented in all these locations. Rapid Response teams from Ministry of Health assisted the concerned States in implementing the micro plan. States were provided logistic support in terms of Oseltamivir, Personal protective equipments and masks.

13.8.6 Outbreak Investigations

Central multi-disciplinary expert teams were deputed to investigate disease outbreaks in the State of Jammu & Kashmir (Anantnag for Hepatitis B & C), Rajasthan (seasonal influenza), Gujarat (Influenza A H1N1), Uttar Pradesh (Aonla, Distt. Bareilly for Cancer cases), Kerala (Febrile illness). Based on the recommendations of the Central Team, public health measures were instituted.

13.8.7 Medical Care Arrangements on Special Occasions

Medical care arrangements were organized by the Directorate General of Health Services for Republic Day and Independence Day celebrations. Medical care arrangements were made for the Heads of States of Bhutan, France, U.K., Egypt, People's Republic of China, Afghanistan, Iraq, Liberia, Hungary, Kuwait during their India visit. Medical care arrangements were also made for Conference of Governors, Asian Pacific Postal Union, 33rd Asia and Pacific Conference of Correctional Administrators.

13.8.8 Shri Amarnathji Yatra

Hon'ble Supreme Court in Writ Petition (Civil) No. 284 of 2012 titled "Court on its own motion Vs Union of India and Ors" vide order dated 20.07.2012 constituted a Special High Powered Committee (SHPC) to look into issues related to health, environment, access control, public amenities etc. during Shri Amarnathji Shrine pilgrimage. Based on the report of the SHPC, Ministry of Health & Family Welfare provided experts for devising the compulsory Health Certificate, conveyed to all States to identify Institutions and doctors for medical examiniation of the pilgrims. MoHFW facilitated identifying specialists and General Duty Medical Officers to augment the team of doctors being deployed by Government of J & K.

Further, Directorate General of Health Services developed a curriculum, held three training workshops in Srinagar, training doctors posted enroute Shri Amarnthji Yatra in higher altitude.

13.8.9 Phailin Cyclone in Odisha

Very High Cyclonic storm, named Phailin hit the coast of Andhra Pradesh and Odisha on 12 October, 2013. MoHFW activated its control room. Quick Response medical, surgical, public health and psychosocial teams were kept on standby for deployment on the request of the State Governments. Due to timely warning by IMD and evacuation of population from affected areas, the adverse public health impact was minimal. To mitigate impact of post cyclone floods in Odisha, MoHFW deputed Rapid Health Assessment teams to assess public health risks. The IDSP unit of Ganjam district was strengthened with public health experts from National Centre for Disease Control, Delhi and All India Institute of Hygiene and Public Health, Kolkata. On the request of Government of Odisha, MoHFW arranged supply of 50 lakh each of Paracetamol tablets, Metronidazole tablet and ORS sachets; 2 crore chlorine tablets, 25 Metric Bleaching Powder and 20000 vials of Anti Snake Venom.

13.9 E-HEALTH (TELEMEDICINE)

13.9.1 Brief Summary: First Indigenously Developed Hospital Information System Software by CDAC Noida at SGPGIMS, Lucknow, UP was deployed in 1996 and DeitY, MCIT, Govt. of India started a Pilot with Indigenous Development of Telemedicine Technology deployments at AIIMS, New Delhi, PGIMER Chandigarh & SGPGIMS, Lucknow in 1999 with First telemedicine network between three institutions AIIMS-New Delhi, PGI-Chandigarh & SGPGI-Lucknow from 1999-2000.

2003-2004 saw the Deployment of SATCOM based TM nodes across the country by ISRO for Tele-education and Tele-consultation services. A Task Force for Telemedicine was constituted in 2005 and in 2006, Planning Commission approved budget for e-Health including Telemedicine in the 11th Five Year Plan. School of Telemedicine & Biomedical Informatics (STBI) was set up at SGPGIMS, Lucknow by Govt. of U.P in 2006 and PHFI was awarded Grant-in-aid to have Ministry of

Health and Family Welfare "Healthy India" Website for Health Education from 2007-08 to 2012-2013.

In 2007 School of Telemedicine and Bio-informatics at SGPGIMS, Lucknow was made National Resource Centre for Telemedicine & Biomedical Informatics by DeitY, Govt. of India.

MoHFW, Govt. of India supported Tele-ophthalmology Project Onco-NET Project in many parts of the country and since 2009 many States are supported under NRHM for Initiatives under National Rural Telemedicine Network. In 2010 SGPGIMS, Lucknow was made National Resource Centre for Telemedicine by MoHFW and MoHFW launched MCTS wherein Pregnant mothers and Children upto the age 5 years are registered and tracked for various healthcare interventions.

Expert Group of MoHFW on EMR/EHR Standards was established and in 2013 after expert consultations the Standards have been notified by the Ministry. EFC Note for Establishment of National Medical College Network has been prepared for Open Tender basis in September 2013 and circulated to line ministries/ departments after administrative and IFD approvals. Comments have been received and issues are being addressed.

Govt. of India Initiative of National Optical Fibre Network (2011) to provide high speed bandwidth connectivity up to every Gram Panchayat wherein 2,50,000 GPs shall have connectivity. As a Pilot Project of Tele-consultation three sites (PHC / CHC) as one Telemedicine Centre in each block have been connected with one medical college in the state for Telemedicine(Tele-consultation and Tele follow-ups) activities.

13.9.2 Three Major Initiatives of Govt. of India providing Bandwidth Connectivity are seen as potential for envisaging E-Health activities, especially Telemedicine:

- Govt. of India has established National Knowledge Network (NKN), a state-of-the-art multi-gigabit pan-India network for providing a unified high speed network backbone for all knowledge related institutions in the country. It is designed to support Overlay, Dedicated and Virtual Networks and to seamlessly integrate with the global scientific community at multiple gbps speed. NKN has already connected 831 institutions including 151 Medical institutions till date.
- **State Wide Area Network (SWAN):** Project supported by Government of India, States to have bandwidth connectivity of 2mbps-10 mbps (scalable to 100 mbps) upto Block Level. In health sector it translates into connecting all medical colleges to DHs, SDHs and CHCs upto Blocks level.

13.9.3 Establishment of NMCN Project (Health Education Content Delivery, Skill Enhancement and Healthcare Outreach Services Project)

Besides Health Education Content Delivery, Central Repository of Medical Education Content & Digital Medical Library Network (access to global knowledge resource and every health professional shall have that available for capacity building and skill development), Technology Enabled Skill Transfer & Mentoring, Platform for Interactive Distance Learning in an Adaptive Environment the Tele-consultation, Tele Follow-up services and m-Health shall be initiated. Virtual Class Rooms and Digital Lecture Theatres shall be utilized for Under Graduate Lecture Sharing, Remote Participation in CME, Skill Share among health professionals (Medical, Dental, Nursing and Others), Open Online Courses and Carrying out Structured skill-based online courses etc. are envisaged. Every medical institution shall have a Knowledge Park, its web portal and contribute to medical science knowledge hub, nationally and internationally and becoming a Virtual Health University.

Since 12th FYP has Rs. 122 crore allocated under e-Health including Telemedicine, EFC Note has been prepared for Rs. 104 crore to establish NMCN wherein one national Resource-cum-Regional Resource centre, 5 Regional Resource centres, One Disaster Recovery Site and 35 Govt. Medical Colleges have been taken up in the Phase-1.

Establishment of National Rural Telemedicine Network: It is envisaged that all health facilities shall be connected and hence a flow of Tele-consultation, Tele Follow-up from PHC to CHC to SDH to DH to Medical Colleges/Super-specialty Hospitals shall be established.

Under NOFN as Pilot Project on Telemedicine by DeitY, MCIT Govt. of India

1. PHC Fatehgarh in Arain block of Ajmer District is connected to JLN Medical College in Rajasthan,
2. CHC Panisagar in Panisagar block of North Triputra District to Agartala Govt. Medical College & GBP Hospital of Tripura,
3. PHC Vadacheepurupalli in Parwada block of Vishakhapatnam Distt. is connected to King George Medical College & Hospital in Andhra Pradesh State for telemedicine services.

Based on inputs and outcomes of Pilot projects, National Telemedicine Network shall be scaled-up all over country utilizing NKN, SWAN and NOFN bandwidth Connectivity.

- **M-Health:** Mobile phones, tablets, I-pads etc. - e-gadgets shall be used for Mobile Health Services for Public Health Education, National Rural Telemedicine Network, Tele-education, EMR/ EHR etc.
- **Healthcare on Wheels:** It is envisaged that Mobile van with diagnostic peripherals and medical team shall go to HTR areas to provide healthcare. Expert Tele-consultation shall take place using possible connectivity in the area (Dish for Satellite connection or Wi-Max or WiFi etc.)

2012-13 Rs. 2591.89 lakhs allocated to to seven States (as per ROPs).

- Himachal Pradesh : Rs. 50 lakh
- Maharashtra : Rs. 317.82 lakh
- Punjab : Rs. 40 lakh
- West Bengal : Rs. 45 lakh
- Dadra & Nagar Havelli : Rs. 10.69 lakh
- Assam : Rs.1559.92 lakh and
- Tripura : Rs. 9.35 lakh

Since 2011 various States are being supported under NRHM for Telemedicine activities.

13.10 SPORTS INJURY CENTRE (SIC), SAFDARJUNG HOSPITAL, NEW DELHI

- Sports Injury Centre (SIC), Safdarjung Hospital is a unique centre of its own kind in India. It was established with aim to provide integrated surgical, rehabilitative and diagnostic services under one roof for the management of sports injuries and related joint disorders.
- The Centre comprises of two separate distinct and highly specialized units working in two different fields i.e. early Sports Injuries (Arthroscopy Unit-I) and late sequel of Sports injuries (Arthritis and Joint Replacement Surgery Unit-II)
- Both units are supported by dedicated staff consisting of Orthopedic Surgeons, Anesthetists, Staff Nurses, Technicians and Physiotherapists. Who are fully trained and possesses requisite expertise in management of sports injuries.
- One of the unique features of this Centre relates to Physiotherapy Unit, which is well equipped to provide physiotherapy/rehabilitative services to the indoor/outdoor patients with specialized treatment through Hydrotherapy, Biochemical and isokinetic.
- State of the art Modular Operation Theatre and Gas Manifold System made operational and surgeries undertaken.
- The latest and modern diagnostic and Laboratory facilities under one roof, comprising of Pathological/Laboratory examinations and Radiological imaging Services including MRI, CT Scan, Digital X-Ray, Bone Densitometer, Color Doppler have been outsourced under Public Private Partnership mode on revenue sharing basis. These tests/radiological and Imaging examinations are conducted on CGHS approved rates for all patients. The services are being provided round the clock.
- The centre is approved by International Society of Arthroscopy Knee Surgery and Orthopaedic Sports Medicine for further training and/or exposure to arthroscopy, knee surgery and orthopaedic sports medicine. The centre is visited by observers from fall over the country and abroad. Also regular

workshops are held where young orthopaedic surgeons from all over the country and abroad come to acquire skills in basic and advanced arthroscopic procedures.

- Faculty of Sports Injury Centre is recognized nationally for their expertise in Arthroscopic Surgeries and are regularly invited for demonstration surgeries at number of institute's and conferences.
- Centre also has a Bio-mechanical Lab which has simulators for the training of budding arthroscopic surgeons. The lab also boasts of an Isokinetic machine which is valuable for monitoring post-operative rehabilitation and also aids in diagnosis of various conditions associated with sports medicine.
- SIC in a very short span of time has achieved a rare feat and established itself as Centre of National repute in providing integrated and dedicated comprehensive service under one roof. The details regarding OPD attendance, physiotherapy, casualty, Psychology clinic and the number of surgeries and minor surgical procedures performed during the current year 2013 (up to 31st September 2013) are as under:

S. No.	Sports Injury Centre (Department)	2011	2013 till Sep.
1.	OPD Attendance including Casualty attendance	55922	38650
2.	Inpatient Attendance	1348	827
3.	No. of surgeries undertaken	1201	781
4.	Minor Surgical procedure	2044	2637
5.	Physiotherapy	49537	28657
6.	Psychology Clinic	2414	900

13.11 TRANSPLANTATION OF HUMAN ORGANS ACT

Government of India enacted, the Transplantation of Human Organs (Amendment) Act 2011 and some of the important amendments in the Act are as:-

i. Tissues included

ii. 'Near relative' definition expanded to include Grandchildren, Grandparents.

iii. Provision of 'Retrieval Centres' for retrieval of organs from deceased donors and registration of these centres under the amended Act. Tissue Banks shall also be registered

iv. Provision of Swap Donation included

v. Mandatory inquiry regarding organ donation in case of brain deaths of ICU patients.

vi. Mandatory 'Transplant Coordinator' in all hospitals registered under the Act

vii. For protecting vulnerable and poor, a provision for higher penalties for organ trading and other violations under the Act.

viii. Brain death certification Board simplified. Wherever, a Neurosurgeon/Neurologist is not available, then an anaesthetist/ intensivist may certify brain stem death in his place.

ix. Establishment of National Human Organs and Tissues Removal and Storage Network and National Transplant Registry

x. Provision of Advisory committee to aid and advise Appropriate Authority

xi. Enucleation of Eye/Cornea permitted by a trained technician permitted.

xii. No organ can be removed from the body of a mentally challenged person before his death.

xiii. No Indian donor can donate to a foreign national unless they are near relatives.

The Draft Transplantation of Human Organs and Tissues Rules were published to enable public at large to file their suggestions and objections. After finalization of the rules, provisions in the amendment Act will be brought into force. A website by the name www.notto.nic.in has been hosted where information with regards to the organ transplantation can be obtained. A computerized system of **National Registry of donors and recipients** is also going to be put in place.

13.12 NATIONAL ORGAN TRANSPLANT PROGRAMME (NOTP)

National Organ Transplant Programme with a budget of Rs. 149.5 crore for 12th Five year Plan has been approved by the Expenditure Finance Committee (EFC). The aim of the programme is to improve access to the life transforming transplantation for needy citizens of our country by promoting deceased organ donation.

The programme envisages creation of NOTTO (National Organ and Tissue Transplant Organization) under Directorate General of Health Services, with a Networking Centre and a Tissue Bank at National Headquarters, five Regional networking Organizations (ROTTO-cum-SOTTO) and five State level organizations (SOTTO). The Regional organization shall also cover the State in which it is located i.e. it will also do the function of SOTTO for the state of its location. The Regional Network facility will have Tissue Bank as well. The State units would be linked to transplant hospitals, retrieval hospitals, organ/tissue matching Laboratories and tissue banks within their area and also to regional and national networking organizations.

There will also be provision of transplant coordinators at identified Government Medical Colleges, good performing private Institutions and Trauma Centers. The project will have main component of IEC to promote organ donation from deceased donors. There will be provision for financial assistance to 100 needy and poor patients of Govt. hospitals every year for immunosuppressant therapy. The programme has also made provision for training of various cadres of staff for transplantation.

13.13 CLINICAL ESTABLISHMENTS ACT 2010 AND NATIONAL COUNCIL FOR CLINICAL ESTABLISHMENTS

After the Act was passed by Parliament in August 2010 and notified on 1st March, 2012, the Act is at present applicable in the following States/UTs:

- States- Arunachal Pradesh, Himachal Pradesh, Mizoram and Sikkim
- Union Territories
- States who have adopted the Act- Uttar Pradesh, Rajasthan, Bihar and Jharkhand

AND will be applicable in such other States which shall adopt this Act under clause (1) of article 252 of the Constitution.

Salient Features & Benefits of the CEA 2010

- All clinical establishments - including diagnostic centres and single doctor clinics, across all recognized systems of medicine in both public and private sector. (Exception: establishments of the Armed Forces) are covered.
- The Act shall assist in compilation of reliable digital registry of all types of clinical establishments at National, State and District level available in public domain.
- Standard application form for registration of clinical establishments to ensure uniformity in information being collected.
- Assist government in obtaining information and data required from clinical establishments for public health interventions including outbreak and disaster management.
- Provisional registration, through a process of self-declaration, without any inspection.
- Permanent registration would be undertaken after categorization, classification and development of minimum standards.
- Application for registration by post, in person or online.
- Mandatory for every clinical establishment to provide treatment to stabilize the emergency medical condition of any individual brought to such establishment.
- Establishment of multi stakeholder institutional bodies:
  - i. National Council of Clinical Establishments
  - ii. State Council/Union Territory Council of Clinical Establishments
  - iii. **District Registering Authority:** Implementing Authority with powers to register and cancel registration

- National Council, through multi stakeholder participation and consultative process would classify clinical establishments into different categories and determine minimum standards and do their periodic review to ensure uniformity across all establishments in a time bound manner.
- National Council shall also publish a National Register and collect the statistics in respect of clinical establishments.
- Contravention of any provision shall be punished with monetary penalties.
- Details of charges, facilities available would be prominently displayed at a conspicuous place at each establishment.
- Every clinical establishment has to be registered. Norms required to be met prior to registration include:
  - o minimum standards of facilities and services; and
  - o minimum requirement of personnel.
  - o Provision and maintenance of records and reports
  - o such other condition as may be prescribed
- As per the Clinical Establishments (Central Government) Rules 2012, under the above mentioned Act:
  - o The clinical establishments shall display the rates charged for each type of services provided and facilities available at a conspicous place in the local as well as English language.
  - o The clinical establishments shall charge the rates for each type of procedures and services within the range of rates determined and issued by the Central Government from time to time in consultation with the State Governments.
  - o The Clinical Establishments shall ensure compliance of the Standard Treatment Guidelines (STG) as may be determined and issued by Central Government or State Government from time to time. Compliance to STG shall ensure that unnecessary operations are avoided.
  - o Cancellation of registration, would occur at any time, if conditions for registration are not compiled.

A website (www.clinicalestablishments.nic.in)has been made operational for providing information on the Act and online registration of clinical establishments and issue of certificate. The Online registration has been made functional in the States of Jharkhand, Himachal Pradesh and UT of Daman and Diu. Ministry has made provision of budget for implementation of the Act by the States/ UT.

National Council for Clinical Establishments under the Chairmanship of DGHS has done following work so far:

1. Application form for provisional registration, Certificate of Provisional Registration, template of minimum standards, information to be displayed by the Clinical establishments have been developed and finalized.
2. The National Council has decided to constitute 5 Subcommittees as given under for further working on specific areas:
   - i. Categorization and Classification of Clinical Establishments
   - ii. Development of Standard Template of Minimum Standards
   - iii. Developing Minimum Standards
   - iv. Statistics to be collected from Clinical establishments
   - v. Defining the range of rates of procedures and services
3. Standard Treatment Guidelines for proper health care for important medical domains have been developed and uploaded on the aforesaid website of the Act.

This Act is a guiding mechanism for providing an overall improvement in the quality of health care sector in the country. All State Governments are expected to adopt this Act gradually. The States having similar legislation have been requested to repeal the same for adopting this Act.

13.14 NATIONAL PROGRAMME FOR PREVENTION & MANAGEMENT OF BURN INJURIES (NPPMBI)

"Burn" is a major Public Health Programme all over the world. In India alone, around 7 million people suffer from burn injuries, out of which, 7 lakh need hospital admission and 2.4 lakh become disabled. As per the data extrapolated from the information received from 3 major Govt. Hospitals in Delhi, approx. 1.4 lakh people die of burn injuries annually. This comes to one death every 4 minutes due to burns. Most of the burn victims belong to the vulnerable group of the society. The misery of burn patients is further aggravated by the fact that, the treatment requires prolonged hospitalization and multiple corrective plastic surgeries, leading to economic hardship. From the information collected from 3 major Government Hospitals in Delhi, there has been a 10 fold increase in OPD cases and 4.5 times increase in admissions during the last five years.

However, the death and disability due to burn injury are preventable to a great extent, provided timely and appropriate treatment is provided by trained personnel. However, trained manpower as well as dedicated burn units are almost non-existing in our country. Keeping in view the magnitude of the problem, a pilot project was initiated by Ministry of Health and Family Welfare during the 11th plan period.

13.14.1 Pilot Project - 11th Five Year Plan

Recognizing the severity of the problem, Ministry of Health & Family Welfare initiated Pilot Programme for Prevention of Burn Injuries (PPPBI) in the year 2010. Three Medical Colleges and six District Hospitals in three States were identified for establishing burn wards with an approved outlay of Rs. 29.70 crores. The districts and the medical colleges covered under the pilot project are as below:-

- **Haryana:** Post Graduate Institute of Medicals Sciences, Rohtak, Gurgaon General Hospital, Panipat Civil Hospital.
- **Himachal Pradesh:** Dr. Rajendra Prasad Medical College, Tanda at Kangra, Hamirpur District Hospital, Mandi Zonal Hospital.
- **Assam:** Guwahati Medical College, Nagaon District Hospital, Dhubri District Hospital

13.14.2 Major Achievements during 11th Five Year Plan:

- Funds were released to states for establishment of Burn Units that are presently in different stages of completion.
- 6 days Training of Surgeons/Medical Officers was imparted for "Burn Injury Management" in 2 batches at Safdarjang Hospital.
- Burn Injury Management protocol was developed.
- Burns Data Registry and Quarterly reporting Format developed.
- Mass Media campaigns were carried through DD and AIR for awareness generation among the masses.
- Awareness and Advocacy campaigns were conducted in the identified states and districts.

13.14.3 12th Five Year Plan Proposal

National Programme for Prevention & Management of Burn Injuries (NPPMBI)-

- **Medical College Component:** During the 12th Five Year Plan, the Project has been approved by the Cabinet Committee for Economic Affairs (CCEA), to be continued as a full-fledged National Programme. The programme consists of 2 components i.e establishing dedicated burn units at 67 Medical Colleges and at 19 District hospitals across the country. During 12th plan, the district hospital component will be implemented through NRHM division whereas; Medical College component will be a part of the "Human resource in Health and Medical Education Scheme" and assistance to be provided to the states will be governed by the norms set under this parent scheme. One of the important criteria under the scheme is that the assistance proposed under the programme for various components will be shared between the Centre and State Governments in the ratio of 75:25.
- **Budget provision and proposed expenditure:** Rs. 500 crore has been allocated for the National Programme for Prevention & Management of Burn Injuries. Out of this, Rs. 450 crore has been

earmarked for developing burn wards in Medical College component and rest 50 crore for district hospital component.

- **Synergy with NRHM- District Component:** During 12th five year Plan, the District Hospital component shall be managed under NRHM. Under this component, 19 District Hospitals will be identified for development of burn wards across the country. The unfinished work of the 6 district hospitals taken up during 11th plan under pilot project will also be taken up along with 19 new district hospitals. Hence total district hospitals to be covered will be (19+6) =25 for consideration of grant. A total of Rs. 50 crore has been allocated under NRHM for the District Hospital Component.
- **Aim:** To reduce incidence, mortality, morbidity and disability due to Burn Injuries.

13.14.4 Objectives of the Programme:-

- To establish adequate infrastructural facility and network for management of burn victims and rehabilitation.
- To improve the awareness among the general masses and vulnerable groups especially the women, children, industrial and hazardous occupational workers.
- To carry out Research for assessing behavioral, social and other determinants of Burn Injuries in our country for effective need based programme planning for Burn Injuries, monitoring and subsequent evaluation.

13.14.5 Establishment of Burn Unit-

- **At Medical Colleges-** The burn units will be a part of the hospital administration, and not a stand alone centre. The ward will consist of 8 general beds and 4 ICU beds. Proposed area for the unit is 725 Sq meters and a consolidated amount of Rs. 2.175 crore will be given to each medical college for construction. Similarly Rs. 1.038 crore will be given annually for manpower and Rs. 1.29 crore for equipments. The responsibility for construction, equipment procurement and hiring of manpower will be of State Governments. The equipments suggested are recommendatory in nature and the hospitals will procure as per state norms. The other supportive facilities like investigation, blood banking and specialists from other discipline will be shared with the hospital facilities.
- **At District Hospitals-** The burn units will be part of the hospital and not stand alone centres. There will be provision of 4 general beds and 2 acute care beds in the burn unit. Proposed area for the unit is 400 Sq meters and a consolidated amount of Rs. 1.20 crore will be given to each district hospitals for construction. Similarly, Rs. 0.38 crore will be given for manpower and Rs. 0.29 crore for equipments. The responsibility for construction, equipment procurement and hiring of manpower will be of State Governments. The equipment and manpower suggested are recommendatory in nature and the hospital will procure as per state norms. Other supportive facilities will be shared with the common hospital facilities.
- **Memorandum of Understanding with the states-** The states will be required to sign a Memorandum of Understanding with the Ministry of Health and Family Welfare before the grants are released.

13.14.6 Expected Outcome:

- Dedicated Burns Care Services in 70 Medical Colleges & 25 District Hospitals.
- Availability of skilled manpower at the Medical Colleges & District Hospitals.
- Increased awareness regarding prevention of burns Injuries, safety measures and availability of services through IEC.
- Reduction in the incidence of burn injury and its consequences, thereby reducing the burden on government exchequer and improving the quality of life of the community.

13.15 INSTITUTE OF SEROLOGY, KOLKATA

Institute of Serology, Kolkata is a sub-ordinate office of Directorate General of Health Services under the Ministry of Health & Family Welfare.

Objective of the Institute

1. Production of various quality diagnostic reagents like VDRL Antigen, species specific Antisera, Anti H Lectin etc. and supply to the Government and Non-Government Institutions like Forensic Science Laboratories and Hospitals all over the country.
2. Forensic Serology for determination of origin of species of different biological exhibits which have already been send to this institute from different FSLs & RFSLs and also to undertake blood group serology in case the species origin is human. This Medicolegal Report is accepted as expert opinion in court of law.
3. Reference centre for A, B, O Blood grouping & Rh typing from different government hospitals of Kolkata.
4. The V. D. Serology Section provides its service to Govt. Medical Colleges & Hospitals of Kolkata. Besides, many projects for diagnosis of STI in sex workers were initiated by several NGOs & Govt. aided bodies and we had supported them by providing diagnostic test results. It also works for internal quality control of the VDRL antigen and standardization of VDRL Antigen produced in Antigen Production (A.P) section.
5. Regional STD Reference Laboratory for East Zone under NACO has been functioning from 1983.
6. Training of Laboratory Technicians in various fields of Serology and Sexually Transmitted Diseases and imparting training in Forensic Serology to post graduate students of Forensic Medicine.
7. To involve our department with National & State run health projects where our laboratory's role is very useful like National AIDS Control Programme and Polio Eradication Programme etc.
8. Isolation of Polio Virus from stool samples of AFP cases from Eastern & NE Region and part of Bihar, Jharkhand by National Polio Laboratory under the WHO and NPSP.
9. Intratypic differentiation of Polio Virus by ITD Laboratory using PCR technique.
10. National Measles Laboratory for detection of Measles from Eastern and North Eastern states and part of Jharkhand, Bihar.

Forensic Serology

Performance Report of Forensic Serology from April 2013 to September 2013	
Total No. of cases received	276
Total No. of exhibits received	1282
Total No. of cases analysed and report	276
Total No. of items tested for species determination	1433
Total No. of cases examined for grouping	284

V. D. Serology

Performance Report of V. D. Serology from April 2013 to September 2013			
Source	**No. of Samples Received**	**No. of Samples Tested VDRL**	**No. of Sample Positive VDRL**
Antenatal Cases (Nos.)	94	94	0
STD Clinic	805	805	36
Total	**899**	**899**	**36**

Antibody Section

Performance Report of Antibody Section from April 2013 to September 2013			
Month	**Production of Antisera**	**Supply of Antisera**	**Supply of Anti H Lectin**
April 2012 to	ml	ml	ml
September 2012	4542	2279	2075
Total	**4542**	**2279**	**2075**

Quality Control & Diagnostic Laboratory

Performance Report of Quality Control & Diagnostic Laboratory from April 2013 to September 2013	
Examination Performed	**No. of Samples**
Standardization of Anti H Lectin	72 Lots
Standardization of Species Antiserum	26
Clinical Diagnostic Tests	00

BGRC Section

Performance Report of BGRC/Production Section from April 2013 to September 2013	
Total No. of Blood Group	279 Nos.
Rh-Negative Cases	06 Nos.
Production of	**Quantity in ml.**
Anti H Lectin (Freeze Dried)	3600 ml

Measles Laboratory

Performance Report of Measles Laboratory from April 2013 to September 2013

Measles	
Total sample tested	267 Nos.
Total sample positive	75 Nos.
Total sample negative	185 Nos.
Total sample equivocal	07 Nos.
Rubella	
Total sample tested	194 Nos.
Total sample positive	134 Nos.
Total sample negative	56 Nos.
Total sample equivocal	04 Nos.

Antigen Production Section

Performance Report of Antigen Production Section from April 2013 to September 2013	
Total VDRL Antigen Production	1360 Ampls
Total Supply of VDRL Antigen	1680 Ampls
Direct Sale	1670 Ampls
Departmental Use	10 Ampls

National Polio Laboratory

Performance Report of National Polio Lab. from April 2013 to September 2013	
Total cases received	8666
Total sample received	7422
NPEV	1185

STD/Bacteriology

Performance Report of STD/Bacteriology from April 2013 to September 2013			
Sl. No.	**Laboratory Test**	**Nos. Tested**	**Nos. Positive**
Syphilis	VDRL	797	35
	TPHA	797	63
Candida	Gram Stain	577	66
	Culture	577	114
Gonorrhoea	Direct Smear	617(CD+UD)	09
	Culture	617	02
Hepatitis B	HBs Ag ELISA	456	06
	Immunocromatographic Method	348	06
HCV	HCV(IgM) Elisa	672	02
HSV - 2	HSV - 2 (IgM) Elisa	276	71
TrichomonasVaginalis(TV)	Wet Mount	577	126
	Culture	577	233
PAP Stain	Endo &Ecto Cervical Smear	581	--
Herpetic Syndrome	Giemsa Stain (MNGC)	58	09
B. Vaginalis	Gram Stain	580	82
CMV	CMV (IgM) ELISA	182	01
C. Trachomatis	C. Trachomatis (IgM) ELISA	92	06

Account Section

	Total Budget	**Expenditure upto the end of September 2013**
Non Plan	55,000,000	23,517,535
Plan	9,000,000	702,071

Chapter 14

QUALITY CONTROL IN FOOD & DRUG SECTOR, MEDICAL STORES

14.1 FOOD SAFETY & STANDARDS AUTHORITY OF INDIA (FSSAI)

The Food Safety & Standards Authority of India (FSSAI) has been established under the Food Safety & Standards Act, 2006, as a statutory body for laying down science based standards for articles of food and regulating, manufacturing, processing, distribution, sale and import of food so as to ensure safe and wholesome food for human consumption. The Act aims to establish a single reference point for all matters relating to Food Safety and Standards, by moving from multi-level, multi-departmental control to a single line of command. Various Acts and Orders that have hitherto handled food related issues in various Ministries and Departments have been integrated in the Act. The safety and quality of food is imperative to meet the country's aim of Universal Health Coverage and Food Security for all. A comprehensive, consolidated Food Safety and Standards Act aligned with the global practices was the first step to achieve this aim. The Food Safety and Standards Authority of India is making continuous efforts for effective implementation of the FSS Act. 2012-13 saw significant achievements in the field of food safety and standards. The following six regulations have been notified w.e.f. August, 2011.

i. Food Safety and Standards (Licensing & Registration of Food Business) Regulations 2011;

ii. Food Safety and Standards (Food Product Standards and Food Additives) Regulations 2011;

iii. Food Safety and Standards (Contaminants Toxins and Residues) Regulations 2011;

iv. Food Safety and Standards (Prohibition and Restriction on Sales) Regulations 2011;

v. Food Safety and Standards (Laboratory and Sample Analysis) Regulations 2011 and

vi. Food Safety and Standards (Packing and Labelling) Regulations, 2011.

Emphasis of the new law

- Safe and wholesome food for human consumption,
- Laying down Food Safety standards on scientific basis,
- Unified law encompassing seven different laws which were governing safety standards and regulations falling under separate nodal ministries,
- All issues relating to manufacture, import, storage, distribution and sale (including labelling) are addressed comprehensively,
- Creation of infrastructure for testing and certification procedures and
- Global standards for food, sanitary and phytosanitary measures, to promote recognition, co-ordination with governmental and non-governmental organisation world over.

Activities

Enforcement Division: FSS Act, 2006 is being implemented by all States/UTs Government w.e.f. 5th August, 2011. States/UTs Government have appointed Food Safety Commissioners, notified Designated Officers, Adjudication Officers and Food Safety Officers for respective areas within the State/UT. The number of licenses and registration issued by the States as on 31.03.2013 are 3,59,446 & 11,95,302 respectively.

Media (Print and Electronic): A lot of activities have been organised to make the stakeholders aware about

the essential elements of the Act, involving print and electronic media. Advertisement on licensing, labelling, are being released in multilingual mode across the country. Creatives are designed and released in newspapers/magazines/including advertorial etc. pamphlets, brochures on the procedure of licensing, registration, labelling, imported foods and similar literature were developed and distributed. Radio jingles were broadcast on various radio channels. Animated video spots were made out of the radio jingles and played in safal outlets in New Delhi. FSSAI branding was done in association with IRCTC.

Participated in events like AAHAR, to spread awareness through posters display, leaflet distribution and involving experts from FSSAI to clarify the queries raised by the Food business operators. Participated in Kumbh Mela by organising training programmes, lectures and street play. FSSAI has involved NGOs to generate awareness in the field of food safety with a broad spectrum of activities.

A dedicated website www.fssai.gov.in , blog and Social networking are in place to update the current happenings in the Authority. FSSAI, You tube channel has original videos to test adulteration in food stuff at the household level.

The IEC materials that are being developed in the Authority are shared with the State/UT Governments which the States can get translated into regional language, and appropriate channel of communication can be taken by the respective States to address various stake holders.

Imports: As per section 25 of the Food Safety & Standard Act, 2006, all imports of articles of food to be subject to the provision of the Act. It provides that no person shall import into India any article of food in contravention of the Act or any rules and regulations made thereunder. It also provides that the Central Government shall, while prohibiting, restricting or otherwise regulating import of article of food under the Foreign Trade (Development and Regulation) Act, 1992 (22 of 1992), follow the standards laid down by the Food Authority under the provisions of this Act and the Rules and Regulations made thereunder. Further, as per section 47 (5) of the FSS Act, 2006, in case of imported articles of food, the Authorised Officer of the Food Authority shall take its sample and send to the Food Analyst of notified laboratory for analysis who shall send the report within a period of five days to the Authorised Officer.

Accordingly, under this Act, FSSAI has a clear mandate of ensuring safety of food items imported into the country. In view of this, FSSAI has already successfully operationalized the Imported food clearance process in a phased manner since August- September 2010 through appointment of Authorized officer in terms of section 47 (5) of the FSS Act, 2006 in 10 ports of entry at Delhi, Mumbai, Chennai & Kolkata Ports (including sea, air and land). Further FSSAI is in the process of operationalizing the additional ports of entry. On an average percentage of number of samples drawn at different ports has seen an increase in 2012-13.

Scientific Committee and Scientific Panels of the Food Authority: FSSAI under the provision of section 14(1) and 13(1) of the FSS Act has constituted a Scientific Committee and Nine Scientific Panels consisting of independent scientific experts for providing scientific opinion on various issues.

National Codex Contact Point: The Food Authority as the National Codex Contact Point (NCCP) has actively participated in various Codex Committees during the year 2012-13. The work proposals by the Food Authority-Standards for Okra & Potato, Development of Code of Hygienic Practices for the Street-Vended Foods and Code of Hygienic Practice for the Storage of Cereals were considered by the respective Codex Committees. India has also participated in a number of Electronic Working Groups.

International Cooperation, WTO/SPS/TBT: The Authority also serves as enquiry point for Sanitary and Phytosanitary (SPS) issues and thus regularly participates in bilateral cooperation with countries in food safety, standards, and capacity building of food testing laboratories, for instance, a Memorandum of Understanding (MoU) has been signed with Netherlands this year. Significant MoU with the Food and consumer Product Safety Authority of the Ministry of Economic Affairs, Agriculture and Innovation of the Kingdom of the Netherland on Cooperation in the field of Food Safety signed on 30th November, 2012.

FSSAI is also a part of India-EU Project on Capacity Initiative for Trade and Development (CITD). This agreement was signed by the Govt. of India on 30th November, 2011. The aim of the project as mentioned in the document is to "modernize and enhance the capacity of India's trade related regulatory institutions and enforcement system in order to meet International standards and requirements".

Quality Assurance: As per Sec. 43 (1) the Food Authority may notify food laboratories and research institutions accredited by National Accreditation Board for Testing and Calibration Laboratories (NABL) or any other accreditation agency for the purpose of carrying out analysis of samples by food analysts under this act. Till date 68 laboratories have been notified by FSSAI for a period of 1 year.

A manual regarding "Guidelines for Recognition of Food Testing Laboratories" was prepared. The document lays down the guidelines for general as well as the technical criteria for recognition, terms and conditions of recognition, withdrawal/cancellation of recognition and financial aspects of the Laboratory Recognition.

Achievements during the year 2012-2013

a) Standards for caffeinated beverages have been framed and the same draft has been notified for public comments.

b) Draft standards for Olive Oil have been notified for seeking public comments.

c) Laboratory parameters for food Products for analysis have been finalized.

d) Fifteen manuals of method of analysis of Food have been finalized.

e) Quick tests for analyzing the adulterants for the purpose of house hold and small industries have been developed and uploaded in the FSSAI's website.

f) Review of the existing standards and harmonization with Codex and other international best practices has been initiated.

g) Strategy paper on upgradation of the 72 public state food laboratory, establishment of one laboratory at each twenty districts has been developed.

Surveillance Division: The Surveillance Division of FSSAI had conducted a surveillance study of fruits and vegetables in Feb, 2013 in Azadpur fruit and vegetable market in early morning. Analytical tests for physical, chemical and microbiological parameters were carried out by NABL Accredited laboratories. The division has also started a nationwide survey on quality of packaged drinking water to ensure the quality and safety of packaged drinking water manufactured by various bottling units across country.

14.2 CENTRAL DRUGS STANDARD CONTROL ORGANIZATION (CDSCO)

The import, manufacture, distribution and sale of drugs, cosmetics and notified medical devices in the country are regulated under the provisions of the Drugs and Cosmetics Act, 1940 and the Drugs and Cosmetics Rules, 1945. The Central Government exercises regulatory control over these products imported into the country through the Central Drugs Standard Control Organization (CDSCO) headed by the Drugs Controller General (India) [DCG(India)]. The manufacture, sale and distribution of drugs in the country are primarily regulated by the State Drug Control Authorities appointed by the State Governments. The objective of the drug regulatory system is to ensure availability of safe, effective and quality drugs, cosmetics and medical devices based on scientific excellence and best possible regulatory practices.

Mission of CDSCO

The mission of Central Drugs Standard Control Organization (CDSCO) has been defined as under:

"To safeguard and enhance the public health by assuring the safety, efficacy and quality of drugs, cosmetics and medical devices".

Organization: The Head-quarters of CDSCO are situated at Food and Drug Bhawan, Kotla Road, New Delhi - 110002. It has under its control zonal / sub-zonal offices, port offices and drug testing laboratories to perform various regulatory functions as prescribed under the Drugs and Cosmetic Act, 1940 and Rules.

There are six zonal offices situated at Mumbai, Ghaziabad, Kolkata, Chennai, Ahmadabad and

Hyderabad and three sub-zonal offices at Bangalore, Chandigarh and Jammu. The Port Offices of CDSCO are situated at notified port of entries. These Port offices are at Mumbai (Sea and Airport), Nava Sheva (Sea Port), Kolkata (Sea and Airport), Chennai (Sea and Airport), Hyderabad (Airport), Delhi (Airport), Kochi (Sea Port) and Ahmadabad (Air Port), Bangaluru (Air Port), Goa (Sea and Air Port).

There are seven functioning central drug testing laboratories under CDSCO, situated at Kolkata, Mumbai, Chennai, Guwahati, Chandigarh, Kasauli and Hyderabad. The testing capacity of these labs is around 8,000 samples per year. In addition, National Institute of Biologicals, Noida, is notified as Central Drug Laboratory for testing Blood Grouping Reagents and certain diagnostic devices. The Homeopathic Pharmacopoiea Laboratory, Ghaziabad tests homeopathic medicines and Indian Veterinary Research Institute, Izzatnagar tests veterinary medicines.

The Central Drug Laboratory, Kolkata is the appellate laboratory in matters of dispute regarding testing of drugs and is NABL accredited for chemical and biological testing. The Central Drug Testing Laboratory, Mumbai is a statutory laboratory involved in testing of samples of drugs from the ports, new drugs and oral contraceptive pills. It is an appellate laboratory for copper T- intrauterine contraceptive device and tubal rings. The Central Drug Testing Laboratory, Chennai is an appellate laboratory for condoms and is NABL accredited for both chemical and mechanical section. The Regional Drug Testing Laboratory, Guwahati tests samples of drugs received especially from States in the East Zone and is NABL accredited for both chemical and biological testing. The Regional Drug Testing Laboraotry, Chandigarh tests survey samples as well as samples sent by Drug Inspectors.

Regulatory Functions Performed at CDSCO

CDSCO is discharging the following functions at its hqrs, zonal/sub-zonal offices, port offices.

Functions discharged at CDSCO headquarters:

- Grant of approval to manufacture and/or import new drugs and to conduct clinical trials as per provisions of the Drugs and Cosmetics Act and Rules.
- Approval of the licenses to manufacture certain categories of drugs as Central License Approving Authority (CLAA) i.e. Blood Banks, Large Volume Parenterals, Vaccines/Sera, r-DNA derived products, in-vitro diagnostic kits for detection of HIV 1 & 2, HCV & HBsAg and notified medical devices.
- Registration of foreign manufacturers of drugs and medical devices whose products are to be imported into the country, grant of licences to import drugs and medical devices along with regulatory control over the quality of these products imported into the country.
- Grant of Test Licences for import of drugs for the purpose of examination, test and analysis.
- Grant of licences to import drugs by Government hospitals or Medical Institutions for the use of their patients.
- Convening the meetings of Drugs Technical Advisory Board (DTAB) to discuss matter arising out of the administration of the Act and processing its recommendations especially related to amendments to the Drugs and Cosmetics Rules, 1945.
- Convening the meetings of the Drugs Consultative Committee (DCC) to secure uniformity throughout the country in the administration of this Act.
- Review and recommend to the Government to regulate, restrict or prohibit manufacture etc. of drug or cosmetics in public interest under section 10A and/or 26A drugs and Cosmetics Act, 1940.
- Conduct workshops and training programmes for skill development in respect of various issues related to quality control of drugs, medical devices and cosmetics.

Functions of the Zonal/Sub-Zonal Offices

Inspection of manufacturing premises jointly with State Governments for drugs covered under the CLAA Scheme i.e. I V Fluids, Large Volume Parenterals, Vaccine &

Sera, Blood & Blood Products, r-DNA products (Biotech Products) etc. for the purpose of grant/renewal of licenses.

- Inspection of private testing laboratories in coordination with the State Drug Inspectors for approval of these laboratories for carrying out tests on drugs/cosmetics on behalf of the licensees.
- Inspection of manufacturing facilities of the firms under WHO GMP Certification Scheme.
- Inspection of drug manufacturing firms for capacity assessment and other provisions at the request of the Central Government.
- Inspections to investigate complaints received from various forums.
- Coordination with the State Drug Controllers to sort out problems involved in the investigations of drugs manufactured in one State and declared not of standards quality in another State and other such matters.
- Launching of prosecutions in cases detected by the zonaloffices.
- Drawing of sample of drugs for test and analysis by the Government Analysts.

Functioning of Airport & Seaport Offices

To control the quality of imported drugs, notified medical devices and cosmetics, the port offices check documents (bill of entry) and draw samples on random basis to check their quality and verify shipping bills of export of drugs as requested by the customs authorities.

Strengthening of CDSCO

The CDSCO is being continuously strengthened to ensure that only safe and effective medicines of standard quality are made available in the country. The sanctioned strength of the organization has increased from 111 posts in 2008 to 475 posts in 2013. Presently it has 197 regular officers, namely, the Drugs Controller General (India), 01 Joint Drugs Controller (India), 15 Deputy Drugs Controllers, 19 Assistant Drugs Controllers, 143 Drug Inspectors, 08 Technical Officers, 04 Senior Technical Assistants and 6 Technical Assistants. The remaining posts are being filled through the UPSC. Thirty one posts of Assistant Drug Inspectors are also being filled up through the Staff Selection Commission. The Government also sanctioned the appointment of 250 contractual staff to assist the organization in coping with the work load at the Head quarter as well as zonal offices.

An ambitious plan has been made under the 12th Five Year Plan for further strengthening of the CDSCO as well as State Drug Regulatory Authorities including enhancement of testing capacities. Outlays of Rs. 1800 crore for Centre and Rs. 1200 crore for States/UTs have been made in the 12th Plan.

Training/workshops conducted with WHO support in the country

Various training programmes/workshops on different topics were held during the period for updating the knowledge and sharpening of the skills of the concerned officials working in CDSCO. Some of such workshops conducted with WHO support are mentioned below.

- Two Workshops on "Quality Risk Management Approach applied to GMP (Advanced)' were conducted by CDSCO in collaboration with WHO, from 18th February 2013 to 22ndFebruary, 2013 at Hotel Mount View, Sector-10 Chandigarh and from 6th May to 10th May, 2013 at Hotel Sagar Plaza, Pune (Maharashtra).
- Two Induction Training programme for newly recruited Drugs Inspectors of CDSCO were conducted in July, 2013 and August, 2013.
- A Workshop on Harmonization of Schedule-Y, ICMR, GCP guidelines on Ethical issues was conducted from 24th - 25th June, 2013 at New Delhi.
- Two Workshops on GMP Regulatory Inspection (Basic)" in collaboration with WHO were conducted at Hyderabad from 23rd and 27th September, 2013, and at Pune from 18th to 22nd November, 2013 for Drugs Inspectors of CDSCO, States and CDL, Kasauli.
- An Interpol Training Programme on investigating traffics of Spurious and Medical Products was conducted for the Drug Control Officers from 08-10 October, 2013 at CBI Academy, Ghaziabad.

- A Lead Audit Course on quality management system as per IS/ISO 9001:2008 for officers of CDSCO was conducted in coordination with the Bureau of Indian Standard from 02-06 December, 2013.

Regulatory Activities at the Headquarters

a) Quality Control over import of drugs

The CDSCO regulates the quality of drugs imported in to the country through the system of registration and licensing as provided under the Drugs and Cosmetic Rules, 1945. This includes registration of overseas manufacturing sites and the drug products (bulk drugs and finished formulations). Import licences are granted to the Indian importers for the import of the drugs from these manufactures as provided under the rules. The quality of imported drugs is further monitored at the port offices when the drugs are actually imported.

During the year 2013, upto November, 2013, the office of Drugs Controller General (India) granted 333 Registration Certificates in respect of manufacturers of the drugs who intend to export their products to India. During the same period, 2419 licences in Form 10 for import of drugs in to the country were also granted.

Permissions were also granted for import of small quantities of drugs for test and analysis in Form 11 of the Drugs and Cosmetics Rules. The office of DCG(India) granted 11,465 test licences for the import of drugs in small quantities for test and analysis upto November, 2013.

b) Quality Control over import of cosmetics

The registration of cosmetics imported into the country was initiated from 1st April, 2013 to ensure that products imported into the country are not only of standard quality but also have been manufactured under Good Manufacturing Practices by genuine/licensed manufacturers. This provision would ensure that only genuine and safe cosmetics are permitted to be imported in the interest of public health safety. The office of DCG(I) granted 265 Registration Certificates by the end of November, 2013.

c) Quality Control over Notified Medical Devices

Medical Devices notified by the Government of India under the Drugs and Cosmetics Act, 1940 are regulated by CDSCO as 'drugs' under the provisions of the Drugs and Cosmetics Rules. The quality control over these devices is regulated through the system of registration and import licences.

During the year 2013, (upto November, 2013), the office of DCG(I) granted 302 Registration Certificates to the manufacturers of the Medical Devices intending to export their medical devices to India while 915 licences in Form 10 for import of medical devices to the country were granted during the same period. In addition, 122 permissions for import of Medical Devices and diagnostics devices for test and analysis were also granted during the same period.

The manufacture of the notified devices is approved by the DCG(I) as Central Licence Approving Authority (CLAA) under the Drugs and Cosmetics Rules. During the year 2013, (upto November, 2013), the office of DCG(I) granted CLAA approval in 75 cases in respect of manufacturing licences for manufacture of medical devices.

d) Grant of permission for introduction of new drugs in the country

New Drugs are permitted to be marketed in the country in accordance with the permission granted by the Drugs Controller General (India) after ensuring that these are safe and efficacious and comply with the requirements of the Drugs and Cosmetics Rules. The applicants are required to provide technical data in respect of safety and efficacy before these could be permitted to be marketed in the country. Fixed Dose Combinations which are required to be marketed for the first time in the country are also considered as new drugs under the Drugs and Cosmetics Rules, 1945.

Vaccines are considered as new drug unless certified otherwise. During the year 2013, (upto November, 2013), permission to import finished formulations of vaccines was given in 4 cases and permissions for manufacture of vaccines as New Drugs was granted in 18 cases. During the same period, in 9 cases new licences for manufacture of vaccines were also granted.

e) Clinical trials

Clinical trials of new drugs are conducted on human subjects in the country to discover or verify the clinical,

pharmacological (including pharmacodynamics/ pharmacokinetics), and/or adverse effects with the object of determining their safety and/or efficacy. The Drugs and Cosmetics Rules provide that clinical trials for a new drug, whether for clinical investigation or any clinical experiments are required to be conducted under and in accordance with the permission granted by the Drugs Controller General (India). The applications for grant of permission to conduct clinical trials on new drugs in the country are examined by the office of DCG(India). Permissions are also required for conducting bioequivalence studies on drugs in chemically equivalent drug formulations to study whether they produce identical therapeutic response in patients or not. During the year 2013, the office of DCG(India) granted no objections for conduct of clinical trials on new drugs in 26 cases upto November, 2013.

In order to strengthen the regulatory provisions over the conduct of clinical trials in the country, following initiatives have been taken.

i. Twelve New Drug Advisory Committees (NDACs) related to different therapeutic areas, consisting of medical experts drawn from various Government medical colleges and institutes from all over the country help in evaluation of applications for marketing of new drugs in the country or to conduct clinical trials on new drugs. 78 meetings of these committees have taken place since 2011, wherein a total of 1122 applications were evaluated. Out of these 331 applications were related to global clinical trials including clinical trials of new chemicals entities.

ii. All Investigational New Drug applications are evaluated by the Investigational New Drug committee under the Chairmanship of Secretary, Department of Health Research & Director General of ICMR.

iii. Under the directions of the Hon'ble Supreme Court of India, in the case of Swasthya Adhikar Manch Vs. Government of India (W.P. Civil 33 of 2012), the Ministry of Health and Family Welfare also constituted two committees for supervising the clinical trials of new chemicals entities. While the first Committee - the Technical Committee is headed by the Director General of Health Services and the second i.e. the Apex Committee, for overall supervision, is headed by the Secretary, Ministry of Health and Family Welfare.

iv. In light of the order of the Hon'ble Supreme Court dated 21.10.2013 directions were issued on 19.11.2013 that in all clinical trials in addition to the requirement of obtaining written informed consent, audio visual recording of the informed consent process of each trial subject, including the procedure of providing information to the subject and his/her understanding on such consent is required to be done while adhering the principle of confidentiality. This is applicable to all new subjects to be enrolled in all clinical trials including global clinical trials.

v. Registration of clinical trial in ICMR registry is mandatory.

vi. Guidelines for conducting clinical trial inspection of clinical trials sites and sponsor/Clinical Research Organizations (CROs) have been prepared and are available at the website of CDSCO.

vii. Drugs and Cosmetics Rules have been amended to strengthen the regulations relating to clinical trials in the country. Details are as under:

- Introduction of rule 122 DAB and APPENDIX XII in Schedule Y vide Gazette Notification G.S.R. 53 (E) dated 30-01-2013, specifying procedures to analyze the reports of Serious Adverse Events occurring during clinical trials and procedures for payment of compensation in case of trial related injury or death as per prescribed timelines.
- Introduction of rule 122 DAC regarding permission and conditions for conduct of clinical trials vide Gazette Notification G.S.R. 63(E) dated 01-02-2013. The rule provides authority for conducting clinical trial inspections and actions in case of non-compliance by the CDSCO.
- Introduction of rule 122 DD for registration of Ethics Committees by the office of

DCG (India) vide Gazette Notification G.S.R. 72(E) dated 08.02.2013. The amendment includes providing the requirements and guidelines for registration of Ethics Committees.

viii. Independent Expert Committees have been constituted to examine the reports of deaths in clinical trials and recommended to DCG(India) to decide the cause of deaths and to determine the quantum of compensation in each clinical trial related death. A formula has been developed for determining the quantum of compensation in case of clinical trial related deaths which is available in CDSCO website.

ix. The Committee set up under the Chairmanship of Prof. Ranjit Roy Chaudhury on approval of clinical trials and new drugs has submitted its report. The Ministry of Health & Family Welfare has examined the recommendations for taking action. The details of the recommendations and the decision of Government thereon are available on the website of CDSCO (www.cdsco.nic.in).

f) Blood Banks

Licences for the Blood Banks are also granted by the office of DCG(India) as Central Licensing Approving Authority. During the year 2013 upto November, 2013, fresh licences were granted in 127 cases while endorsement of blood components on the existing licences were issued in 85 cases.

g) National Regulatory Authority (NRA) Assessment by WHO

India has a Rs. 19,000 crore worth vaccine industry which is exporting two thirds of the vaccines manufactured in the country while one third is domestically consumed. The major international procurement agencies for vaccines are WHO, UNICEF, Gates Foundation, Clinton Foundation, etc. which purchase vaccines for the use across the world. These agencies procure vaccines on the basis of assurance by the WHO that these are of high quality and safe and efficacious for use.

WHO had conducted an extensive four day audit from 10-14 December, 2012 in respect of the vaccine clearance procedures adopted by the National Regulatory Authority (NRA) i.e. office of the Drugs Controller General (India), and was satisfied that the procedures adopted by the NRA which are stringent enough and the international community can be assured that the vaccines permitted for manufacture by the said authority are of high quality, safe and efficacious.

Subsequent to NRA assessment, WHO continues to accept the applications of Indian vaccines manufacturers for pre-qualification programme for supply of vaccines to UN agencies. Japanese Encephalitis, Pentavalent and OPV vaccines manufactured by Indian vaccine manufacturers have been pre-qualified by WHO in 2013.

h) Amendments to the Drugs and Cosmetics Rules, 1945

Apart from the amendments relating to clinical trials mentioned above, the following amendments have been incorporated under the Drugs and Cosmetics Rules, 1945 in the year 2013 to make it responsive to the present day needs of the society.

i. A new Schedule H1 containing certain antibiotics, anti-TB drugs and habit forming drugs has been incorporated under the Drugs and Cosmetics Rules, 1945 for having stricter regulatory control over these drugs vide Gazette notification G.S.R. 588(E) dated 30.08.2013.

ii. The amendments to the Drugs and Cosmetics Rules, 1945 made vide Gazette notification G.S.R. 724(E) dated 07.11.2013 are as under:

- Revision of the definition of loan licence.
- Deletion of the clause 'or its inclusion in Indian Pharmacopoeia whichever is earlier' in the explanation of rule 122E for a new drug to be considered as a new drug.
- Incorporation of a clause under Schedule D specifying the requirement of permission of DCG(India) for import of dual purpose items by the importers.
- Inclusion of Sindoor under Schedule S so that it conforms to the standard prescribed by BIS.
- Shifting of Ketamine hydrochloride from Schedule H to Schedule X.

i) Drugs and Cosmetics (Amendment) Bill, 2013

The Ministry of Health and Family Welfare introduced the Drugs and Cosmetics (Amendment) Bill, 2013 in the Rajya Sabha for the amendments to the Drugs and Cosmetics Act, 1940 on 29th August, 2013 for upgradation and restructuring the Drugs Regulatory framework for ensuring the manufacture and sale of safe and efficacious drugs in the country. It has been proposed to create a Central Drug Authority headed by the Secretary, Department of Health and Family Welfare and introduction of a new Schedule under the Act, containing drugs for which Central Licensing Authority would be empowered to issue manufacturing licences. The Bill also contains separate chapters on clinical trials and regulation of medical devices in the country. The Bill was referred to the Department Related Parliamentary Standing Committee on Health & Family Welfare for examination and report. The report of the Committee, the Seventy-Ninth Report on the Drugs & Cosmetics (Amendment) Bill, 2013 has been received and the same is under, examination in the Ministry.

j) Drugs Technical Advisory Board (DTAB)

The Drugs Technical Advisory Board is a statutory body under the Drugs and Cosmetics Act, 1940 to advice the Central Government and the State Governments on technical matters arising out of the administration of the said Act and Rules made thereunder. The Board is headed by the Director General of Health Services and DCG(I) acts as Member Secretary. Four meetings of the DTAB were held during the year 2013 as under:

i. 62nd meeting of DTAB was held on 30th January, 2013.

ii. 63rd meeting of DTAB was held on 16th May, 2013.

iii. 64th meeting of DTAB was held on 19th July, 2013.

iv. 65th meeting of DTAB was held on 25th November, 2013.

k) Drugs Consultative Committee

The Drugs Consultative Committee is also a statutory committee under the Act, consisting of Central and State Drug Controllers to advice the Government on matters relating to uniform implementation of the Drugs and Cosmetics Act and Rules made thereunder. DCG(I) acts as Chairman of the Committee. Two meetings of the Drugs Consultative Committee were held during the year 2013 as under:

i. 45th meeting of DCC was held on 4th & 5th February, 2013 at New Delhi.

ii. 46th meeting of DCC was held on 12th & 13th November, 2013 at New Delhi.

l) Banning of Drugs

The Drugs and Cosmetics Act, 1940 provides powers to Central Government to prohibit manufacture etc., of any drug or cosmetic in public interest. Drugs about which reports are received, are likely to involve risk to human beings or animals in the present context of the knowledge are examined for their safety and rationality through the expert committees/DTAB. Manufacture and sale of the drug if considered necessary is prohibited by Central Government in public interest through a gazette notification.

During the year 2013, following notifications under Section 26A were issued by the Government of India:

i. The manufacture for sale, sale and distribution of 'Dextropropoxyphene and formulations containing Dextropropoxyphene for human use' was suspended with immediate effect vide G.S.R. 332(E) dated 23.05.2013.

ii. The manufacture for sale, sale and distribution of 'Analgin and all formulations containing analgin for human use' was suspended with immediate effect vide G.S.R. 378(E) dated 18.06.2013.

iii. The manufacture for sale, sale and distribution of 'Fixed dose combination of flupenthixol + Melitracen for human use' was suspended with immediate effect vide G.S.R. 377(E) dated 18.06.2013.

iv. The manufacture for sale, sale and distribution of 'Pioglitazone and all formulations containing Pioglitazone for human use' was suspended with immediate effect vide G.S.R. 379(E) dated

18.06.2013. The matter was reviewed by the DTAB and it recommended that the suspension be revoked and the drug formulations allowed to be marketed subject to certain conditions. The Ministry of Health and Family Welfare had accordingly issued a revised Gazette notification G.S.R. 520(E) dated 31.07.2013 permitting the manufacture for sale, sale and distribution of Pioglitazone and all formulations containing Pioglitazone for human use subject to the conditions recommended by DTAB.

m) Good Distribution Practices for Pharmaceutical Products

The Guidelines on Good Distribution Practices for Pharmaceutical Products have been prepared by CDSCO. These guidelines have enumerated detailed procedures for organization and management, personnel, quality system, warehousing, temperature controls, transportation, documentation etc. including guidelines for recalls and returns. The draft guidelines are being finalized in consultation with the State Drug Control Authorities and other Stakeholders.

14.3 INDIAN PHARMACOPOEIA COMMISSION (IPC)

The Indian Pharmacopoeia Commission is poised to publish periodically the Indian Pharmacopoeia, the official and authentic book of standards. Its seventh edition of Indian Pharmacopoeia i.e. IP 2014 was released by Hon'ble Health & Family Welfare Minister, Government of India on 04/11/2013. The book will come into effect from 01/01/2014. The work of publishing the book was completed within the stipulated time schedule.

The Indian Pharmacopoeia Commission was successful in achieving the target of coming out with 300 Indian Pharmacopoeia Reference Substances (IPRS) and is on way to achieve the target of 400 IPRS by 31/03/2014. The Commission is striving vigorously for preparing, certifying and distributing Indian Pharmacopoeia Reference Standards which will go a long way to save valuable foreign currency which the Country is forced to incur on account of import of Reference Standards of life saving drugs. IPC for the first time has come out with IPRS Impurities, which in turn help in generating more revenue and save foreign currency.

The Commission intends to promote the use of generic drugs rationally. The work of publishing of the 5th edition of National Formulary of India, the book of reference, for the use of clinicians, pharmacists and nurses is under way in IP Commission. The Apex Body and Core Committees has been constituted and approved by the Ministry for bringing out the 5th edition of NFI. The Commission has procured high end scientific and technical instruments which are very essential to cope up with international parameters of efficiency, efficacy and quality of drugs.

The 2nd World Pharmacopoeia Summit was held in New Delhi on 18-19th April, 2013. The summit was attended by many pharmacopoeial bodies across the world.

The Pharmacovigilance Programme of India which was recasted to Indian Pharmacopoeia Commission by the Ministry from All India Institute of Medical Sciences, New Delhi have collected approximately 56,000 Adverse Drug Reactions (ADR) till date. Out of which 50,000 ADRs have been committed to UPPSALA, Monitoring Centre, Sweden. The Commission is in process of enhancing the number of Adverse Drug Reaction Monitoring Centres from 90 to 150. The Commission is briskly analysing and validating the Certificate of Analysis (COA) of new Drugs.

14.4 DRUG DE-ADDICTION PROGRAMME (DDAP)

The Constitution of India under Article 47 enjoins that the state shall endeavour to bring about prohibition of

the consumption of intoxication drinks and drugs, which are injurious to health. 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 come under the purview of the Narcotics Control Bureau under the Ministry of Home Affairs and the Department of Revenue as the administrator of the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 and the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988. The demand reduction activities focus upon awareness building, treatment and rehabilitation of drug using patients. These activities are run by the Ministry of Social Justice and Empowerment as the nodal Ministry and to some extent by the Ministry of Health and Family Welfare. The Ministry of Health & Family Welfare operates a limited Drug De-addiction Programme by providing financial grants for augmenting post abuse treatment facilities in select Central Government hospitals / institutions and the Government hospitals / institutions in North-East States. Under this programme, a National Nodal Centre, the "National Drug Dependence Treatment Centre (NDDTC), Ghaziabad (U.P.)", has been established under the All India Institute of Medical Sciences (AIIMS), New Delhi. The NDDTC receives regular annual recurring grants-in-aid from the Ministry. Other institutions receiving regular annual recurring financial assistance under this programme are Dr. Ram Manohar Lohia Hospital, New Delhi, Sucheta Kriplani Hospital, New Delhi, PGIMER, Chandigarh, JIPMER, Pondicherry and NIMHANS, Bangalore. The purpose of these centres is not only to provide de-addiction and rehabilitation services to the patients but also to conduct research and provide training to medical doctors in the area of drug de-addiction.

14.5 DRUG DE-ADDICTION & TREATMENT CENTRE, DEPARTMENT OF PSYCHIATRY, PGIMER, CHANDIGARH

Drug De-Addiction and Treatment Centre (DDTC), PGIMER, Chandigarh, established in 1988, has a 20 bedded inpatient section, an outpatient department and a community clinic at Kharar, Punjab. In 2013, an Urban Outreach Clinic has also been started in Manimajra, U.T. Chandigarh. At the Centre, nearly 11304 patients have been seen in walk-in and follow-up clinics and admitted around 226 patients. Counselling sessions were done to 12196 patients. Laboratory services were provided to 3872 patients. A total of 280 yoga sessions and 268 Art of Living sessions had also been provided to patients. In community clinics, around 22 camps were conducted and a total of 396 patients were seen. Various training programmes have also been initiated for various categories of professionals and para-professionals. A number of original pieces of research have been carried out in areas relevant to alcohol, drug abuse and dependence. Various research publications have come out from research conducted at the DDTC and published at reputed national and international scientific journals. Post-doctoral course i.e. DM in Addiction Psychiatry has also been approved and it is being started from January, 2014. It is first such course in the country which will create a newer cadre of de-addiction experts and specialists.

14.6 NATIONAL DRUG DEPENDENCE TREATMENT CENTRE (NDDTC), AIIMS, GHAZIABAD (U.P.)

The National Drug Dependence Treatment Centre (NDDTC) has continued to provide leadership in the management of drug dependence in the country by its multi-faceted activities through this year. The NDDTC has been in forefront in the country to develop models for treatment of drug dependence in the country. Opiate Substitution Therapy and Methadone Maintenance Treatment programme have got a major boost this year, with more and more centres in the country starting these treatment modalities for opiate drug dependence.

Besides providing clinical care at its Centre at Ghaziabad in its outpatient and inpatient services, it has strengthened its outreach services for the management of drug and alcohol dependence in the community through its outreach clinics at Sundar Nagari and Trilokpuri in Delhi. The number of new cases registering at all facilities has been increasing steadily, with more cases coming for follow-up and less number dropping out of treatment. To aid the clinical services, the Laboratory services at the

NDDTC provides timely and accurately the screening results of body fluids for detecting presence of abused drugs, and also the investigations like biochemical, haematological, and also HIV screening.

The Centre has been carrying out research with the priority aim of providing much needed solutions to find out cost-effective interventions that can help in establishing practising guidelines for other centres. This is being done through many funded and non-funded projects. The NDDTC has attracted funding for these research project from NID, ICMR, UNODC, NCPCR, NACO, GFATM and others.

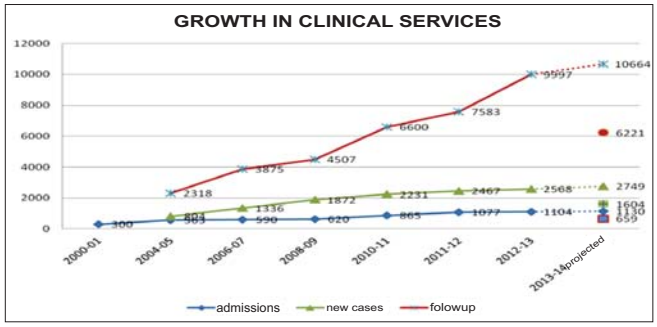
The NDDTC has continued to contribute towards capacity building of medical officers and other health professionals at the national level. It has also been playing a key role at the international level, by helping in capacity building in countries like Bhutan, Maldives, Bangladesh etc.

The NDDTC has been regularly publishing research articles in peer-reviewed journals of national and international repute. This year it also brought out 9 manuals for various substance abuse disorders for benefit of different levels of health workers. Its faculty members are involved in a number of national and international committees, taskforces, governmental and non-governmental agencies towards management and policy framework issues of substance abuse.

14.7 CENTRE FOR ADDICTION MEDICINE, NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES, BANGALORE

The Centre for Addiction Medicine (CAM), has completed more than two decades of clinical service, training and resource generation, research and advocacy in the area of addictive disorders.

The activities of the CAM were audited by the team from Voluntary Health Association of India as part of the Evaluation of the Drug DE addiction Programme under the Ministry of Health and Family Welfare.



**Plotted With Projected Scores For The Year 2013-14. Projection based on the growth in first 7 months of the year.*

A. Clinical Services

The CAM has registered 1609 new patients and 6221 patients in out-patient follow up over the period of 7 months from April to October 2013, during the review year 2013-14. 659 patients were admitted to the CAM in-patient ward during the above period for in-patient treatment. 118 of them were admitted in general psychiatry wards.

There is a comprehensive inpatient programme consisting of individual and family assessment, individually tailored treatments which involve pharmacological treatments for withdrawal and long term prevention of relapse, individual and group counseling, family counseling and intensive aftercare.

Impact of after care workers and tele-health facilities

Aftercare programme includes (a) measures for lapse management, including a novel and effective option for brief admission to prevent lapses converting to relapse; and (b) active tele-health and home-visit contacts run by the special cadre of after-care workers. These measures have been able to dramatically increase patient retention rates (from 21% to 69%) and rapid return to functioning after lapses.

Special Clinics:

a. The CAM runs a separate Opioid substitution Clinic for buprenorphine maintenance programme using international best practices.

b. The CAM has also integrated the tobacco cessation clinic along with drug de-addiction activities.

Expansion during the current year

In response to the growing public demand for patient care, public awareness, community activity, research and policy, several new initiatives have been initiated during the current year.

1. The 20 bedded in-patient facility for substance using women, the first of its kind in the country is almost complete and the services will be started from January 2014.

2. The drug-toxicology laboratory which tested more than 6000 samples for drugs and alcohol in urine and blood has had to add one more e-machine for testing samples to keep up with the growing demand. The lab has been receiving requests from outside agencies for tests to be done, since it is the only facility for such testing in the region.

3. The CAM conducted several research studies on behavioral addictions such as pathological gambling, internet and cell phone addiction and finding that the still under-recognised problem is quite common, has begun offering services for treatment of behavioral addictions.

4. The gym facility which was started during last year has received great response and is used by patients regularly.

5. Social workers who work in the community have been successful in educating the community regarding addiction and recovery and are providing preventive strategies for drug and alcohol related problems. Their main objective is:

    - Early recognition of substance users,
    - Offering treatment for the needy people,
    - Offering preventive counseling,
    - Community level education for addiction and high risk population.

They have communicated to around 2800-3000 people in Bhovi colony and around 2000-2500 people in Someshwara colony. They are coordinating with the corporate and private health services, school and education departments like anganwadi, nursery, primary and high schools, law enforcing services, religious institutions, NGOs, self-help groups and youth clubs.

The community team has identified more than 400 persons with substance use problems and have motivated them to avail treatment from the centre.

B. Training and Training-Resource Generation

Intramural Training: As in previous years post-graduate trainees in psychiatry, psychology, psychiatric social work, psychiatric nursing from the National Institute of Mental Health and Neurosciences, Bangalore received hands-on training in management of persons with addiction.

Extra-Mural Training:

a. Regional Technical Training Centre for the capacity building of Injecting Drug Users- Targeted Intervention staff of the Southern Region including the four southern states [Tamil Nadu, Kerala, Andhra and Karnataka] has been commissioned from October 2013.

b. Medical officers, Social Workers and Psychologists of the state of Himachal Pradesh, under the auspices of the National Rural Health Mission were trained in early recognition, assessment and management of addictive disorders. This is part of an ongoing process to facilitate management of alcohol, tobacco and other drug problems along with consultations for routine consultations for non-communicable disorders as well as set up specialized treatment facilities in each district of Himachal Pradesh.

c. During the year more than 55 post-graduate trainees from institutions across the country, across the disciplines of psychiatry, psychology, and psychiatric social work were posted for periods from 2 weeks to 3 months for specialized training in addiction management.

The following workshops and training activities were conducted at the CAM.

1. A one month orientation programme on Substance Abuse Management is being conducted during the month of November 2013. This programme is

conducted for both medical and non-medical personnel including lay counselors who are interested in substance abuse management. This year around 11 participants who have registered for the programme from across the country, along with 24 psychologists and social workers from Himachal Pradesh.

Figure 1: Orientation Programme on Substance Use Management

2. Medical Officers in the Southern District "National capacity building - Fourth training workshop of Training of doctors on substance use disorders was held between 17th to 30th July 2013 at NIMHANS, Bangalore. This activity has been funded by Department of Revenue, Ministry of Finance, Government of India.

3. Sixth training workshop for medical officers from Himachal Pradesh was conducted during 16th to 30th April 2013. This programme which was very well received has been appreciated and now a batch of 12 psychologists and 12 social workers from Himachal Pradesh are posted here for training.

4. The Tobacco Cessation (TCC) team have conducted more than 5 to 6 awareness programmes in the community during the year and also had a 2 day training programme for Dentists from different hospitals where more than 25 doctors were trained.

5. The CAM, TCC staff from NIMHANS conducted awareness programme under collaboration of Central Board of Workers Education. The topic was covered on tobacco related problems, behavioral counseling and treatment.

6. Technical session on "Tobacco Cessation" in the Karnataka state level consultation on ban on 'Tobacco Advertising Promotion and Sponsorship' (TAPS) on 05/07/2013.

7. Workshop "Tobacco related problem and its Intervention"on 24th and 25th September, 2013 at Centre for Addiction Medicine, NIMHANS.

a. Prof. Pratima Murthy and Prof. Vivek Benegal in their capacity as visiting professors at the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health,Tezpur delivered 5 training lectures and conducted 2 skill workshops.

b. Faculty members from the CAM conducted training sessions and workshops as part of different Continuing Medical Education Programmes, in different regions of the country. Some important ones are listed below:

- Alcohol Control Measures at course on NCD Prevention and Control for Harvard School of Public Health Scholars and Lown Foundation Fellows. New Delhi (January, 2013).
- "Assessment in SUD" and "Management of Opioid Use Disorders" at NRHM- NIMHANS conducted training programme in February 2013.
- Invited talk on Counselling for Alcohol and Drug Addicts, RRTC South Zone II, sponsored by NC-DAP (National Centre for Drug Abuse Prevention), National Institute of Social Defence, Ministry of Social Justice and Empowerment, Govt of India, 13 April 2013, Bangalore.
- Two day workshop on Tobacco Cessation services for Dentists in September 2013.

Training Resources Created

A Treatment Providers manual for family based relapse prevention and a work-book for relapse management for persons seeking treatment for addictive disorders and their care-givers was published and is currently in routine use with in-patients at the CAM.

14.8 MEDICAL STORE ORGANIZATION (MSO)

Medical Stores Organisation under the Directorate General of Health Services is a century old Organisation.

Originally, it was created primarily to meet the need of Medical Stores of the troops and Military based Hospital and to hold reserves in the event of hostilities with other countries. In 1942, the Army authorities established their own depot and MSO came under civil administration of the central government. The Medical Stores consists of seven Medical Store Depots located at Mumbai, Kolkata, Chennai, Hyderabad, Guwahati, Karnal and New Delhi. The main function of Medical Store Organisation is to procure store and supply of quality medicines to its indenters at a competitive price through its seven GMSDs located at various places.

The Depots at Mumbai, Chennai and Kolkata have Quality Control Laboratories attached to them for quality testing before dispatch of medicines to the indenters.

The MSO operates through two formularies, one for proprietary/branded drugs and other for generic drugs. During 2013-14 it has undertaken rate contract for 514 branded drugs and 157 generic drugs. As per the indents made by its about 1800 indenters, it supplied medicine to them. An exhaustive new formulary consisting of 1447 Generic drugs has been finalized.

The Medical Stores Depot had arranged immediate medical relief supply of ORS, and other essential lifesaving medicines for flood affected areas of the States of Uttarakhand and cyclone affected area of Odisha during 2013-14. The medical store depots also arranged 196350 doses of quadrivalent meningococcal meningitis vaccine and 13899 doses of influenza vaccine for Haj Pilgrims during 2013-14.

To bring transparency and accountably in the working of MSO online programme has been developed by NIC. Procurement and supply of proprietary & generic drugs for all the indenters is being done online.

GMSD, Karnal, Mumbai, Chennai and Kolkata are having cold chain facilities and handling storage & distribution of vaccines. It has been decided to improve and modernize cold chain facilities in all existing seven GMSDs so that the storage and distribution of vaccine can be undertaken more effectively.

The GMSDs are also storing and distributing the material for National Programme like T.B Programme, Family Welfare Programme etc. & necessary provision of enhancing their storing capacity for the store relating to these National Programme is being carried out by GMSDs.

Chapter 15

MEDICAL EDUCATION, TRAINING & RESEARCH

15.1 INTRODUCTION

The Centre has set up regulatory bodies tor monitoring the standard of medical education, promoting training the research activities. This is being done with a view to sustain the production of medical and para-medical manpower to meet the requirements of health care delivery system at the Primary, Secondary and Tertiary levels in the country. This chapter discusses the status of these activities conducted by the various bodies and institutions.

15.2 MEDICAL COUNCIL OF INDIA (MCI)

The Medical Council of India was established as a statutory body under the provisions of the Indian Medical Council Act,1993, which was later, replaced by the Indian Medical Council Act (IMC), 1956 (102 of 1956). The main functions of the Council are:

i. Maintenance of uniform standard of Medical Education or undergraduate and postgraduate level;
ii. Maintenance of Indian Medical Register;
iii. Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications;
iv. Provisional/permanent registration of doctors with recognized medical qualifications, registration of additional A qualifications, and issue of good standing certificate for doctors going abroad; and
v. Continuing Medical Education, etc.

As per the IMC Act, 1956 prior permission of the Central Government is mandatory for opening of a new medical college, increase in an admission capacity and starting of new or higher course of studies as per provisions laid down in Establishment of Medical College Regulations, 1999 and Minimum Standard Requirements Regulation, 1999.

The Medical Council of India has been re-constituted on 6th November, 2013 vide notification dated the 5th November, 2013 replacing the Board of Governors who were nominated by the Central Government under the provisions of the Ordinance of 15.05.2010 in supersession of the Council to perform the function of the Council.

At present, there are 387 medical colleges in the country out of which 181 are in government and 206 in private sector with annual admission capacity of about 51,979 MBBS and 24,196 Postgraduate students per year. 25 new medical colleges have been granted permission for the academic year 2013-14 and a total of 6350 MBBS seats and 1081 PG seats increased for the year.

15.2.1 Schemes to meet the shortfall of Human Resource in Health Sector

i) **Schemes for strengthening and up-gradation of State Government Medical Colleges for increase of PG Seats:** The Central Government is also implementing a Centrally Sponsored Scheme for strengthening and up-gradation of State Government Medical Colleges for Starting/ Increasing Postgraduate seats with priority to the disciplines like Anatomy, Forensic Medicine, Obst. & Gynaecology, Paediatrics, Anaesthesiology, General Medicine, General Surgery, Microbiology, Physiology, Pharmacology, Community Medicine, Geriatric, Transfusion Medicine and Bio-Chemistry. Under this scheme, central share of Rs. 1350 crores has been earmarked. Till 31.03.2014, central share amounting to Rs. 716.94 crore has been released to 72 State Government Medical Colleges in 20 States.

ii) **Scheme for establishment of new Medical Colleges attached with existing District/Referral Hospitals:** The Central Government has approved

a centrally sponsored scheme for "Establishment of new medical colleges attached with existing district/referral hospitals". Under the scheme, 58 medical colleges with intake capacity of 100 in each to increase 5800 seats at undergraduate level in Government sector with central share of Rs. 8457.4 crores and State/UT share of Rs. 2513.7 crores with a fund sharing between the Central government and the State governments in the ratio of 90:10 for North Eastern and Special Category States and in the ratio of 75:25 for other States. The objective is to utilize the existing infrastructure of district hospitals for increasing additional undergraduate seats in a cost effective manner by attachment of new medical college with exiting district/referral hospitals.

iii) **Strengthening and up-gradation of State Government Medical Colleges for increase in intake capacity of MBBS seats:** The Central Government has approved a Centrally Sponsored Scheme for "Up-gradation of existing state government/central government medical colleges to increase MBBS seats in the country". Under the scheme 10,000 MBBS seats will be created in the country with central share of Rs. 7,500 crores and State/UT share of Rs. 2,500 crores with a fund sharing between the Central government and the State government in the ratio of 90:10 for North Eastern and Special Category States and in the ratio of 70:30 for other States with upper ceiling of the cost per MBBS seat pegged at Rs.1.20 crore. The scheme envisage to mitigate the shortage of Doctors by increasing the number of undergraduate seats in the country for equitable health care accessibility across country and to achieve the desired doctor population ratio.

15.3 DENTAL COUNCIL OF INDIA (DCI)

The Dental Council of India (DCI) is a statutory body constituted by an Act of Parliament viz. Dentists Act, 1948 (XVI of 1948) with the main objective of regulating the Dental Education, Dental Profession, Dental ethics in the country and recommend to the Govt. of India to accord permission to start a Dental College, start higher course & to increase of seats. For this purpose the Council periodically carries out inspection to ascertain the adequacy of courses and facilities available for the teaching of Dentistry.

This Council had received 259 applications in prescribed form/scheme from the Central Government for (i) establish new Dental Colleges (ii) starting MDS Courses (iii) increase of seats in BDS/MDS/PG Diploma Courses for evaluation & recommendation in accordance with the provision of the Section 10A of the Dentists Act, 1948. During the said period, the Council had recommended to the Central Government to grant its permission to (i) establish 5 new Dental Colleges, (ii) start MDS course in 105 specialities at 41 Dental Colleges (iii) start PG Diploma course in 3 specialities at 2 Dental Colleges (iv) increase of admission capacity in BDS courses at 6 Dental Colleges, increase of admission capacity in MDS courses in 90 specialities at 35 Dental Colleges and increase of admission capacity in PG Diploma course in 1 speciality at 1 Dental College. The Central Government on recommendation of the Council had permitted 4 new Dental Colleges, for starting of MDS Course in 99 specialities at 40 Dental Colleges, for starting of PG Diploma course at 2 Dental Colleges in 5 specialities, for increase of seats in BDS course at 5 Dental Colleges, for MDS course at 35 Dental Colleges in 87 specialities and for PG Diploma course at 1 Dental College in 1 speciality.

This Council had recommended to the Central Government to allow/renew its permission for 2nd/3rd/4th/5th/6th year in BDS course at 23 Dental Colleges and for 2nd/3rd/4th/5th year with increased intake capacity in 16 Dental Colleges, allow/renew its permission for 2nd/3rd/4th year in MDS course at 111 Dental Colleges in 384 specialities and for 2nd/3rd/4th year with increased intake capacity at 51 Dental Colleges in 215 specialities, allow/renew its permission for 2nd/3rd year in PG Diploma course at 3 Dental Colleges in 8 specialities and for 2nd year with increased intake capacity at 1 Dental College in 1 speciality. The Central Government on recommendation of the Council had allowed/renewed its permission for 2nd/3rd/4th/5th/6th year in BDS course at 22 Dental Colleges and for 2nd/3rd/4th/5th with increased intake capacity at 15 Dental Colleges, allowed/renewed its permission for 2nd/3rd/4th year in MDS course at 108 Dental Colleges

in 461 specialities and for 2nd/3rd/4th with increased intake capacity in 246 specialities at 54 Dental Colleges, renewed its permission for 2nd/3rd year in PG Diploma course at 2 Dental Colleges in 3 specialities and increase of seat in 1 speciality at 1 Dental College. During this period 1111 inspections of the various Dental Colleges in the country had been carried out by the Council's Inspectors/Visitors.

This Council had taken decision to recommend to Central Government for recognition of the BDS/MDS/PG Diploma qualifications awarded by 26 Indian Universities under Section 10(2) of the Dentists Act, 1948. The Government of India on the recommendation of the Council had issued 115 notifications of recognition of BDS/MDS qualifications awarded by the 45 Indian Universities under Section 10(2) of the Dentists Act, 1948. The Council had recognised the Dental Mechanic Course at 2 Dental Colleges and Dental Hygienist Course at 1 Dental College.

The Govt. of India, Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi has sanctioned an amount of Rs. 20 lakhs as Grant-in-aid to the Council for the year 2013-2014.

15.4 PHARMACY COUNCIL OF INDIA (PCI)

The Pharmacy Council of India (PCI) is a body constituted under section 3 of the Pharmacy Act, 1948 to regulate the profession and practice of Pharmacy. The objectives of the Council is to prescribe minimum standards of education required for qualification as a pharmacist, uniform implementation of educational standards, approval of course of study and examination for pharmacists, withdrawal of approval, approval of qualifications granted outside India and maintenance of Central Register of Pharmacists.

The Council arranged 1813 inspections of diploma, degree and Pharm. D. institutions and held a number of meetings of the Executive Committee and central council during the last one year as a result of which approval of 308 Diploma & Degree institutions was extended u/s 12 of the Pharmacy Act; 120 new Diploma & Degree institutions was extended u/s 12 of the Pharmacy Act; 31 new Pharm. D. institutions were granted approval of the conduct of course and 10 new Pharm. D. (Post Baccalaureate) institutions were granted approval for the conduct of course.

At Present 710 institutions with 42,282 admissions for Diploma in Pharmacy and 930 institutions with 62,375 admissions for degree in Pharmacy has been approved by the Pharmacy Council of India.The Pharmacy Council of India Regulations on curbing the menace of ragging in Pharmacy Colleges, 2012 has been notified in the Gazette of India.

Continuing Education Programmes (CEP) plays an important role in the growth of the knowledge bank of the pharmacist. The PCI from its own resources is giving a financial assistance of Rs. 10,000/- per course subject to ceiling of 12 courses to the State Pharmacy Council for the conduct of CEP for pharmacists.

Grant under 11th Five Year Plan and Annual Grant-in-aid: A new initiative for strengthening/up-gradation of Pharmacy institutions and continuing education programme for pharmacy teachers and practicing pharmacists was approved by the Standing Financial Committee under the Chairmanship of the Secretary (Health & Family Welfare) for Rs. 65.00 crores during 11th Five Year Plan. The scheme is still continuing in 12th Five Year Plan. The Central Govt. has provided Grant-in-aid of Rs. 20.00 lakh for the financial year 2013-14.

Pharmacist Day and Pharmacy Award: PCI declared Pharmacist's day for the first time to be celebrated in 25th September, every year. Accordingly PCI celebrated the Pharmacist Day on 25.09.2013 at Siri Fort Auditorium, New Delhi.

15.5 DEVELOPMENT OF PHARMACY EDUCATION

Strengthening/Up-gradation of Pharmacy Institutions: The Scheme was approved by the Standing Finance Committee (SFC) of the Ministry of Health and Family Welfare in the meeting held on 27.12.2010 under the Chairmanship of Secretary (H&FW) with an outlay of Rs. 65 crores.

Setting up of college of Pharmacy in Government Medical Colleges: In this Rs. 824.30 crore has been allocated in the 12th Plan and Rs. 26.65 crore in the

financial year 2013-14. The proposal of the Govt. for establishment of college of Pharmacy in Govt. Medical College is in the interest of Pharmacy Profession and the Pharmacy Council of India fully supports the same. Such a move will: -

a. Enable the deserving students to get quality education.

b. Ensure the availability of skilled competent pharmacist workforce to the society.

c. Create job opportunities for pharmacy teachers.

15.6 DEVELOPMENT OF ALLIED HEALTH (PARAMEDICAL) SERVICES

Two centrally Sponsored Schemes regarding paramedical services under this section as follows:-

1. A centrally sponsored scheme named "Establishment of National Institute of Paramedical Sciences and Eight Regional Institute of Paramedical Sciences as well as developing the existing RIPANS, Aizawal as the 9th RIPS and manpower development to support State Government Medical Colleges through one time grant" has been initiated by Ministry of Health & Family Welfare during the 11th Plan period and shared between the Centre & State Government have been allocated in the ratio 85:15.

➢ The Scheme aims to augment the supply of skilled paramedical manpower and promote paramedical training through standardization of such education/ courses across the country. This Capacity Building scheme will also lead to:-

- Reduction in regional imbalances in availability of Paramedics;
- Introduction of courses in New/Cutting Edge Disciplines;
- Augmentation of Capacity for Planning, Monitoring, Evaluation etc. and
- Provision of quality assured services through in-service training, action research, onsite support etc.

➢ The Scheme has two components:-

i) Establishment of one National Institute of Paramedical Sciences (NIPS) at Najafgarh, Delhi and eight Regional Institutes of Paramedical Sciences (RIPS) at Bhubaneswar, Lucknow, Coimbatore, Chandigarh, Hyderabad, Bhopal, Bhagalpur and Nagpur.

ii) To support State Govt. Medical Colleges for conducting paramedical courses through one time grant at a cost of Rs. 352.00 crores.

➢ Under the scheme Rs. 107.90 crore has been released so far as per details given below:-

i) Rs. 86.00 crore has been released to HLL Lifecare Ltd., the Project Management consultant for construction of NIPS & RIPS.

ii) Rs. 1.20 crore has been released to PHFI to support MoHFW towards preparation of a business Model for the establishment of NIPS & RIPS as well as faculty development.

iii) Rs. 21.22 crore to Five Govt. Medical Colleges to start new courses and increase intake capacity of existing courses.

2. Setting up of State institutions of paramedical science in States and setting up of college of paramedical education under 12th Plan. EFC has been under process.

15.7 INDIAN NURSING COUNCIL (INC)

The Indian Nursing Council is an autonomous body under the Govt. of India, Ministry of Health & Family Welfare. Indian Nursing Council (INC) Act, 1947 gives statutory powers to INC maintain uniform standards and regulation of nursing education all over the Country.

The prime responsibility of Indian Nursing Council is to set the norms and standards for education, training, research and practice within the ambit of the relevant legislative framework.

Inspections:

1. First Inspection is conducted to start any nursing programme prescribed by Indian Nursing Council on receipt of the proposal as per calendar of events.

2. Periodic inspections are conducted to monitor the institutions offering quality education.

3. Re-inspection and inspection for enhancement of seats is conducted based on the application of the institution & the calendar of events.

Income: A sum of Rupees 9,33,20,008 has been received from the nursing education institutions towards inspection/affiliation fee and publication from 1.4.2012 to 25.10.2013.

Institutions recognized by Indian Nursing Council: The course wise number of Nursing Institutions recognized as on 25.10.2013 are as follows:

Sr. No.	Programme	Total
1.	ANM	1865
2.	GNM	2939
3.	B.Sc.(Nursing)	1658
4.	P.B.B.Sc. (Nursing)	750
5.	M.Sc. (Nursing)	571
6.	Post Basic Diploma Programme	294

Number of Registered Nurses: 15,62,186 Nurses, 7,26,557 ANM's and 55,498 Health Visitors have been registered with various State Nursing Council up to 31st December 2012.

New Initiatives:

1. **Capacity building of ANM Tutors:** In order to strengthen pre-services education of Auxiliary Nursing & Midwifery (ANM) Training programme. Indian Nursing Council in collaboration with (JHPEIGO) has initiated the project. The main objective: higher functioning educational institutions, better prepared Nurses and Midwives workforce who are competent, confident and ready to work upon graduation, especially in rural areas.

2. **On line details of the institutions:** Indian Nursing Council has developed web based teaching faculty & other details wherein institute has to update their teaching faculty details on Indian Nursing Council website. This will be online registration for Teaching faculty, Clinical facilities including students enrolled every year.

3. **Live Register:** Detailed project report on the Live Register has been developed.

4. **e-learning Module:** On HIV/AIDS care and treatment e-learning has been developed and is available on Indian Nursing Council website.

5. **National Consortium for Ph.D. in Nursing:** National Consortium for Ph.D. in Nursing has been constituted by Indian Nursing Council to promote research activities, in various fields on Nursing in collaboration with Rajiv Gandhi University of Health Science, supported by WHO. A total 234 students have been enrolled under National consortium of Ph.D. in Nursing.

6. **Website of Council:** The website of Council is www.indiannursingcouncil.co.in &www.indiannursing council.org which is being updated regularly.

15.8 EXISTING SCHEME OF DEVELOPMENT OF NURSING SERVICES

In order to improve the quality of Nursing Services, the following programmes have been implemented during 2013-14.

1. **Upgradation of Schools of Nursing attached to Medical Colleges into Colleges of Nursing:** Under the revised one time assistance of Rs. 6.00 crores approved for upgrading a School of Nursing into a College of Nursing in order to increase the availability of graduate nurses, the funds are released to the institute subject to the condition that State Government/Institution will bear the recurring expenditure. The financial assistance is meant for civil works including addition and alteration of school and hostel building and for furniture, audio-visual aids.

   A sum of Rs. 4.18 crore has been released during the year 2013-14 to School of Nursing at Udaipur, Rajasthan.

2. **National Florence Nightingale Award for Nursing Personnel:** National Florence Nightingale Award was given on 12.5.2013 by the Hon'ble President of India to 35 nursing personnel as a mark of highest recognition for meritorious

services in the nursing profession in the Country. Each award carries a Certificate of Merit and Cash Award of Rs. 50,000.

3. New Scheme of Strengthening/Up-gradation of Nursing Services under Human Resource:-

- **Opening of ANM/GNM Schools:** CCEA has approved this Ministry's proposal for opening of 132 ANM Schools and 137 GNM Schools under XI plan period. A Sum of Rs. 11,75,12,500 has been released during 2013-14 for opening of 5 ANM and 1 GNM School.
- **Launch of National Nursing Portal:** National Nursing Portal designed and developed by National Informatics Centre, Hyderabad was launched by Smt. Anuradha Gupta, AS&MD, (NRHM) on 14th February, 2013; The Nursing Portal is an online resource center for nurses, students, nursing institutions, national and state nursing councils and boards and Ministry of Health and Family Welfare; The purpose of the portal is to bring the entire nursing & midwifery cadre, students, State Nursing Councils (SNC), Indian Nursing Council (INC), Ministry of Health and Family Welfare (MoHFW) and the other stakeholders on a common platform and to improve the nursing & midwifery services by providing useful information to all the stakeholders.

15.9 RAJKUMARI AMRIT KAUR (RAK) COLLEGE OF NURSING, NEW DELHI

The Rajkumari Amrit Kaur College of Nursing was established 67 years ago with the objective to develop model programmes in Nursing Education. The College continues to offer four regular programmes i.e. B.Sc. (Hons.) Nursing, Master of Nursing, M.Phil and Ph.D. in Nursing. Besides these, the College conducts short-term continuing education courses. The institution works in close association with Ministry of Health & Family Welfare, Hospitals, Health Center and Allied agencies.

Admissions and Graduation

The admissions to B.Sc.(Hons.) Nursing and Master of Nursing and M. Phil in Nursing are made on the basis of merit in the selection test as laid down by the Academic Council of the University of Delhi.

i)	Total admissions made in July, 2014	:	90
	B.Sc. (Hons.) Nursing 1st year	:	66
	Master of Nursing 1st Semester	:	24
ii)	No. of Foreign students	:	03
iii)	No. of Physically handicapped students	:	Nil
iv)	No. of participants in short term courses		
	National level	:	58
	State Level	:	240

Scholarship and Financial Aid:

- 52 B.Sc.(Hons) Nursing students were awarded Merit Scholarship by the Department of Welfare for SC/ST/OBC & Minority, Government of N.C.T of Delhi.

Budget

The Budget Provision for the 2013-2014 was Rs. 6,50,00,000/- (Rupees six crore fifty lakh only) in Non-Plan and Rs. 10,00,00,000/- (Rupees Ten crore) only in plan scheme.

Continuing Education

Two national level short term courses and 13 State level workshops were conducted for updating the skills of nursing personals working in Delhi. Apart from that professional study programmes, educational tours and individual study programmes were planned and co-ordinated for visiting nurses, health professional and students from other states.

Rural Field Teaching Centre, Chhawla

The Rural Teaching Centre was established in 1950 for the purpose of providing objective oriented rural community health experience to the students. It covers 7 villages with an approximate population of 52,000 and is situated 32 kms away from the college. The centre provides an integrated comprehensive health and family welfare services to the community. Special emphasis is given on MCH services, Family Planning, Immunization, Family Welfare Services, Nutrition, Adolescent Girl's

Health and Health Education Programme by the students and staff of rural unit in collaboration with the staff of RHTC, Najafgarh. Staff and students also participated in National Health Programmes like Malaria Control Programme, Dengue Control Programme, Revised National Tuberculosis Control Programme, AIDS Control Programme, Diarrhoea Disease Control and Intensified Pulse Polio Programme etc. The centre also has DOTS and Microscopic centre for screening and treatment of T.B. & MDRTB patients. In addition, the centre provides mobile van clinic services to seven villages with special emphasis on primary, secondary and tertiary levels. RFTC Chhawla is also a 'Team Movement Point' for pulse polio programmes.

Library

The College Library has a total 20588 books. Number of books purchased during the year, 2013-2014 is 207.

Number of Journals purchased are Foreign Journals - 27, Indian Journals-3, Newspapers -6 and Magazines -7.

The total expenditure on books and journals during the period was Rs. 21,51,878/- (Rupees Tewnty One lakh Fifty One thousand Eight Hundred and Seventy Eight) only. Xerox facilities and lending facilities were provided to the students and staff.

Other Activities

Despite the limitations of accommodation, faculty positions, other restraints and constraints, the College has made great strides in the field of nursing and health care. Some teachers of the college are engaged in many areas of research in different fields of nursing and nursing education. Some of them are providing consultative and advisory services and are participating in some projects and meetings at national level.

In accordance with the Delhi University regulation "Policy on Sexual Harassment Ordinance XV(D): Prohibition of and Punishment for Sexual Harassment of University of Delhi", A College Complaint Committee of 9 members including two outside members has been formulated for dealing with cases of Sexual Harassment.

Achievements

- The College continued to work as Programme Study Centre for Ph.D. programme offered by Ph.D. Consortium initiated by Indian Nursing Council and R.G.U.H.S.
- The College is functioning as sub-recipient for Global Funds for AIDS, Tuberculosis and Malaria (GFATM) Project. The College is conducting following activities under the project:-

➢ 1 NACO TON were conducted in which 15 participants were participated

➢ 1 ANM TOT were conducted in which 37 participants were participated

➢ 2 ANM TON were conducted in which 65 participants were participated

➢ 2 RE-TON was conducted in which 78 participants were participated.

15.10 NATIONAL ELIGIBILITY CUM ENTRANCE TEST (UG), 2013 FOR ADMISSION TO 15% ALL INDIA UG SEATS-2013 CONDUCTED BY CBSE

National Eligibility cum Entrance Test, 2013 was conducted by Central Board of Secondary Education (CBSE) on 5th May, 2013; 18th May, 2013 and 26th May 2013 for 15% All India Quota Seats and 85% State Quota seats in Medical/Dental courses all over the country. Total 658040 candidates appeared in the Test out of which 366317 candidates have been declared qualified for the Test. The result was declared on 5th June, 2013 whereas a total of 13645 candidates were declared eligible to participate in the counseling for 15% All India Quota Seats. Allotment was in 148 Government Medical Colleges and 32 Dental Colleges on 3012 MBBS Seats and 281 BDS seats respectively.

Allotment of college and courses to successful candidates were made as per their Rank by Online Counseling conducted by Directorate General of Health Services (DGHS) in Ministry of Health & Family Welfare for the academic year 2013-14 in three rounds. The whole admission process for 15% All India quota of MBBS/ BDS seats was successfully completed by 29/8/2013.

15.11 ALL INDIA ENTRANCE EXAMINATION FOR ADMISSION TO 50% ALL INDIA PG SEATS-2013 CONDUCTED BY NBE

In Compliance with directions of the Hon'ble Supreme Court of India, the National Board of Examination, New Delhi conducts the All India PG Entrance Examination on all India Basis.

The Entrance Examination was held at 51 Centers in 33 capital cities across the country on 23rd November - 6th December, 2012. A total of 95673 candidates were registered and 90377 candidates appeared in the Examination for admission to MD/MS and Diploma Courses. The result was declared on 16th May, 2013 for enabling the allotment of seats for the merit/wait list candidate in 136 Medical Colleges all over India as per prospectus for 2013 approved by Ministry of Health & Family Welfare, Government of India. There were 5534 recognized/approved seats in MD/MS and Diploma Courses under the 50% All India PG Quota for the academic year 2013-14. The allotments were made to the successful candidates through On-line Counseling conducted by DGHS in Ministry of Health & Family Welfare, Government of India. The whole allotment process of 50% All India PG Quota Counseling-2013 was successfully completed by 21/08/2013.

15.12 ALL INDIA ENTRANCE EXAMINATION FOR ADMISSION TO MDS COURSE UNDER 50% ALL INDIA QUOTA - 2013 CONDUCTED BY AIIMS, NEW DELHI

In Compliance with directions of the Hon'ble Supreme Court of India, the All India Institute of Medical Sciences, New Delhi conducts the All India PG Entrance Examination for MDS course under 50% All India Quota basis.

The Entrance Examination was held at 33 Centers in 06 capital cities in the country on 13/01/2013. A total of 16549 candidates were registered and 15172 candidates appeared in the Examination for admission to MDS Courses. The result was declared on 20th May, 2013 for enabling the allotment of seats for the merit/wait list candidate in 26 Dental Colleges all over India as per prospectus for 2013 approved by Ministry of Health & Family Welfare, Government of India. There were 192 recognized/approved seats in MDS Courses under the 50% All India PG Quota for the academic year 2013-14. The allotments were made to the successful candidates through On-line Counseling conducted by DGHS in Ministry of Health & Family Welfare, Government of India. The whole allotment process of 50% All India PG Quota Counseling-2013 was successfully completed by 21/08/2013.

15.13 ALLOCATION OF MEDICAL/DENTAL SEATS FROM CENTRAL POOL

A Central Pool of MBBS and BDS is maintained by the Ministry of Health and Family Welfare by seeking voluntary contribution from the various States having medical colleges and certain other Medical Education Institutions. In the academic session 2013-14, 225 MBBS and 30 BDS seats were contributed by the States/UTs and medical institutions. These seats were allocated to the beneficiaries of the Central Pool, viz., States/Union Territories, which do not have Medical/ Dental Colleges of their own, Ministry of Defence (for the wards of Defence Personnel), Ministry of Home Affairs (for the children of para-military personnel and Civilian Terrorist Victims), Cabinet Secretariat, Ministry of External Affairs (for meeting diplomatic/bilateral commitments and for the children of Indian staff serving in Indian Mission abroad), Ministry of Human Resource Development (for Tibetan Refugees) and Indian Council for Child Welfare (for National Bravery Award winning children).

MDS Seats

There are 4 MDS seats in the Central Pool contributed by Government of Uttar Pradesh, which are allotted to the in-service doctors sponsored by the States/Union Territories without MDS teaching facility on a rotational basis. For the academic session 2013-14, no eligible in-service doctors were sponsored by the beneficiary States/UTs.

Post Graduate Medical Seats for Foreign Students

There are 5 P.G. medical seats in the Institute of Medical Sciences, Banaras Hindu University, Varanasi reserved for foreign students in a calendar year. The foreign students against these seats are nominated by the Ministry of Health & Family Welfare on the advice of

Ministry of External Affairs. During the academic year 2013-14, two seats were allocated to the candidates from Nepal.

15.14 NATIONAL BOARD OF EXAMINATIONS (NBE)

The National Board of Examinations conducts examinations in a planned and scientific manner with regards to validity and reliability of assessment. A sound examination linked with evidence in educational research and evaluation system reduces subjectivity and promotes uniformity and standardization. The intent is to ensure accurate measurement of professional competence and adherence to quality assurance through scientifically structured tests keeping in view the objectives of the NBE. Structured training and practical/clinical/viva-voice examinations and a continuous review of evaluation processes are the major thrust areas for achieving this goal. Exams held during the year 2012-13 are as follows:

Examinations Details	Appeared	Pass
Centralized Entrance Test (CET)	45718	36921
Centralized Entrance Test (Super-Specialities)	1590	1166
Fellowship Entrance Test	740	681
DNB Final Examination	5748	3118
Fellowship Exit Examination	120	86
Foreign Medical Graduates	13953	3664
National Eligibility-Cum-Entrance Test for Post Graduate Courses (NEET-PG)	90276	70297

Post-Doctoral Fellowship Programmes

India has expertise in various sub-specialty areas, with medical institutions having requisite technology and trained manpower delivering high quality medical services. There are many young medical post-graduates with aptitude for higher learning and considering the need to increase manpower that can render highest degree of professional work; the National Board has started Post-doctoral Fellowship courses.

Well-equipped centers, after due procedure have been identified in concerned specialties for imparting hands on training. Candidates with DNB/MD/MS/DM/MCH qualification in the concerned specialty are eligible to pursue NBE fellowship training. Selection is based on an entrance test and centralized counseling. The trainees go through a structured training programme, maintain performance record books and undergo examination at the end of the training. Successful candidates are awarded the fellowship of National Board at the annual convocation. The sub-specialties in which the fellowship programmes are available along with the 170 seats during the reporting period.

Accreditation Committee

NBE approves the accredited centers of studies which provide adequate facilities for training. During the year 2012-13, two meetings of the Accreditation Committee were held on 3rd May 2012 and 4th December 2012. The committee recommended accreditation to 42 hospitals for Broad specialty, 22 hospitals for Super specialty and 7 hospitals for FNB courses accounting to 112 seats for broad specialty, 57 seats for Super specialty and 15 seats for FNB courses also renewal was granted to 164 hospitals for Broad specialty, 53 hospitals for Super specialty and 26 hospitals for FNB courses accounting to 550 seats for Broad specialty, 133 for Super specialty and 63 for FNB courses.

Continuing Medical Education Programme/ Workshops

NBE in its continuing endeavor to strengthen research and facilitate capacity building in Research Methodology periodically conducts workshop for benefits of Post Graduate trainees and faculty members.

Workshops in Research Methodology:

i. St. John's Medical College & Hospital, Bengaluru, Karnataka

ii. PSG Institute of Medical Sciences & Research, Coimbatore, Tamil Nadu

iii. Seth GS Medical College & KEM Hospital, Mumbai, Maharashtra

iv. Indian Institute of Public Health (IIPH), Hyderabad, Andhra Pradesh

v. Indian Institute of Public Health (IIPH), Delhi

vi. University College of Medical Science & GTB Hospital, Delhi

vii. Kanchi Kamakoti Childs Trust Hospital, Chennai, Tamil Nadu

External Appraisal

The purpose of local appraisal is to further improve the quality of training, assess the training infrastructure for the DNB candidates and also assist the local institutions to develop into a center of academic excellence. This would further add value to the services being rendered in these accredited hospitals/institutions. During the year 2012-13, 1484 assessors appointed for hospitals/ medicals institutions all over India and feedback of shortcomings observed and suggestions for further improvement of each candidate and hospital were also communicated to the concerned hospital and DNB Trainee for further improvement.

Thesis & Research

As per NBE norms, writing a thesis is essential for all DNB candidates towards partial fulfillment of eligibility for award of DNB degree certificate. During the period i.e. 1st April 2012 to 31st March 2013 the outcome of the thesis assessment were 3657.

Development of Regional Offices

The regional office at Bengaluru has been already operationalised last year and the Regional Office at Hyderabad is also being operationalised this year. The Regional offices have been equipped to strengthen service delivery, research, training and assessment. In addition to the above, a centre at Chennai is also at the final stage of establishment by taking over the building from Southern Railway Headquarter Hospital.

Further it is also stated in the matter that the Board is also under the process of developing regional offices at Jammu & Kashmir and in the North-East region.

NBE Contact Center

National Board of Examinations inaugurated a centralized office i.e "NBE Contact Center" for the purpose of communicating a large volume of telephonic and email queries. The purpose of developing NBE Contact Center is to provide valid, appropriate and satisfactory information on each query raised. NBE Contact Center is functioning for both Inbound and Outbound calls. An Inbound Contact Center of NBE is operated by Candidate Care Executives (CCEs) to manage incoming query and e-mails from the candidates.

Outbound Contact Center of NBE is operated for calling the candidates/doctors/hospitals etc for providing them the information regarding their thesis status, results, hospital accreditation, CME workshops and for taking their valuable feedback which is used for internal trainings and improvements. During last year approx. 57000 telephonic calls were answered by NBE Contact Center delivering solutions to approx. 95% of total queries.

Satellite Education

Satellite based interactive sessions are conducted using television broadcast on Gyan Darshan Channel every Thursday (2.30 pm to 7.30 pm). During last year approx. 213 Teleconferencing sessions were conducted by National Board of Examinations delivering a broadcast of approx. 160 hours of programme. These sessions provide two-way audio communication and one-way video communication between the faculty and the DNB students and it is also available on DTH Platform.

Gyan Vani (Radio FM): NBE also conducts interactive sessions on FM Radio every Thursday from 5.00 pm to 6.00 pm on Radio Gyan Vani. This transmission is available all over India. The Radio session provides an economical and convenient access for the Post Graduate trainees across various hospitals to eminent faculty members and important topics from the curriculum. During the year 2012-13, a total of 44 sessions were held delivering 44 hours of programme.

NBE Awards for Teacher and Institutes: NBE has also instituted awards for teacher & medical institutions for excellence in teaching under the following categories to honor distinguished faculty members & accredited institutions for their valuable contribution to DNB programme in the following categories:

1. Emeritus Teacher Award
2. Eminent NBE Alumni Teacher Award
3. Distinguished DNB Teachers of Excellence Award
4. Excellence in teaching for DNB programme - NBE accredited hospitals

15.15 NATIONAL ACADEMY OF MEDICAL SCIENCES (INDIA)

The National Academy of Medical Sciences (India) was established in 1961 as a registered Society with the objective of promoting the growth of medical sciences. The National Academy of Medical Sciences (India) is a unique institution which fosters and utilises academic excellence as its resource to meet the medical and social goals. Over the years the Academy has recognized the outstanding achievements of Indian scientists in the field of medicine and allied sciences and conferred Fellowship and Memberships. Fellows and Members are chosen through a peer review process consisting of screening by the Advisory Panel of Experts and the Credentials Committee, election through voting by the Council and by all the Fellows.

As on 10th January, 2014, the NAMS has on its roll 3 Honorary Fellows, 850 Fellows and 5771 Members (MAMS-1731 and MNAMS 4040).

The 53rd Annual Conference of the Academy was held from 25-27 October, 2013 at the All India Institute of Medical Sciences at Jodhpur. Dr. R. Chidambaram, Principal Scientific Advisor, Government of India, was the Chief Guest.

A Regional Symposium on "Sleep Medicine" was held on 25th October, 2013.

A NAMS Scientific Symposium on "Regenerative Medicine" was held on 26th October, 2013.

Eighty one candidates were given Scrolls of Fellowship and Membership of the Academy at the ceremonial occasion of the Convocation of Academy held at All India Institute of Medical Sciences at Jodhpur on 26th October, 2013.

Lifetime Achievement Award was conferred on noted Cardiologist, a distinguished Fellow and Past President of NAMS, Dr. S. Padmavati at the ceremonial occasion of the Convocation of Academy held at All India Institute of Medical Sciences at Jodhpur on 26th October, 2013. .

Nineteen Bio-medical Scientists of the Country have been chosen for Orations and Awards for the 2013-14.

Thirty Bio-medical Scientists elected as Fellows and Fifty eight elected as Members of the Academy for the year 2013.

During this year, NAMS-AIIMS collegiums has been formed with AIIMSs at Bhopal, Bhubaneswar, Jodhpur, Patna, Raipur, and Rishikesh in order to provide the benefit of rich pool of expertise of eminent Emeritus Professors and Fellows of NAMS to advise and support academic programmes at the newly established AIIMSs.

The Academy has been recognized by the Government of India as Nodal Agency for Continuing Medical Education for medical and allied health professionals and is advising the Government of India in several matters of National Health Policy and Planning. National Academy of Medical Sciences encourages and sponsors nationwide CME programmes, Symposia and Workshops in basic sciences and applied clinical disciplines; high priority is accorded to activities that would result in the practical application of recent advances in medicine and promotion of research in areas of national health priority.

CME: Since 1982, supporting CME programmes is an important activity of the NAMS to keep medical professionals abreast with newer/current medical problems of the country and to update their knowledge for better delivery of medical education, patient care and health care at large. In this financial year 2013-14, Fifteen CME programme proposals have been sanctioned so for financial assistance.

The Academy also contributes towards Human Resource Development by selecting and sending Junior Scientists to Centres of excellence for training in advanced methods and techniques. Seven Scientists/Teachers have been selected for advance training at specialized centres during 2013-14.

Intramural CME Programmes: The Academic Committee identifies, from time to time, topics of

national and academic relevance for funding as intramural CME Programmes. The Academy provides TA/DA and honorarium to Fellows who attend the CME programmes as Observers.

Two Regional Symposia were held (1) NAMS-PGI Symposium on Non-alcoholic Fatty Liver Disease in Children and Adolescence held at Postgraduate Institute of Medical Education and Research, Chandigarh on 10th March, 2013 and (2) NAMS-NIF Symposium on Micro-nutrient Deficiencies held at Nutrition Foundation of India, New Delhi on 22nd March, 2013.

NAMS Tele-education Programme: NAMS has made a major effort to improve the outreach of CME programme by establishing tele-linkages between medical colleges so that more medical colleges can participate and benefit from CME programmes.

15.16 ALL INDIA INSTITUTE OF MEDICAL SCIENCES (AIIMS), NEW DELHI

All India Institute of Medical Sciences (AIIMS) was established in 1956 by an Act of Parliament as an institution of national importance. AIIMS was conceived to be a center of excellence in modern medicine with comprehensive training facility. This was in pursuance to the recommendations made by the Bhore Committee in 1946.

The institute has been entrusted to develop patterns of teaching in undergraduate and postgraduate medical education in all its branches so as to demonstrate a high standard of medical education to all medical colleges and other allied institutions in India, to bring together at one place educational facilities of the highest order for the training of personnel in all important branches of health activity, and to attain self-sufficiency in postgraduate medical education.

For pursuing academic programmes, the AIIMS has been kept outside the purview of the Medical Council of India. The Institute awards its own degrees. The AIIMS continues to be a leader in the field of medical education, research and patient-care in keeping with the mandate of the Parliament.

The Institute is fully funded by the Government of India. However, for research activities, grants are also received from various sources including national and international agencies. While the major part of the hospital services are highly subsidized for the patients coming to the AIIMS hospital, certain categories of patients are charged for treatment/services rendered to them.

AIIMS has manpower of over 10,000 including over 750 faculty members, supported by a large number of resident doctors, nurses, paramedics, scientists, non-medical officers and staff.

Till date, the Institute has awarded degrees to 5198 specialists (MD, MS, MDS, MHA-176/2013). 1344 super-specialists (DM/M.Ch.-85/2013), 2646 MBBS doctors (50/2013), 996 Ph.Ds (52/2013), 764 Postgraduates (M.Sc & M.Biotech.-46/2013) and 2565 nurses and paramedical professionals including 109 B.Sc-Hons.

These figures of course include 509 degrees awarded by the Hon'ble President, AIIMS, Minister of Health and Family Welfare on the occasion of 41st Institute Annual Convocation held on 12.09.2013.

AIIMS has been active in sharing its knowledge and expertise through CMEs, Conferences and Workshops. There is a provision for short term, long term and elective training to students and employees from various organizations in India as well as abroad. During the year 2013-2014 the various persons underwent training are as below:

S.No.	Training	No. of trainees
1.	WHO Fellows - Foreign nationals	70
2.	Elective Training (Undergraduate)-Foreign nationals	37
3.	Postgraduate training - Foreign nationals	26
4.	Conference/Workshops/ Symposium etc.	188
	Total	**321**

During the last year the faculty and the scientists of the institute have published over 1800 research papers in

national and international journals, written books and monograms and also contributed a large number of chapters in books. Over 500 young scientists at different positions like research fellows, research associates and Ph.D. students have been engaged in significant research projects. 508 research projects are in progress and they brought extramural funds of Rs. 69 crore, which is 25% increase from last year's funds and that was very creditable.

211 research projects were successfully completed this year, bringing new knowledge and useful research data at the institute. Rs. 5 crore institutional funds were also distributed to young faculty for undertaking 58 new research projects, involving newer areas like Cardiology, Neuro-Sciences, Stem Cell Studies, Drug Designing, Protein Research, Genetics and Immunology.

During the institute's foundation day celebration on the 25th September, 2013, 12 faculty members were awarded with cash prizes and certificates of excellence for their outstanding research publications during the preceding year. A health exhibition was also held on this occasion showcasing institute's contribution to Health sciences. "AIIMS Foundation Day Lecture" had been started last year and this year Professor T. Ramasami, Secretary, Ministry of Science and Technology, Govt. of India, a distinguished scientist delivered lecture on "Perspectives on Health Research".

The work on building a Convergence Centre, which will house all modern platform based state-of-the-art technology for the faculty, scholars and students to undertake the research is progressing at a fast speed. It will soon become the knowledge hub which will allow to store and manage large clinical material and research data for enhancing capability in research.

Medical Education

AIIMS is running various academic programmes including undergraduate, postgraduate and Ph.D programme. The admissions and selections for various these courses the details of admissions made to various courses in year 2013 are as:

S. No.	Course Name	No. of students admitted/residents recruited during 2013-2014
1.	MD/MS/MDS/MHA	118
2.	DM/M.Ch	42
3.	Ph.D	44
4.	Senior Residents (Non-Acad.)	201
5.	Junior Residents (Non-Acad.)	163
6.	M.Sc Courses	19
7.	M. Biotechnology	15
8.	M.Sc Nursing	24
9.	MBBS (AIIMS, New Delhi)	72
	MBBS (6 new AIIMS)	600
10.	B.Sc (Hons.) Nursing (AIIMS, New Delhi)	77
	B.Sc (Hons.) Nursing (6 new AIIMS)	360
11.	B.Sc (Nursing) Post-Certificate	24
12.	B.Sc (Hons.) Ophthalmic Techniques	19
13.	B.Sc (Hons.) Medical Technology in Radiography	9
	Total	**1787**

AIIMS organized various orientation programmes including integrated self-enrichment orientation programme for fresh MBBS students from July 15-17, 2013. Workshop for MBBS students was also conducted at AIIMS by CREST from July 18-27, 2013. These programmes focused on improving communicative understanding and collaboration with senior students of these students as well as orient them about various work stations at AIIMS.

Specially designed orientation programmes in research and patient care, including communication and soft skill acquisition were also offered to the new Resident doctors and Assistant Professors in this year.

In addition, AIIMS conducted entrance examination and counseling leading to final selection of students to MBBS and B.Sc. (Hons.) Nursing courses for 6 new AIIMS.

Centre/Department wise information regarding important achievements and newer facilities at AIIMS:

Department of Anatomy: The Department of Anatomy has established a State of the art E-learning facility which is utilized by all Departments. It has established state of art cadaveric and plastination facility used by various clinical Departments for demonstration and national/ international workshops in Neurosurgery, Otolaryngology and Orthopaedics. The Department has Human cytogenetic and molecular reproductive and genetic facility which leads in cutting edge genetic research and offers genetic diagnostic services for various Endocrinological, Gynaecological, Ocular and Haematological disorders. The Department also has Fluorosis diagnostic laboratory and several labs working in neuro and developmental biology. The Department has established problem based and integrated teaching learning modules to make learning interactive and interesting. The faculty delivered over 50 lectures, published over 50 articles in high impact factor journals. Faculty was invited for CME, delivering prestigious orations and taking lectures in other universities and medical colleges.

Department of Biochemistry: The Department of Biochemistry has innovative teaching programmes involving problem based learning and case oriented small group discussions for MBBS students, which seek to develop the students ability in critical thinking and analysis. The Department provided short-term research training to 4 postgraduate (MD & M.Sc.) students from BPKIHS, Dharan, Nepal. Research exposure to undergraduate students was also provided to a number of students in the form of summer training. The Department has attracted research funds amounting to Rs. 12 crores approximately from ICMR, DST, DBT, DRDO, CSIR and Indo-Canadian, UKIERI and some other international agencies. 32 funded research projects with Departmental faculty being the Principal Investigators are ongoing in the Department. This has led to several publications in reputed National and International journals.

Two faculty members received the 2nd and 3rd prizes under AIIMS excellence award for best publications. One faculty member was elected President of Indian Association for Cancer Research for 2 years (2014-16).

Nine Ph.D. students received awards at various National conferences. One Ph.D. student received Gold Medal for best work in clinical research. One Ph.D. student received Indo-German DAAD Fellowship of 6 months. Twelve students were awarded Ph.D. degree, 4 MD degrees and 3 M.Sc. degrees. The Department organized a Flowcytometry workshop.

Department of Biostatistics: The Department had many research projects, mostly collaborative in nature with various centres/departments in the Institute. Faculty members and scientists: Served on various administrative and scientific committees in the Institute; Invited members of various scientific committees of the ICMR, DBT, DST, AYUSH, TERI, NIREH and NIMS; Served on Data Safety Monitoring Boards (DSMB) of several National and International Clinical Trials; Delivered invited lectures all over the country during various workshops on Research Methodology and Biostatistics; and, Examiners to various universities in the country. In the last one year, faculty and scientists had ninety two research publications in various peer reviewed medical journals. Faculty members and scientists continued to be reviewer for almost all the major medical journals in the country and for a number of International Medical Journals from various medical specialties.

Department of Biophysics: A significant contribution has been made in research by the Department of Biophysics is concerned with determining the molecular basis of biological process, rational structure based drug design and discovering new specific biomarkers. The structure of the iron-free true C-terminal half of bovine lactoferrin produced by tryptic digestion and its functional significance in the gut has been determined. The three-dimensional structure of peptidyl-tRNA hydrolase from the multidrug resistant bacteria, *Acinetobacter baumannii*, has been determined. Proteomic analysis of seminal plasma has resulted in the identification of a high molecular weight multiprotein complex. Expression of COX, LOX, p38b and p38α enzymes has been correlated with clinic-pathological stage of cancers in different sites and effect of therapy.

The heparin binding carboxypeptidase E protein has been shown to exhibit antibacterial activity in human semen. The identification of clinical mycobacterial isolates by protein profiling using matrix assisted laser desorption ionization-time of flight mass spectrometry has been completed. The Department provides facilities for data collection on protein and small molecule crystals, medical bioinformatics, protein sequencing and peptide synthesis, proteomics, dynamic light scattering and kinetic parameters using binding studies with BIAcore.

Blood Transfusion Services: The Blood Transfusion services of C.N. Centre caters to round the clock transfusion needs of patients admitted in C.N Centre of AIIMS by collecting, processing and providing safe and quality blood and blood components. The activities include both inhouse and outdoor blood collection, blood donor motivation and pre-donation and post-donation counseling, blood component preparation and various serological tests. Components like packed red cells, plasma, fresh frozen plasma, platelet rich plasma, platelet concentrate, cryoprecipitate, leucodepleted red cells and platelets are available in adequate nos. at all times. Facility for Apheresis procedures and autologous donation is available. Serological tests performed in the BTS include tests for blood grouping, screening for irregular antibodies, compatibility tests using latest technology like column agglutination. Every unit of blood collected is tested for transfusion transmissible infections like Hepatitis B, Hepatitis C, HIV- 1 and 2, syphilis, Malaria. In addition, test for CMV is carried out for heart transplant cases. Automation is used in most of the laboratories in the department for better output and quality. Donor blood samples are also being screened by NAT (Nucleic Acid Amplification test) as an additional screening test to detect HIV/HCV/HBV.

Department of Cardiac-Anaesthesia: Collaboration with university of florida. "Neurological biomarkers following Desflurane vs TIVA in the patient undergoing arotic valve replacement" Dr. Poonam Malhotra and Dr. George Mychaskiw.

- Papers Published - 9
- Workshop/Conferences - 5
- Chapters in Book - 5

Department of Cardiac-Radiology: The DM programme in Vascular Radiology got approved during this year. The faculty of the Department delivered 20 lectures and conducted 2 workshops at national and international scientific meetings. Additionally, they are members of editorial boards and reviewers for numerous scientific journals. The departmental faculty has been running 5 research projects and 3 thesis. They published 11 research papers in various national and international journals. The department continues to provide cardiovascular imaging and vascular interventional treatment services to patients referred from various specialty departments in the hospital.

Department of Cardiothoracic & Vascular Surgery: The Department of Cardiothoracic & Vascular Surgery was in the forefront in the field of patient care, teaching and research. 44791 patients were seen in the Out Patient Department and 4043 surgeries of all types of cardiovascular ailments across of all age groups were performed with excellent results. In the field of research, the faculty of the Department published more than 50 research papers in national and international journals of repute and presented more than 50 invited lectures and oral papers in national and international conferences. There are 15 national and international research projects under way in the Department. The Department successfully organized live operative workshops on Mitral Valve Repair and Wet Lab session on Bentall Procedure, besides a workshop on Aortic Dissection. These benefitted a large number of surgeons and medical and para-medical staff from all over the country.

In addition, to cope up with the tremendous patient-load, and to conduct India-centric research in field of cardiovascular sciences, the Cardiothoracic Centre has proposed 800 bedded National Cardiovascular Centre in Jhajjar Campus of AIIMS which has been approved in principle by the Ministry of Health & Family Welfare.

Centre for Dental Education and Research: The Centre for Dental Education and Research was approved for designation as WHO Collaborating Centre on "Oral Health Promotion" by WHO. An innovative, low-cost technology "SealBio" was indigenously developed for treatment of infected non-vital permanent mature teeth in adults, which was granted patent by Australian patent office.

Department of Clinical Neuro Psychology: In the last one year a separate **Cognitive Disorders and Memory** has formally started.

Department of Dermatology & Venereology: The Department of Dermatology & Venereology was involved in organising XI International Congress of Dermatology, December 4-7, 2013 in New Delhi that was attended by more than 4000 delegates. Prof. V.K. Sharma awarded the International League of Dermatological Societies Award the ILDS 2014 **"Certificate of Appreciation" for life long dedication and contribution to International Dermatology**. Department is continuing research of vitiligo and psoriasis. Department has carried out Genetic research with Indo-US collaborative (ICMR) project funded by National Institute of Health, USA. The project involved the genome wide association study of 2000 psoriasis patients and 2000 controls. The initial investigation had identified some novel MHC (major histocompatibility) i.e TNIP and IL 12B and non-MHC loci (ULK1) that may have potential therapeutic implication. There are three Ph.D and 17 MD Dermatology & Venereology under training in the department. The Department is providing special services like vitiligo surgery, lasers for birth marks like portwine stain nevus of ota and CO2 fractional laser, PUVA and narrow band therapy. Conducted 4 fellowships in dermatology for IADVL members.

Department of ENT: Expanded the frontiers in minimal invasive surgery for head and neck. The Department was the first to start transoral robotic surgery in the country and has applied the experience in excision of parapharyngeal tumors and also performing the supraglottic laryngectomy by this technique. The Department has started providing services of Outreach OPD at Jhajjar and plans to extend the operation services to its patients at CHC Ballabgarh. The Department has utilized its state of art temporal bone lab facility to provide surgical training to residents and delegates and organized temporal bone courses. Department hosted 9 visitors from national and international centers for short term training/ observership at the institute.

Department of Forensic Medicine and Toxicology: The Department of Forensic Medicine and Toxicology is continued to provide round the clock medico-legal services like in cases of injury, sexual offences, poisoning etc. to the South and South-East district of Delhi. About 1500 such calls were attended during this period. A total of 1728 medico legal autopsies were conducted at main mortuary. The Department examined cases of age estimation, potency, DNA Fingerprinting, medical examination etc. referred from the court, CBI and other investigating agencies. About 603 such cases were dealt during this period. Doctors of the Department attended court of law in about 814 cases from Delhi and other States. About 149 tests were performed for various poisons referred from the clinical Department of AIIIMS, medico-legal cases and in academic cases

National Drug Dependence Treatment Centre: The centre currently functions as a national resource centre for Ministry of Health and Family Welfare, Government of India, Ministry of Social Justice and Empowerment, National AIDS Control Organization, United Nations Office on Drugs and Crime (UNODC) Regional Office for South Asia, WHO (India) and WHO SEARO. Recognizing the role and leadership that the centre enjoys nationally and internationally, the centre has been declared as the WHO Collaborating Centre on substance use disorders (WHO-IND 95). It has also been designated as a Regional Learning Centre by UNODC and Regional Technical Training Centre by Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Round 9.

The centre is 50 bedded and offers clinical care through out-patient, in-patient services for drug dependent persons and runs three specialty clinics-Tobacco Use Cessation, Adolescent Drug Use, and Dual Diagnosis (Substance Use Disorder and Psychiatric Illness) clinics. These patients along with women drug users are admitted to the ward in special sections. Presently, the centre operates two community based clinics in urban slums at Trilokpuri and Sundar Nagri (East Delhi) areas. During the Year 2013-14, a total of 72722 patients were seen in out-patient, of whom 4299 were new and 27385 were old cases of whom 971 persons were admitted in the ward and 41038 were seen in various community clinics.

Department of Neurosurgery: During the last financial year department treated 43766 patients in OPD and more than 3400 surgeries were performed in

neurosciences centre. The gamma knife centre acquired a new dedicated MRI machine which became functional on 22nd November. The gamma knife centre has treated more than 3700 patients from its inception, out of which nearly 563 patients were treated last year. This number is amongst the highest number of patients treated in a year till now. On the newly functional MRI machine more than 613 MRI were done and it has helped the patients and department immensely. Department of neurosurgery also acquired new endoscopes for cranial and spinal surgery and more than 200 procedures were performed endoscopically. In the intraoperative MRI suite, many complex cases of brain tumors are being operated and more than 600 patients have been operated in this high end theatre.

The center for epilepsy became fully functional (as a center of excellence funded by DBT). More than 100 epilepsy surgeries were performed at the neurosciences centre during the past one year.

Department of Neuro-Anaesthesiology: Anaesthetic management for 2,973 neurosurgical procedures (Elective-2181; Emergency-792) and 416 neuro-radiological procedures (246 diagnostic; 170 therapeutic) was performed. More than 3,000 patients were managed in neurosurgical intensive care unit. A total of 2,217 patients (1,607 new and 610 old) were seen in PAC clinic OPD. A total of 815 patients (181 new and 634 old) were seen in pain clinic OPD (298 were treated with nerve blocks).

Four Departmental and one funded research projects were completed while 22 research projects (05 funded, 16 departmental and 01 collaborative) were going on. Faculty and residents published 31 articles (11 international, 20 national) in scientific journals. Seven abstracts published in international journals. One chapter in a book was written by faculty.

Department of Neurology: Launch of first of its kind *'prospective cohort study to unravel the causes of stroke and cognitive decline: a cross-cultural perspective'* as a DBT-funded Indo-Dutch collaborative project with secured funding of approx. Rs. 31 crore for eight years. Completed first randomized controlled trial on the role of positive airway pressure therapy in prevention of new vascular events among stroke patients. Ongoing CSIR, ICMR and DBT funded projects for identification of novel clinical and molecular markers for cerebellar ataxias. Completed customized comprehensive management of 300 patients with refractory epilepsy and 253 customized polysomnographic sleep studies in 2013-14. Facility of Quantitative Sudomotor Axonal Reflex Test (QSART) started in our Neurophysiology lab. Rural communities at Biyavra (MP), Naksalbari (WB), Chatarpur (Odisha), Anuppur (Chhattisgarh), Jhansi (UP), Wadi (Karnataka), Karad (Maharashtra) and Dalmau (UP) were provided specialized Epilepsy Screening Clinics and epilepsy education using the Lifeline Express.

Department of Neuro-Radiology: Latest state-of-art Biplane flat panel DSA system was installed in the Department and made fully functional in the month of October 2013. These systems along with the existing 2nd Biplane DSA suites are capable of all advanced neurovascular applications including intra-operative CT facility. Department of Neuroradiology, AIIMS is the first to have two state-of-art Biplane DSA suites. Latest state-of-art 1.5T MRI installed adjacent to GK facility was made fully operational to enhance diagnostic and GK knife planning facility for neurosciences centre patients. This system will be soon made soundless to enhance the patients comfort and co-operation.

Department of N.M.R.: The Department has procured and installed the state-of-the-art high field Animal MRI system (7T) for preclinical and other biomedical research using small animals. The Department developed a method to distinguish malignant breast tissue from normal lactating breast tissue using diffusion MRI and MR spectroscopy. HOD was elected as FNA (Fellow of the Indian National Science Academy; INSA) and also awarded the prestigious Drs. Kunti & Om Prakash Oration Award for significant contribution in the field of biomedical sciences of the Indian Council of Medical Research (ICMR), Government of India in September 2013.

Department of Pediatric Surgery: The Department of Pediatric Surgery at AIIMS offers State-of-the-art patient care not only in General Pediatric Surgery but also in the field of Neonatal surgery, Urology including Intersex disorders, Thoracic surgery, Oncology, GI Surgery and Neuro-surgery in children up to 14 year of age. Department faculty is also actively involved in various

intramural and extra mural research projects pertaining to congenital malformations and cancers in the field of molecular biology and the stem cell research. Department being on the forefront in patient care, research and teaching and training, receives large number of requests from India and overseas to visit the department and seek training in Pediatric surgery and its sub-specialties.

Departmental of Physiology: The Department of Physiology provides rTMS at dorso lateral prefrontal cortex after through investigation of the chronic pain syndrome by objective methods in fibromyalgia patients. rTMS is a safe, economical, non-invasive technique. During the year more than 40 patients have been cured of their symptoms. Intraoperative neuro monitoring was done in 70 surgeries. In 10 cases, the neurological alarms were sounded after which the surgeons took corrective measures. No permanent neurological deficits were found in any of the patients. There were no false positive and false negative cases. A total of 332 (three hundred and thirty two) subjects were enrolled and trained for yoga-based lifestyle modification at IHC during the year 2013-2014. This includes patients of chronic diseases (like diabetes type 2, hypertension, obesity, depression, etc.) referred from different departments from AIIMS.

Department of Radiodiagnosis: The institute has a well-equipped multi-modality general radiology Department with high end state-of-the-art equipments. Over 3 lakh radiological investigations were performed during the last year. A high-end Digital Subtraction Angiographic machine with advanced features was installed in the department last year for performing various radiological interventions. Upgradation of the existing Radiology Information System and PACS was done to improve reporting and archiving of data. A continuing medical education programme on 'Recent advances in applied physics' was organized here specifically focused to postgraduate students. The 11th National conference of Indian Association of Radiological Technologists was organized by the Department which was attended by various national and international faculty and delegates. The Department was involved in over 20 research projects last year and is currently involved in over 100 ongoing projects which is expected to take it to new heights. The Department faculty published over 70 research papers in the previous year. With many more research projects and education programmes to come the Department serves as a role model to other institutes in the country.

Department of Reproductive Biology: Started several (over 25 more parameters) newer tests for hormones, vitamins, tumor markers, etc (under standardization) under CRIA unit facility. Molecular cytogenetic technique using STR/microsatellite markers in addition to ongoing FISH (fluorescent in situ hybridization) services.

Stem Cell Facility: Initiation of construction of cGMP facility as per ICMR- DBT guidelines for newer clinical trials in various diseases like myocardial infarct, stroke, limb ischemia, spinal cord injury, ocular surface disorders, retinitis pigmentosa, vitiligo etc. Differentiation of Mesenchymal Stem Cells from various tissue sources like bone marrow, adipose tissue, dental pulp etc. into cells of various lineages:

- Neuronal Cells, especially dopaminergic neurons
- Cardiomyocytes

Conducting AIIMS-IIT Delhi, Collaborative High Impact Research Project: In this interdisciplinary proposal we are exploring to develop a corneal tissue construct *in vitro* that possesses the biomimetic multilayered structure and precise cell orientation, in order to achieve transparency, mechanical integrity, higher transplant success rates. *INDO-US DBT funded Vision Research Programme:* This project aims to develop corneal constructs by Tissue engineering, addressing these issues by following two different approaches- (a) first by culturing corneal cells on micro-patterned films, and then (b) using decellularized cornea constructs. These insights will be correlated with pathological conditions, and ultimately feasibility studies will be done to apply such bioengineered tissues as 'tectonic corneal grafts. *In-vitro* studies to explore strategies for extended utilization of donor corneal tissues by harnessing their full clinical potential. This project aims to maximize the existing corneal pool by Improving preservation techniques, Establishing newer sterilization methods, Developing better storage media.

Medical Record Section (Hospital)

OPD Attendance

1.	Main Hospital	:	1313791
2.	Casualty	:	134096
3.	EHS	:	178189
	Total	**:**	**1626076**

Admissions

1.	Main Hospital	:	93898
2.	CNC	:	20185
	Total	**:**	**114083**

Surgical Procedures (Major & Minor)

1.	Main Hospital	:	81192
2.	CNC	:	7536
	Total	**:**	**88728**

15.17 JAWAHARLAL INSTITUTE OF POSTGRADUATE MEDICAL EDUCATION & RESEARCH (JIPMER), PUDUCHERRY

JIPMER seeks to be the model health system of India through innovations in education, patient oriented research, population health & service excellence. It's mission is to develop compassionate, ethically sound health professionals and provide service of the highest order across the health care continuum, through innovations in education that yield lifelong learners and leaders in health care. Original research in basic sciences and patient oriented discoveries will lead to clinical transformation across the organization that is patient centered, safe, effective, accountable and transparent. It's emphasis is on quality and value in all endeavours. Institute emphasize partnerships with organizations encompassing congruent ideals and advocacy for community wellness and public health with a focus on socio-economic disparities.

Academic Highlights

- The admission to first year MBBS course in JIPMER is through All India Entrance Examination. For the academic year 2013-14 the total number of seats were 150. A total of 69,391 applications were received and 52,298 candidates appeared in the Entrance Examination for the first year MBBS Course, 2013-14 session. Out of the 19,240 candidates who qualified in the Entrance Examination, 146 candidates were admitted based on their category merit rank. Four candidates nominated for the Academic Session 2013-14 by the Government of India were admitted.
- Besides the popular MBBS course, JIPMER conducts various courses in many other disciplines. A certificate course is conducted in the discipline of Emergency Medical Technology as Emergency Medical Technician Certificate Course. It has 20 seats and in the year 2013-14, 20 candidates were admitted.
- B.Sc. courses are available in Nursing and Allied Medical Sciences. There are B.Sc. courses in 9 disciplines. The total number of seats is 133 and in the year 2013-14, a total of 124 candidates were admitted.
- JIPMER also has M.Sc. courses in 5 disciplines. These courses have a total of 46 seats and 43 candidates were admitted in the year 2013-14.
- Postgraduate medical degree courses (MD/MS) are available in 23 disciplines. There are a total of 126 seats in these courses. In the academic year 2013-14 a total of 126 candidates were admitted in MD/MS courses.
- Super-speciality medical courses (MD/MCh) are conducted in 16 disciplines. These courses have a total of 32 seats. In the academic year 2013-14 a total of 32 candidates were admitted.
- Ph.D. programmes are available in 8 disciplines at JIPMER. These programmes have a total of 18 seats. Fifteen candidates were admitted in Ph.D. programmes in the academic year 2013-14.
- Besides above courses, Fellowship programme is available in 5 disciplines. There are 15 seats for the Fellowship programmes at JIPMER. A total of 7 candidates were admitted to Fellowship programmes in the academic year 2013-14.

While JIPMER is currently ranked among the top 3 best medical schools in India, its goal is to move to the top. Towards this, institute has embarked on investments in 3 areas: infrastructure enhancement, curriculum innovation and research. With respect to infrastructure, a new hostel complex and JIPMER Academic Center were commissioned during the last academic year. The new hostel complex houses 1100 students and has full-fledged sports complex including indoor gym & common facilities. JIPMER Academic Center is the home for preclinical departments, academic offices & department of medical education.

The curriculum innovations include enhancement of integrated modules, case based & rapid cycle learning methods, inclusion of patient safety & health care quality concepts at all levels, clinical effectiveness discourses & simulation based strategies, to name a few. National Teacher Training Center of the institute will be expanded to meet the national needs of capacity building for teachers and bring in teaching innovations to align with national health missions. JIPMER's Learning Resource Centre, under development, will house simulators for task training, creating physiologic scenarios for learning, error reduction & team building and other e-learning modules such as telemedicine, virtual reality & robotics. This will also be a national resource for continuing education in support of national health missions in all spheres of health care, including physicians, nurses, allied health professionals & community workers.

JIPMER invested Rs. 2.57 crores in its library last year, including addition of journals & 1409 new books, to add to collection of 41,650 books in the central library & 6556 in the book bank. Library is in the process of setting up 2nd Computer lab with Wi Fi connectivity and additional journals at the cost of Rs. 1.25 crores. In order to expand JIPMER's online library resources we will explore subscription for Science Direct through consortia.

Clinical Achievements

JIPMER Hospital has daily average number of out-patient attendance of 6,058 and daily average number of in-patient attendance of 1434. In the year 2013-14, a total of 15,15,047 out-patients were treated in JIPMER Hospital. In the year 2013-14, a total of 57,473 admissions were made in the Hospital. A total of 32,04,021 investigations were carried out in the year 2013-14. Total number of deliveries conducted were 11,062. Total number of operations performed were 29,416. The total attendance in Emergency Medical Service (Main Casualty) was 1,91,165 and the total attendance in OG Casualty was 20,383.

JIPMER launched a novel programme on patient safety in October 2012, with a CME across the organisation and formation of JIPMER Quality Council. This quality cell is comprised of representatives from all departments institute wide, and is making great strides in many domains of quality. During the last year JIPMER started Renal Transplantation and Bone Marrow Transplantation towards becoming a Multiorgan Transplantation Center. It witnessed several medical & surgical 'firsts' for JIPMER during the last year including Single Incision Laparoscopic Surgery (SILS).

Other Achievements

A "Clean JIPMER, Green JIPMER, Strong JIPMER" campaign was launched last year. The campaign goals are to create a culture of civic responsibility for campus cleanliness, renewable energy, water conservation, reducing carbon emission and employee wellness, so as to develop sustainable environmentally sound campus. Over 900 trees & saplings have been planted with additional 2000 planned in the coming months. In order to beef up infrastructure, an engineering division has been formed, new roads are being laid across whole campus and IT networking with fibre optic/copper cables as well as campus wide Wi Fi connectivity have been enabled. A new website has been developed. To modernize the whole enterprise, a 'REDO JIPMER' campaign was rolled out last year- REDO being an acronym for Restructuring to ensure Empowerment, Decentralization & Ownership in all spheres of activities. In order to ensure all aspects of 'wellness', in addition to physical wellness initiatives, JIPMER have enhanced its counselling programme for students, staff & faculty.

Future Plans: Our priority targets during the 12th five year plan include:-

1. JIPMER International School of Public Health;
2. Institute of Allied Health Sciences;
3. Center for Healthcare quality, Health IT, Health Administration & Patient safety;
4. Augmentation of Power with creation of 110 KVA substation and renewable energy solutions such as solar power;
5. Apex Emergency, Trauma & Disaster Management Center;
6. Expansion of Regional Cancer Center into a National Comprehensive Cancer Care Center;
7. Multi Organ Transplant Programme including stem cell & regenerative medicine;
8. Expansion of Laboratory Services, BSL3 facility, Pneumatic tube conveyer system;
9. Staff Wellness Center including swimming pool and
10. Upgradation of various specialties and super-specialties.

CME on Patient Safety

Introduction of In-Campus Vehicle for Patients

The Fourth Convocation of JIPMER was held on 20.04.2013. Prof. (Dr.) M.S. Swaminathan delivered the Convocation address. During the Convocation 289 degrees were awarded to MBBS, B.Sc., PG (MD/MS), DM / M.Ch and Ph.D., students who have successfully completed the course during the year 2012-13. Medals in various disciplines were awarded to 64 students.

15.18 POSTGRADUATE INSTITUTE OF MEDICAL EDUCATION & RESEARCH, CHANDIGARH

The Postgraduate Institute of Medical Education and Research, Chandigarh was declared as an Institute of "National Importance" and became an Autonomous Body by an Act of Parliament (Act 51 of 1966), on 1st April, 1967. The Institute is fully funded by the Government of India. The main objectives of the Institute are:-

I. To develop patterns of teaching of undergraduate and postgraduate medical education in all its branches so as to demonstrate a high standard of medical education;

II. To bring together as far as may be in one place educational facilities of the highest order for training of personnel in important branches of health activity and

III. The attain self-sufficiency in postgraduate medical education to meet the country's need for specialists and medical teachers.

The Institute has excelled in all the three areas namely-patient care, medical education and research. The patient care load over the years has been increasing exponentially and now it has become enormous. From an annual attendance of 1,25,163 out patients and 3,328 admissions in 1963-64, the figure has gone up to 19,11,490 out-patients and 72,382 admissions in the current year. The Institute is spearheading the medical education of large number of medical colleges of the country and abroad.

The Institute continues to excel in quality research and the clinicians and basic scientists published 1096 papers during the year and 116 scientists were awarded fellowships, orations and other national and international awards. Last year various Departments of the Institute completed 190 research projects funded by DST, WHO, DBT, ICMR and other outside agencies and 552 research projects were being continued and supported by national, international and PGI research funds.

The Golden Jubilee celebrations of the Institute were duly set in motion on 7th July 2012. A commemorative souvenir befitting the occasion and other mementoes to keep the memory intact in the future, were released on the inaugural day. A documentary film about PGI's contributions was made which has won wide acclaim. A five rupee commemorative postage stamp was released by the Hon'ble President of India, Sh. Pranab Mukherjee who had graced the Annual Convocation during the year. A resume summarizing the major research achievements of the last 50 years has been published. This document speaks volumes about the work of the Faculty. In January 2013, a first of its kind symposium on Medical Equipment, Safety and Innovation was held in the Institute. The Closing function and 51st Foundation Day was held on July 6, 2013, with chief guest Hon'ble Vice-President of India, Sh. Hamid Ansari. On March 15th, 2013, the Hon'ble President of India visited the Institute and was the Chief Guest for the 33rd Convocation of the Institute. The President awarded Gold medals to the students for their outstanding research & academic excellence awarded 393 degrees.

The Institute celebrated its first Research Day on August 11th, 2013 which gave the researchers the opportunity to present their work in one place. Over 200 research posters were on display. On this occasion, the Institute invited eminent researchers, faculty members, scientists from biomedical research institutions in the Tricity such as IISER, NIPER, CSIO etc.

Academic Activities

Postgraduate Institute of Medical Education & Research, Chandigarh has been empowered to grant medical, dental and nursing degrees, diplomas and other academic distinctions and titles under the PGIMER, Chandigarh Act, 1966.

Hospital Services

The Postgraduate Institute of Medical Education & Research, Chandigarh provides tertiary care in all the medical and surgical specialties to patients, who come not only from the adjoining States but also from far-off States like Odisha, West Bengal and Bihar.

The patient care services in PGI have expanded from Nehru Hospital to a number of independent centres like New OPD Block, Advanced Pediatric Centre, New Emergency Block, Advanced Eye Centre, Drug De-addiction Centre, Advanced Cardiac Centre and Advanced Trauma Centre with enhanced number of hospital beds and operation theatres. Research activities have been undertaken in the field of Hospital Administration.

The total bed strength of the PGI has increased to 1948 beds. The number of patients who attended the out-patients departments and those admitted for treatment during the last three years is as under:

Patients Attendance	**2012-13**	**2011-12**	**2010-11**
Outdoor	19,70,708	18,49,015	16,62,391
Indoor Admissions	72,382	68,175	64,969
Surgeries	**2012-13**	**2011-12**	**2010-11**
Minor	1,23,988	99,078	72,885
Major	34,286	34,222	32,055

Emergency and critical patients were attended to round-the-clock.

Emergency Services

The Emergency Complex and Advanced Trauma Centre provide all medical and surgical services including investigations and operations under one roof. The Emergency services are supervised by the Assistant Professor, Department of Hospital Administration and assisted by Senior Medical Officers (Casualty). They are responsible for dealing with medico-legal cases providing poor free services to deserving patients and supplying life saving medicines and consumable items. MHA Residents assist in day-to-day administrative working. The Emergencies are managed by medical/ surgical and super-speciality consultants and senior residents. A disaster area having cupboards containing equipments and life saving drugs has been earmarked and is used for treating mass casualties. A well-equipped VIP room is maintained to meet any emergency situation in case VIPs are brought to the Emergency.

	2012-13	2011-12	2010-11
OPD	66,204	58,625	52,894
Admissions	36,067	33,637	32,563
Major Surgeries	11,409	10,294	9,539
Minor Surgeries	1,819	1,505	1,490

Engineering Wing

During the financial year from April 2012 till March 2013, Rs. 4984.08 lacs have been spent under 'Non Plan' and Rs. 1197.50 lacs have been spent for new works under the 'Plan' head.

A. During the aforementioned year, this department has completed the following major works:-

1. The Advanced Trauma Centre (ATC) has been made fully functional.
2. The construction work of the 250 bedded hospital (Expansion of Nehru Hospital) is going to be commenced shortly.
3. The fully furnished Auditorium of NINE has been handed to its user Department.
4. The work of Oxygen Plant and Hot water supply system in Advanced Cardiac Centre (Phase-II) has been completed and certain civil works are near to completion.
5. An agreement for Modernization of Nehru Hospital and Research Blocks 'A' and 'B' has been signed with National Building Construction Corporation (NBCC) Ltd., New Delhi on 26.03.2013 and work shall commence soon.
6. During the Golden Jubilee year, an Alumni Cell has been set up at the Kairon Block of the Institute.

B. The following works already started and sanctioned by the Ministry of Health & Family Welfare, New Delhi under the 11th Five Year Plan are near completion and will soon be handed over to its users:-

1. Advanced Cardiac Centre (Phase II)
2. Advanced Eye Centre (Phase II)
3. Renovation of PGI Houses (Sector-12 & 24, Chandigarh)
4. Renovation of Hostels
5. Renovation of Trauma-`A' (Old Emergency)

C. Similarly, there are certain other major works like construction of new Hostels, residential houses, National Institute of Paramedical Sciences (NIPS) and hostels etc. sanctioned by the Ministry of Health & Family Welfare, New Delhi under the OBC Expansion Scheme are yet to be commenced due to some clearances, technical hurdles and other formalities of the Chandigarh Administration and the Forest Department. The work will be commenced soon after getting clearances of these projects.

15.19 LADY HARDINGE MEDICAL COLLEGE & SMT. S.K. HOSPITAL, NEW DELHI

The Lady Hardinge Medical College, New Delhi was established in the year 1916 with a modest beginning of just 14-16 students. Over the years, the Institution has matured as a pioneering Institute for Medical Education for MBBS girl students. The College, which is affiliated to the University of Delhi since the year 1949, has continued to admit students from all over India, as well as from foreign countries. A separate out-patient block was started in 1958 to cater the needs of ever increasing population of Delhi.

The Hospital statistics for the period 2013-14 (till date) is as under:-

Bed Strength	:	877
OPD Attendance	:	450508
Indoor Admissions	:	31524
Sterilization	:	747
Bed Occupancy	:	68%
Surgeries Performed		
Major	:	6219
Minor	:	6992
Total	:	13211
Deliveries conducted	:	11283

On obtaining the requisite approval the Comprehensive Redevelopment Plan (CRP) of Lady Hardinge Medical College & associated hospitals started at a great pace. It was a proud moment of the Institute that the Hon'ble Prime Minister of India laid the foundation stone for the construction of new patient care, academic, hostel and residential facilities on 3rd November 2012.

Department wise highlights and achievements during the year 2013-14

Department of Medicine: Department of Medicine is functional with six medical units. The Department is having modern intensive coronary unit, rheumatology clinic, medical ICU with four ventilators and two cardiac beds, four bedded thalessemia day care centre for adults (opened in August 2011) which is having a regular registered patient load of 30 patients. The department actively provided support of medical experts for the relief camp in the relief camp set up in Uttrakhand & Andhra Pradesh.

Department of Microbiology: Department is having facility for Voluntary Counseling Test Centre (VCTC), Prevention of Parent To Child Transfer (PTCT) for HIV patients, HIV DNA PCR lab under National Pediatric HIV Initiative to diagnose HIV infection in newborns up to 18 months under National AIDS Control Programme. The Department is also having surveillance facilities for meningococcal Dengue fever.

Department of Surgery: Department of Surgery has the facility for endo-urological procedures like TURP (for BHP), TURBT (Bladder tumors), URS, Thoracic surgery for Carcinoma lung (lobectomy, pnuemonectomy, mediastinoscopy), Vascular surgery procedures-making A-V fistula for CRF patients awaiting transplant/undergoing dialysis, Comprehensive surgical and medical management of Gastro-intestinal, Urological, Breast Cancer, Plastic & Reconstructive Procedures, Impendence, Manomentry for diagnostic and research purpose and Advance laparoscopic surgeries using high definition camera.

Department of Ophthalmology:

- M.S. (Ophthalmology) 100 % result.
- MBBS: 100% Result.
- Participated in various blindness prevention activities like such as Eye donation week, glaucoma week, Motiabind Mukti Abhiyan Programme.
- Organized Comprehensive Eye Health Care Camps with NGOs.

New Initiatives: Procured and installed the following new equipments to augment surgical and diagnostic facilities:

- Phaco emulsification machine for cataract surgery.
- OT table.
- Radio frequency knife for oculoplasty surgery.
- Ultrasonic Pachymeter.
- Plasma sterilizer for Eye OT.
- Ophthalmic Operating Microscope.
- Slit Lamp.

Department of Community Medicine: The Department of Community Medicine is actively involved in undergraduate (intake 200/year) and postgraduate (intake 9/year) teaching and training. Seven theses by the postgraduate students were completed during the year. Department of Community Medicine also provides comprehensive health care services in the community through Urban Health Centre, Kalyanpuri, Primary Health Centres at Palam

and Mehrauli and Child Health Promotion Centre at Kalawati Saran Children Hospital. Special emphasis is given on MCH services, family planning, immunization, nutrition and health education.

From January to October 2013, OPD services were attended by 93,509 patients and Antenatal care was provided to 3556 women. 2,961 children were given the immunizations and contraceptive were provided to more than 20,000 beneficiaries. The Department is also involved in training programmes of students enrolled for Post Graduate Diploma in Maternal & Child Health from Indira Gandhi National Open University, training of nursing students in Community Health and Public Health administration. Faculty members are also involved as Resource Persons in various training programmes organized by National Institute of Health & Family Welfare, International Institute of Health Management Research, National Institute of Public Cooperation & Child Development, National Centre for Disease Control and Training Programmes under various National Health Programmes. The Department is a nodal centre for various national programmes namely Pulse Polio Immunization, Vector Borne Disease Control Programme and RNTCP.

Department of Skin & STD: Patch testing for diagnosis of allergic contact dermatitis in children and few new Dermatosurgical procedures has been started in the Department.

Department of Pathology: The department has been chosen as one of the 7 centers for the project entitled "Creating the Virtual Medical classrooms a pilot" National Knowledge Network (NKN) project, New Delhi for teaching and also diagnostic for patient care Flowcytometry & Automated Coagulometer. Quadruple bags with integral filters for pre storage leukoreduction facility to blood bank.

Department of Biochemistry:

- MBBS students (200 admissions annually),
- Postgraduate MD Biochemistry training (4 admissions per year),
- Routine Clinical Biochemistry lab, Hormone lab, 24 hours Emergency lab,
- More than 7 lacs investigationsare done annually and
- Molecular Biology work for PG dissertation, Postgraduate practical work, ICMR-STS projects, Project proposals in ICMR (4 projects), Ph.D. thesis.

a. New initiatives:

New tests introduced:

- Hormone assays: Serum Testosterone, Estrogen, Progesterone, PSA (total & free) and b-HCG
- Urine quantitative analysis

The new instruments procured:

- Electrochemiluminiscence based analyser
- Electrolyte analyser
- Biosafety Hood
- Lyophiliser
- Urine analyser
- Cold Centrifuge

15.20 KALAWATI SARAN CHILDREN'S HOSPITAL (KSCH), NEW DELHI

Kalawati Saran Children's Hospital (KSCH) is a premier referral Children's Hospital of national importance. The Hospital started functioning in the year 1965 for imparting medical care service exclusively for Paediatrics patients upto 18 years of age. At present it has 370 beds. Under the scheme for the improvement of KSCH (JICA) the bed strength of this Hospital is being increased to 500.

Kalawati Saran Children's Hospital is one of the busiest children hospitals in the country and caters to a daily OPD attendance of 800-1000 children, and 80-100 new admissions per day from Delhi and neighbouring States. The hospital is a Sentinel Centre for Poliomyelitis, Tetanus and Measles. It has the unique distinction of having a separate Pediatric Emergency with direct inflow of patients. It also houses the Diarrhoea Training and Treatment Unit, the first such unit in the country, which has also been recognized by WHO and Govt. of India as a training centre for diarrhoeal diseases. The hospital has also served as a training centre for ARI, UIP and other National Health Programmes.

Neonatal wing of the hospital, with 86 beds catering to 15,000 deliveries a year, is the biggest neonatal unit in the country and is providing state of art services for premature and sick newborns including ventilator care. The Institution is a super speciality hospital in real sense with its fully developed subspecialities like Neurology, Nephrology, Gastroenterology & Nutrition, Hematology, Pulmonology and Endocrinology.

Indo-Japan Friendship Block of Kalawati Saran Children's Hospital has been constructed with an expenditure of over Rs. 54 crores for the building and the latest equipment for various sections of the Hospital which has been helpful in easing out the problem of inadequate space and technological upgrading of the Institution.

The Hospital has established with the approval of Ministry of Health & Family Welfare, a **"National Nutritional Rehabilitation Resource and Training Centre"** with the support of UNICEF. The Centre has 12 dedicated beds for management of Severe Acute Malnutrition (SAM). The Centre has organized two national level Training of Trainers on the request of Ministry of Health & Family Welfare.

Kalawati Saran Children's Hospital is designated the National Nodal Centre for Facility Based Newborn Care.

Infant and Young Child Feeding Counseling Centre was started in Kalawati Saran Children's Hospital to strengthen IYCF practices. Autism evaluation cell was started in the Hospital. Hemophilia follow-up clinic facilities are provided on first Wednesday (afternoon) of every month in the Department of Physical Medicine & Rehabilitation Department. Once a month After Completion of Therapy (ACT) clinic for follow-up of children treated for lymphoma and leukemia was started in the first Monday of every month.

The Hospital statics for 2012-13 are as under:-

1.	Name of Hospital	:	KSC Hospital	
2.	No. of Beds			
3.	Distribution of Beds	:	EW }	
			ICU }	45
			CCW }	
			Unit -I	54
			Unit -II	60
			Unit III	63
			Unit -III Extended Ward	
			NN Ward	50
			Surgical	36
			Ortho	10
			DTTU	10
			TDCC	12
			Nursery	30
			PMR	05
4.	No. of Discharges	:	27773	
5.	No. of Admissions	:	Male 18772	Female 9074 Total 27846
6.	Bed Occupancy Rate	:	110.0	
7.	OPD attendance	:	Male 254976	Female 137295 Total 392271
8.	Casualty	:	Male 35256	Female 19833 Total 55089
9.	Immunization No. of patient vaccinated	:	65250	
10.	Total no. of Surgical Operation	:	Major 1296	Minor 1830 Total 3126
11.	Total no. of X-ray examination	:	46628	
12.	Total no. of Clinical Lab examinations	:	392271	
13.	Total no. of Bio-Chemistry Examination	:	1537797	
14.	Total no. of Microbiology Examination	:	39822	
15.	No. of patients admitted in ICU	:	1256	
16.	Neonatal & Nursery Care	:	9166	
17.	a) ECG	:	1553	
	b) EEG	:	1465	
	c) BERA	:	45	
	d) EMG	:	50	
18.	Patients attended in PMR Deptt.	:	69345	
19.	Gross Death Rate	:	6.7	

(Figures in thousand of Rupees)

20.

Budget	Allocation	Actual Expenditure
Plan 2210	227500	218429
N.Plan 2210	282000	279271
Plan 4210	27280	21885

15.21 MAHATMA GANDHI INSTITUTES OF MEDICAL SCIENCES (MGIMS), SEVAGRAM, MAHARASHTRA

The Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sevagram is India's first rural Medical College. Nestled in the Karmabhoomi of Mahatma Gandhi, in Sevagram, this Institute was founded by Dr. Sushila Nayar in 1969. Kasturbsa Hospital has the distinction of being the only hospital in the country which was started by the Father of the Nation himself. Over the past 44 years the Institute has grown to be one of the top 25 reputed colleges of the country and has been accredited by National Assessment and Accreditation Council (NAAC) in 'A' grade. The credit goes to Govt. of India, Govt. of Maharashtra and the Kasturba Health Society (KHS) who share the expenditure in the ration of 50:25:25 respectively.

The Institute believes that Gandhian values and principles are as relevant today as ever before. The entrance examination to the MBBS course includes a separate qualifying paper on Gandhian Thought. The students and staff of the Institute adhere to a unique code of conduct, where they are expected to wear handwoven khadi, participate in shramdan, attend all-religion prayer on every Friday evening, abstain from non-vegetarian food, alcohol and tobacco.

The Institute offers MCI recognized degrees and diplomas in 19 postgraduate disciplines and Ph.Ds in seven Departments. Since 1991, all graduates of the Institute have to serve for two years in rural areas and 96 non-governmental rural organizations have joined hands with the institute to fulfill this dream. This rural service is a mandatory eligibility criterion for getting post-graduation in this Institute. The Report of the Task Force on Medical Education of the National Rural Health Mission spells out the need to draw inspiration upon MGIMS Sevagram's, initiatives and experience in curriculum innovation and rural placement of its graduates. It suggests launching a participatory exercise with MGIMS and other like-minded institutions, so that national guidelines can be formulated. Several such visionary and innovative education strategies which started from the Institute have now been adopted by the Government.

The Institute has been running an OPD and 6-bed hospital as part of its Tribal Health Research Project in Melghat all these years with two of its faculty members. However, in view of high maternal and infant mortality rates, in 2012 it has decided to take this initiative forward with the help of the faculty and residents of MGIMS who are posted to the Melghat campus on rotation. In 2012 it has started a new 30 bed hospital for women and children in the tribal area of Utawali, Dharni. The centre has an OT for emergency services and ophthalmic operations.

The Government of Maharashtra has also recognized this as a referral unit. Since it was started in Jan. 2012, much to the respite of the tribal population 32 caesarian sections and 80 gynecological operations have been done. A total 197 ophthalmic procedures have been conducted and as many as 8053 patients were examined in the OPD with 1036 admissions.

Academics

One of the report of the Task Force on Medical Education of the National Rural Health Mission had spelt out the need to draw upon MGIMS Sevagram's initiatives and experience in curriculum innovations and rural placement of its graduates and had suggested launching a participatory exercise with MGIMS and other like-minded institutions, so that national guidelines could be formulated. As a result of that during current year the Ministry of Health & Family Welfare, Govt. of India has selected MGIMS and CMC Vellore in co-ordination with the Centre for Innovations in Public Services (CIPS), Hyderabad as co-coordinators to disseminate to other colleges the innovations conducted by the two Institutes. As an initial initiative, five medical colleges, one each in Kakinada (A.P), Vadodara (Gujarat), Patiala (Punjab), Jorhat (Assam) and Agartala (Tripura) have been selected and MGIMS and CMC are interacting with them in order to help

them replicate the innovations introduced in the curriculum by the MGIMS, Sevagram and CMC, Vellore.

Innovations in the Curriculum- Undergraduates

The entrance examination includes a separate qualifying paper on Gandhian Thoughts, the marks of which are added to the aggregate for the calculation of merit. The institute conducts its own PMT at 5 different centres in India. After admission, the students attend the Orientation Camp and are kept in Gandhiji's Sevagram Ashram where they experience in practical the ethos of Gandhian ideology. Then a few months later for the Social Service Camp they are posted in an adopted village where they stay for 15 days in the village itself alongwith the villagers in order to get acquainted with rural life and get the feel of the problems and voes faced by the villagers. Alongwith they assist in the total health check-up of the village. Each student is allotted 4-5 families to be taken care of till the end of his/her graduation.

In the final year when the students are academically more mature and equipped with knowledge they are again posted for ROME camp at one of the Primary Health Centre under Institute's control where they, under supervision, learn to treat the patients and also take up projects pertaining to rural social and health problems.

Medical Education Unit

The Medical Education Unit was formally started in 1994 as per the MCI guidelines. Over the years it has developed into a highly competent unit. It provides inhouse training to faculty, postgraduates, interns and students on various teaching learning modules, research methodology, communication skills etc. Seven of the faculty have received fellowships from FAIMER (Foundation for Advancement of International Medical Education and Research) and two of them are now faculty and resource persons for Regional Centres in India with one of them is also being the global faculty of FAIMER-Institute, Philadelphia. This unit is also organizing programmes for enhancing the skills of the faculty. In the year under review workshop was held on construction of Multiple Choice Questions (MCQ). The topic was thoroughly debated and discussed in interactive sessions. Two separate workshops, one on Medical Education Technology and another on Mentoring was conducted where the role and responsibility of mentor was defined and dilemas they face were discussed.

Centralized Skill Laboratory

The skills lab is primarily designed to teach and assess learners at all levels- from first- year medical and nursing students to postgraduate students and staff. The models and mannequins that are available in the clinical skills lab are designed to provide learners with the ideal setting to practice the clinical skills of history taking, physical examination, communication, and interpersonal skills. The lab provides the students with the opportunity in a safe environment to practice clinical techniques on simulators.

Hospital Activities

The Kasturba Hospital which has gradually expanded from a 15 bedded Hospital to a 780 bedded hospital primarily caters to the rural populace as three fourth of the patients that visit hospital come from rural areas. Besides Wardha district the patient load comes from adjoining parts of Andhra Pradesh, Madhya Pradesh and Chhattisgarh. It acts as a tertiary care hospital with all the modern health care amenities but provides health services at affordable cost. It has a unique insurance scheme in which this year 58186 families, equivalent to 232548 members were insured.

Total Beds Teaching-660 Service Beds-100 Private beds-20	780
OPD	709002
Outreach patients examined	192511
Indoor patients	44903
Investigations (Patho, Bio. and Microbiology)	681608
X-rays	59479
Ultrasound	23976
CT Scan/MRI	5546
Surgeries performed	13954
Blood Donations Camp	44

New Medicine Block inaugurated

MGIMS added a new edifice to its existing infrastructure- an imposing modern building which houses 192 beds alongwith all services provided by the Department of Medicine. The new state- of-the-art construction spread across 70,000 sq feet area comprises of an out-patient Department, triage facility, medical wards, a 26- bedded Intensive Care Unit (ICU), facilities for endoscopy, hemodialysis, a prayer room and a well-equipped conference/seminar room with all modern amenities.

The Department of Radiology recently installed a Magnetic Resonance Imaging 1.5 Tesla MRI machine. This state of the art machine has 16 channels and S2 gradient system which are comparable to the best machines in its class. This machine incorporates all essentials in patient monitoring without compromising on the comfort of the patient. This machine enables the color mapping of the functional areas of the brain, tactography, perfusion imaging etc. thus helping in the evaluation of neurological and psychiatric patients. It has also opened broader avenues into neurological research.

The Department of Radiotherapy with the help of grant-in-aid from the Centre under the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS) Scheme and special grant from the State Government, has received the status of Tertiary Cancer Center. Computerized radiotherapy unit for portal imaging and dosimetry have already been installed in the Department and the Dual Energy (6MV and 15MV) Electron Linear Accelerator (LA) compatible with all latest modern techniques will very soon replace the existing Linear Accelerator.

The Department of Microbiology has been carrying out both laboratory and community-oriented funded research. The thrust on research has been primarily on tuberculosis, its prevalence, diagnosis, drug resistance (MDR & XDR), NTM and short course chemotherapy. Work has also been undertaken on Interferon Gamma Assays in tuberculosis. As one of the major achievements, the Department has been certified by National Mycobacteriology Certification System of Central TB Division, Ministry of Health & Family Welfare, Govt. of India for Tuberculosis drug susceptibility testing by conventional culture based DST. It is now a certified referral centre for first line drug resistance testing under the RNTCP programme.

The Department of Obst. & Gynae has been running various projects which aim at reducing maternal mortality, imparting family life education to adolescent girls. Community Based Reproductive Health Care camps were organized at 58 adopted villages. Diagnostic, cancer detection and screening camps were held at various villages. The faculty has taken up some Govt. of India projects as Maternal Near Missed (MNM) Project for developing national policy.

The Department of Ophthalmology runs a Sentinel Surveillance Unit under the National Programme for Control of Blindness for Wardha district. This year 6930 cataract surgeries were performed. IOL implantation was done in 6891 patients and conventional cataract surgery was performed in 39 patients. LASIK (Laser-Assisted in Situ Keratomileusis) is the latest addition to the range of quality services being provided. LASIK is a procedure that permanently changes the shape of the cornea, using an excimer laser. The LASIK Centre at MGIMS has the aim of providing excellence and affordability in laser vision correction. LASIK surgery machines are also evolving with new cutting edge technology for improving the vision and eliminating or reducing the dependence on glasses and contact lenses.

The Department of Pathology runs a Population based Cancer Registry of Wardha district with financial assistance from ICMR. It is the only centre that provides data on both rural and urban population.

The Directorate of Health Services (Maharashtra) has selected the **Department of Pediatrics** as the only nodal center in Vidarbha and one of the only 3 nodal centers in Maharashtra State for training of government health personnel (including pediatricians, medical officers, nurses) in Facility Based Newborn Care. The Department has also been selected as training center by Govt. of Maharashtra for 6 months training of Medical Officers in Pediatrics under the Medical Officers Certificate Programme.

Community Work

The Department of Community Medicine has been implementing community-based programmes to enhance health care services to therural communities. It has under its administrative control adopted four PHCs; Anji, Gaul, Kharangana and Talegaon with a population of more than 120,000 and developed a model of decentralized healthcare delivery at village level through community-based organizations and the Panchayati Raj Institutions. It has formed 325 Self-help groups, 9 Kisan Vikas Manch and 54 Kishori Panchayat in the adopted villages which provide a platform for dissemination of behavior change communication messages. It runs community outreach clinics in 24 villages to take curative health care to the rural populace. Through innovative strategies, family life education is provided to adolescent girls both in schools and out of schools in all the programme villages. The Department is actively involved in conducting community-based health research through partnership with various national and international agencies. The thrust areas of research includes developing a decentralized model of health care delivery for rural areas, safe motherhood and child survival and life-style disorders.

The Department is continuing its participation in National Ongoing Programme such as Universal Immunization Programme (UIP), Revised National Tuberculosis Programme, National Leprosy Elimination Programme, Integrated Disease Surveillance Programme, Integrated Child Development Services, National Rural Health Mission, Adolescent Health Programme, National Vector Borne Disease Control Programme and Emergency Obstetric Care (EmOC).

The Dr. Sushila Nayar School of Public Health (DSNPH) was started on 23 Jan 2007, in response to the National Health Policy 2002, to promote teaching and training of public health in the country. The centre works in partnership with like-minded individuals and institutions so that advocacy and policy research on priority public health issues may be initiated. The School also works in collaboration with the health system to improve accessibility and availability of health care to the marginalized and downtrodden.

Research

The focus of the Institute has been on community based medical research. Quality research has been the hallmark of this rural institute and the large number of funded projects awarded to the various Departments is ample testimony to the potential of the researchers. Being located in Sevagram has never been a hurdle in acquiring either funds or facilities as the enthusiasm and the dedication of the faculty surpasses all other deterrents. The Institute brings out biannually its own scientific journal named J MGIMS which is indexed in INDMED.

Awards & Fellowships	
Faculty	11
Students	39
Publications	163
On-going Funded Research Projects	39
On-going Non Funded Research	71
Short Term Projects by ICMR	09
Research Projects completed	38
Nos. of Conferences Attended by the faculty	66
Nos. of Workshop/Meeting attended by the faculty	160
Educational programmes/Conferences/ CMEs organised	47

GENDER BUDGETING

STUDENTS ADMITTED

	Male	Female	% Female
MEDICAL STUDENTS			
UGs-100	53	47	47.00%
PGs-61	41	20	32.78%
NURSING STUDENTS			
Kasturba Nursing School	-	40	100%

PATIENTS ADMITTED

	Total Patients	Male	Female	% Female
Indoor	44903	44903	24037	53.53%
OPD	709002	349538	359464	50.70%

TOTAL NO. OF EMPLOYEES

Total Employees	Male	Female	% (Female)
1047	576	471	45%

15.22 NATIONAL CENTRE FOR DISEASE CONTROL (NCDC), NEW DELHI

The Institute in under administrative control of the Director General of Health Services, Ministry of Health and Family Welfare, Govt. of India. The Director, an officer of the Public Health subcadre of Central Health Services, is the administrative and technical head of the institute. The Institute has its headquarters in Delhi and had 8 branches located at Alwar (Rajasthan), Bengaluru (Karnataka), Kozhikode (Kerala), Coonoor (Tamil Nadu), Jagdalpur (Chhattisgarh), Patna (Bihar), Rajahmundry (Andhra Pradesh) and Varanasi (Uttar Pradesh). There are several technical Divisions at the headquarters of the institute i.e. Centre for Epidemiology and Parasitic Diseases (Dept. of Epidemiology, Dept. Parasitic Disease), Division of Microbiology, Division of Zoonosis, Centre for HIV/AIDS and related diseases, Centre for Medical Entomology and Vector Management, Division of Malariology and Coordination, Division of Biochemistry and Biotechnology.

In each division there are several sections and laboratories dealing with different communicable diseases. The divisions have well equipped laboratories with modern equipments, capable of undertaking tests using latest technology. The activities of each division are supervised by an officer in-charge, supported by medical and nonmedical scientists, research officers and other technical and paramedical staffs. The branches are also well equipped and staffed to carry out field studies, training activities and research.

A. Integrated Disease Surveillance Project (IDSP): Integrated Disease Surveillance Project (IDSP) was launched with World Bank assistance in November 2004. The project envisaged data collection on a number of communicable as well as non-communicable disease risk factors, but later focused on epidemic prone diseases only in 2007 on the recommendations of international and national experts. The project was extended for 2 years up to March 2012. The project continues in the 12th Plan with domestic budget as Integrated Disease Surveillance Programme under NRHM for all States at an outlay of Rs. 640.4 crores.

Project Components:

- Integration and decentralization of surveillance activities through establishment of surveillance units at Centre, State and District level.
- Human Resource Development-Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team and other Medical and Paramedical staff on principles of disease surveillance.
- Use of Information Communication Technology for collection, collation, compilation, analysis and dissemination of data.
- Strengthening of public health laboratories.

Current Status of IDSP Implementation

Surveillance units have been established at all State and District Headquarters (SSUs, DSUs). Central Surveillance Unit (CSU) is integrated with National Centre for Disease Control (NCDC), New Delhi.

Human Resources and Training

Considering the non-availability of health professionals in the field of epidemiology, microbiology and entomology at District and State level, Ministry of Health & Family Welfare approved the recruitment of trained professionals under National Rural Health Mission (NRHM) in order to strengthen the disease surveillance and response system by placing one epidemiologist each at State/District headquarters, one microbiologist and entomologist each at the State headquarters. The recruitment of 400 epidemiologists, 165 microbiologists and 23 entomologists has been completed under IDSP till March 2014. Induction training given to majority of them. Training of State/ District Surveillance Teams (Training of Trainers) and Rapid Response Teams (RRTs) has been completed in all 35 States/UTs.

The main focus of training for State level participants is on basics of disease surveillance, concepts of epidemiology and data management, whereas the district training focuses on correct procedures of data collection, compilation and reporting and outbreak response. A need based special two-week disease surveillance and Field Epidemiology Training Programme (FETP) have

been initiated for the District Surveillance Officers. 606 District Surveillance Officers have already been trained in this special 2- week FETP.

IT Network

The IT network has been established at 776 sites (connecting all the State/UTs and district headquarters, medical colleges, Infectious Disease Hospitals (IDHs), and premier health institutions for data entry, data transference, analysis and video conferencing with the help of National Informatics Centre (NIC) and Indian Space Research Organization (ISRO) to provide the terrestrial and satellite connectivity. However, satellite connectivity is not available since September 2010. Recently, ISRO has allocated the bandwidth and has started migration of network from GSAT-3 to GSAT-12 to restart the satellite connectivity. IDSP has started one stop portal (http://www.idsp.nic.in) for data access and transmission, trend analysis and free resources like training material, guidelines, advisories for health personnel related to disease surveillance.

Data Management

Under IDSP data are collected on epidemic prone diseases on weekly basis (Monday-Sunday). The information is collected on three specified reporting formats, namely "S" (suspected cases), "P" (presumptive cases) and "L" (laboratory confirmed cases) filled by Health Workers, Clinicians and Laboratory staff respectively. The weekly data gives information on the trends and seasonality of diseases. Whenever there is a rising trend of illnesses in any area, it is investigated by the Rapid Response Team (RRT) to diagnose and control the outbreak. Data analysis and actions are being undertaken by respective State/District Surveillance Units. Emphasis is now being laid on reporting of surveillance data from major hospitals. Presently, about 90% districts in the country report weekly surveillance data on epidemic prone diseases through e-mail or portal.

In addition, States and districts have been asked to notify the outbreaks immediately to the system. On an average of 30-35 outbreaks are reported every week to Central Surveillance Unit (CSU). A total of 553 outbreaks of epidemic prone diseases were reported and responded through IDSP in 2008, 799 outbreaks in 2009, 990 outbreaks in 2010, 1675 outbreaks in 2011, 1584 outbreaks in 2012 and 1964 outbreaks in 2013. 285 outbreaks have been reported and responded till 31st March, 2014. Earlier only a few outbreaks were reported in the country by the States/UTs.

Media scanning and verification cell was established under IDSP in July 2008 to detect and share media alerts with the concerned States/Districts for verification and response. A total of 2402 media alerts were reported from July 2008 to September 2013. Majority of alerts were related to diarrhoeal, food borne and vector borne diseases.

Strengthening of Laboratories

50 identified district laboratories are being strengthened for diagnosis of epidemic prone diseases. Till date 29 States i.e. 42 labs have been made functional. These labs are also being supported by a trained manpower to manage the lab and an annual grant of Rs. 4 lakhs per annum per lab for reagents and consumables.

In 9 States (Gujarat, Punjab, Rajasthan, Uttarakhand, Karnataka, Tamil Nadu, Maharashtra, Andhra Pradesh and West Bengal), a referral lab network has been established by utilizing the existing functional labs in the medical colleges and various other major centers in the States and linking them with adjoining districts for providing diagnostic services for epidemic prone diseases during outbreaks. Additional 23 identified medical college labs in Bihar, Assam, Odisha, Tripura, Kerala, Haryana, Jammu & Kashmir and Manipur were included in the laboratory network in 2012-13.

In addition, a network of 12 laboratories has been developed for Influenza surveillance in the country. These Laboratories are testing clinical samples of Influenza A H1N1 in different regions of the country.

B. Up-gradation of National Centre for Disease Control:

- All statutory approvals on building plans from local authorities have been received. The final approval on building plans from North Delhi Municipal Corporation received on 28.01.2013.
- The National Buildings Construction Corporation

(NBCC) has been engaged as an Agency for construction of civil works and services. They have further engaged M/s. Era Infrastructure Engineering Limited and M/s. Krishna Builder for construction work under phase-I. The construction work started in February, 2013. The Hon'ble HFM laid the Foundation Stone on 28.04.2013. About 30% of the construction work has been completed.

- During the Annual Plan 2013-14 the approved outlay is Rs. 100.00 crore (Revenue: Rs. 5.25 crore and Capital: Rs. 94.75 crore. For 2014-15 the proposed outlay is Rs. 4.80 crore under Revenue and Rs. 200.00 crores under Capital.
- 103 new Scientific & Technical posts and 11(eleven) administrative posts have been created under upgradation of NCDC.

C. Division of Parasitic Diseases:

(i) Yaws Eradication Programme (YEP): Yaws Eradication Programme (YEP) was launched as a centrally sponsored scheme in 1996-97 in Koraput district of Odisha, which was subsequently expanded to cover all the 51 Yaws endemic districts in ten States (Andhra Pradesh, Odisha, Maharashtra, Madhya Pradesh, Chhattisgarh, Tamil Nadu, Uttar Pradesh, Jharkhand, Assam and Gujarat). The programme aimed to reach the un-reached tribal areas of the country.

National Centre for Disease Control has been identified as the nodal agency for the planning, monitoring and evaluation of the Programme. The Programme is implemented by the State Health Directorates through the existing health care system. The number of reported cases has come down from 3751 to nil during the period from 1996 to 2004 and subsequently no case has been reported from any of the States till September 2013.

The programme envisaged achieving its objective through adopting following strategies:

- ➢ Case finding: active case search, passive surveillance, rumour reporting
- ➢ Treatment of cases and contacts
- ➢ Manpower development
- ➢ IEC activities
- ➢ Multi-sectoral approach
- ➢ Sero -survey in 1-5 year children

The disease has been declared eliminated on 19th September, 2006. However, monthly surveillance, active search operations, verification of rumour reports, health education and sero-survey in 1-5 year children are being undertaken as per the international requirements to eradicate the disease. During the year a total of 140 sera samples collected from 1-5 years children and examined. All the samples were found to be negative for Yaws disease by RPR/TPHA test.

Funds in the form of "Grant-in-aid" are being provided to the States for operational cost to undertake activities under YEP.

(ii) Guinea Worm Eradication Programme (GWEP): In 1983-84, National Centre for Disease Control (Formerly: National Institute of Communicable Diseases) was made the nodal agency by the Ministry of Health & Family Welfare, Govt. of India for planning, co-ordination, guidance and evaluation of Guinea Worm Eradication Programme (GWEP). At the beginning of the Programme i.e. in 1984, about 40,000 GW cases were reported in 12,840 guinea worm endemic villages across 89 districts of seven endemic States, viz. Andhra Pradesh, Gujarat, Karnataka, Madhya Pradesh, Maharashtra and Rajasthan. The State of Tamil Nadu remained free from GW disease since 1982.

The last guinea worm case in India was reported in July 1996 in Jodhpur district of Rajasthan. World Health Organization certified India as guinea worm disease free country in February 2000. However, routine surveillance is being continued till the disease is eradicated globally.

D. Zoonosis Division: The objectives of the division is to provide technical support for outbreak investigations, conduct operational research and trained manpower development in the field of zoonotic diseases and their control in the country. Diagnostic support is provided to State Governments for laboratory diagnosis of zoonotic infections of public health importance.

The Division has Reference Laboratory for Plague. It has also been recognized by the World Health Organisation as WHO Collaborative Centre for Rabies. Currently the work is being carried out on following Zoonotic diseases: Plague, Rabies, Kala-azar, Arboviral infections (Dengue, JE & Chikungunya), Toxoplasmosis, Brucellosis, Leptospirosis, Rickettsiosis, Hydatidosis and Anthrax.

Major Role and Activities of Division during 2013-14 are as follows:

S. No.	Referral diagnostic services provided to the States		No. of samples tested (01.04.13 - 31.03.14)
1.	Rabies	(a) Post-mortem diagnosis in animal brain samples by Negri body, FAT, BT	04
		(b) Diagnosis in hydrophobia cases by	06
		(c) Assessment of antibodies by ELISA test	
		(i) Human	295
		(ii) Animal	Nil
2.	Kala-azar	(a) Parasitological Diagnosis by smear examination and culture	38
		(b) Serological diagnosis by IFA test	165
3.	Toxoplasma	Serological and Diagnosis by IFA test	559
4.	Brucellosis	Serological diagnosis by tube agglutination test	119
5.	Rickettsiosis	Serological diagnosis by Weil Felix test, ELISA	1158
6.	Hydatidosis	Serological by ELISA	24
7.	Arboviral Diseases	(a) Serological diagnosis by IgM ELISA test for Japanese Encephalitits	
		1. Human Sera Samples	534
		2. Human CSF	669
		(b) IgM ELISA test for Dengue	379
		(c) IgM ELISA test for Chikungunya	185
8.	Plague	(a) Serological diagnosis by PHA and PHI in rodent Sera	Nil
		(b) Culture for Isolation of Y. Pestis From rodent organs	5055
9.	Leptospirosis	Serological diagnosis by ELISA	396
10.	Anthrax		08
11.	Viral Isolation	Chikungunya	1
		Dengue	200
		Rabies	13
		AES/JE	173
12.	Lyme's Disease by ELISA		10
13.	Hanta virus by ELISA		36

Three New Initiatives under the 12th Five Year Plan (2012-2017)

1. National Rabies Control Programme:

Human Component: MoU has been signed with 5 States.Expert meeting was held to develop operational guidelines for implementation of the programme. Nodal officers have been identifies by 12 States. National guidelines on Animal bite management & Rabies prophylaxis has been uploaded on NCDC Website.

Animal Component: MoU has been signed with AWBI. During 2013-14, 70 lacs were transferred to AWBI for carrying out various activities under animal component.

2. Programme for Prevention and Control of Leptospirosis: MoU has been signed with 3 States. Expert meeting was held to develop operational guidelines for implementation of the programme.

3. Strengthening of Intersectoral Coordination for Prevention and Control of Zoonotic Diseases: Expert meeting was held to develop operational guidelines for implementation of the programme. During 2014-15, 2 crores has been allocated.

E. Centre for AIDS & Related Diseases: Details of routine activities undertaken by the centre from April 2013 to Mar. 2014.

National Reference Laboratory:

- Confirmation of HIV sero-status of all samples received from SRLs and their ICTCs, which are showing indeterminate or discordant results-80.
- **External Quality Assessment Scheme (EQAS) for HIV Serology:** Participated in National EQAS for HIV serology conducted by NARI, Pune. The results had 100% concordance.
- Conducted two round of EQAS for HIV serology for 13 linked State Reference Laboratories (SRLs) and their ICTCs in the States of Delhi, Haryana, Rajasthan and Jammu & Kashmir.
- **HIV/HBV/HCV diagnostic kits evaluated:** A total of 44 batches of diagnostic kits (33 batches of HIV rapid test kits, 1 HBV rapid 5 batches of HCV ELISA test kits and 04 HIV ELISA and 1 HbsAg ELISA were evaluated). A total of approximately 22,000 tests were carried out in this evaluation.

Serology Laboratory:

- Confirmation of HIV sero-status of samples received from non-SRL laboratories or hospitals (both private & government)-104.
- HIV-2 confirmation of patients referred through ART Centres of seven States of Delhi, Punjab, Chandigarh, Haryana, Rajasthan, Jammu & Kashmir and Himachal Pradesh-29.
- Samples tested under HIV Sentinal Surveillance programme-1575.
- HIV testing of clients visiting ICTC-552.

Immunology Laboratory:

- CD4/CD3 count in HIV positive patients referred from linked ART centre/ PPTCTCs-3420 samples.
- This centre participated in National EQAS for CD4 testing conducted by NARI, Pune in collaboration with QASI, Canada in April and September, 2013 and performed satisfactorily.

STI/Opportunistic Infections:

- Qualitative RPR for Syphilis-192
- Semi Quantitative RPR : 35
- TPHA-192
- A total of 2 samples were tested for opportunistic infections.
- Participated in Inter Laboratory evaluation of quality assurance of serological tests for Syphilis (VDRL/RPR) - Series VIII conducted by VMMC and Safdarjang Hospital, New Delhi. The qualitative results had 100% concordance.

NABL Accreditation:

- The centre has received certification for renewal of accreditation by NABL (National Accreditation Board for Testing and Calibration Laboratories)

in the field of medical testing conforming to ISO 15189:2007 Standard from 14 February, 2014 to 13 February, 2016.

F. Microbiology Division: Details of routine activities undertaken by the Division of Microbiology from April-2013 to March-2014.

Broad activities of the Division:

- Routine and Referral diagnostic services for viral, bacterial and mycotic diseases.
- National laboratory for Polio surveillance (AFP) and supplementary surveillance (sewage).
- Laboratory support to outbreak investigations.
- Laboratory support to IDSP.
- Microbiological analysis of environmental samples.
- Training on laboratory aspects.
- Preparation and supply of reagents, culture media, diagnostic kits and other materials as support to outbreak investigations in the country as well as to the network of collaborating laboratories in various organizations and institutes in the country.
- Outbreak investigations for unknown pathogens.

Achievements of the Division:

- Approval from the standing finance committee on AMR and viral hepatitis has been obtained and activities under the programme will begin by March 2014.
- WHO accredited national polio laboratory testing more than 100 samples/day.
- 12 labs under IDSP are carrying out Influenza surveillance.
- Around 10 research projects/MD thesis /PHD on various topics have been successfully undertaken.
- Indo Swedish collaboration for Antimicrobial resistance.

Two New Initiatives under the 12th Five Year Plan (2012-2017)

1. National Programme on Prevention & Control of Anti- Microbial Resistance:

- Anti-Microbial Resistance Surveillance Programme.
- The SFC has been approved for the 12th Five Year Plan(2012-2017).
- Two separate groups i.e. the Expert Working Group and the Steering Committee have been constituted under the chairmanship of the DGHS for implementation of the programme.
- In the first phase of the programme 10 Medical College Labs have been identified and signing of the Memorandum of Understanding between the Colleges and the NCDC is underway, following which funds will be transferred.
- A common unified National Treatment guidelines for treatment of different infectious diseases is to be formulated, which can serve as a guide to the doctors all over the country. In this regard there have been two meetings of the Expert Working Group in the months of February & March.

2. Viral Hepatitis Surveillance Programme:

- The SFC on "National Hepatitis Surveillance Programme in Various Geographical Location of India under 12th Five year plan (2012-2017)" has been approved.
- The first meeting of the Expert Working Group was conducted at NCDC, New Delhi to develop treatment guidelines for various types of Viral Hepatitis.
- In the first year two medical colleges (SKIMS, Srinagar & MMC, Chennai) have been identified to be included under the surveillance network.

Coxsackie B Virus: To find out the association between myocarditis and Coxsackie B virus, paired serum samples from 32 cases from different hospitals were received and tested. All the samples were found negative to Coxsackie B group (B1-B6) virus infection.

Measles: one hundred fifty seven (157) clinically suspected cases of SSPE were reported to the laboratory. Eighty three (83) of these cases were confirmed by laboratory tests showing of high titre anti measles antibodies in serum and CSF samples. No such case, so far, is reported following measles vaccination.

Viral Hepatitis: A total of 827 serum samples were received and tested for various markers of viral hepatitis.

Congenital Viruses: A total of 537 samples from women having bad obstetric history and congenitally malformed babies and viral encephalitic cases were tested for antibodies against Rubella, Cytomegalo virus & Herpes simplex virus infections. 136 serum and 118 CSF were tested for HSV encephalitis.

Viral Encephalitis: 237 cases from viral encephalitis from Delhi hospitals were received and tested for anti-measles, Vericella (08/37 positive) Mumps (1/10 positive), EV-71 (18 negative), and Anti Parvo B-19 (47 negative) antibodies.

Influenza Surveillance: 1783 Nasal and throat swabs from all over the country from suspected cases of Swine flu were tested for respiratory including Swine flu. Out of which 56 for H1N1 positive, 109 for H3N2 positive, 7 positive for Influenza A seasonal and 4 positive for Influenza B.

National Polio Surveillance

AFP Surveillance: The Virology laboratory of NCDC has been accredited as WHO National Polio Lab to assist NPSP on lab based surveillance. In this regard, 17620 contact stool specimens, 8921 cases were received and tested. Isolates found positive for polio virus were processed for further typing and intratyping characterization. No wild poliovirus has been reported till date.

Supplementary Surveillance: As per Govt. of India, Ministry of Health & Family Welfare, NCDC has been selected to carry out supplementary surveillance by collecting sewage samples on weekly basis from 7 sites selected by NPSP to see the presence of any wild poliovirus in the sewage. In this regard, 363 sewage samples have been collected and tested at NCDC and include 4 sites of Punjab 108 sewage samples collected and tested. Positive isolates were tested at NCDC, Delhi. No wild poliovirus since October, 2010 has been reported.

Tuberculosis: A total of 78 clinical samples (mainly sputum and few other samples like CSF, pleural fluid, Pus and urine) obtained from suspected cases of tuberculosis. 14 samples were found to be positive in culture (only 3 samples were found to be AFB smear positive). In addition, 125 serum samples obtained from different States of India and evaluated serological diagnostic RPR test kits for YAWS Diseases. Not found positive samples.

Bacteriology: 60 samples (including CSF, blood) obtained from suspected cases of pyogenic meningitis were processed. 234 clinical samples from suspected diphtheria cases in Delhi were processed for diphtheria cases in Delhi. 207 urine samples were subjected to culture examination. Blood culture was carried out in 75 samples from cases of enteric fever. 22 pus, throat swabs were processed. 46 blood samples were processed for widaltest and Typhi dot IgM and 4 C. diphtheriae isolates received from Government General Hospital, Rangaraya Medical College, Kakinada (Andhra Pradesh) for identification.

Antimicrobial Resistance (AMR) Study: Monitoring of carbapenems resistance in environmental, Community and Hospitalized Patients Having Urinary Tracy Infections (UTI) 493 were processed from Environmental, Community and Hospitalized Patients Having Urinary Tracy Infections (UTI) for AMR Studies.

Diarrheal Diseases Laboratory: A total of 402 stool samples and Rectal swabs were collected from different hospitals of Delhi out of which, 74 are positive for Ogawa, 5 NAG, 12 Salmonella, 15 Shigella, 19 Enteropathogenic E. coli., 1 Giardia lamblia.

Environmental Laboratory: A total of 286 drinking water samples belonging to different drinking water sources (collected during outbreak investigations of water borne diseases, samples from air-line caterers serving VVIP flights, referred samples from schools, hospitals, domestic sources etc.) were tested for bacteriological standards by the MPN Coliform method. 217 of these were found satisfactory, while the remaining 69 were unsatisfactory.

Mycology Laboratory: Mycology Laboratory diagnostic services were provided to referred patients from different Government Hospitals/Medical Centers of Delhi. Out of 56 clinical samples (CSF-18; Tissue-19; Pus-5, Fluid-01 and NAIL-05, Gastric Fluid-01, Sputum-01, blood culture-04, throat swab-02, Urine-01 were isolated.

G. **Division of Biotechnology:** The division is actively involved in disease diagnosis during epidemics and outbreak, operational research, manpower development, advisory role and other

multifarious activities towards prevention and control of a cascade of epidemic prone disease of larger public health importance. The division is collaborating with different divisions of NCDC and with outside Organizations/Institutes.

Broad mandate of the Division:

(i) Referral Molecular Diagnostic Support in the field of genomics of important epidemic-prone diseases which includes:

- ➢ Fool-proof Molecular Diagnostic support for confirmation of pathogen,
- ➢ Tracing the origin and source of infection of emerging/re-emerging diseases,
- ➢ Tracking-down the routes of pathogen transmission,
- ➢ Identifying reservoirs sustaining transmission,
- ➢ Identifying new, emerging and re-emerging pathogens,
- ➢ Genotyping and Sub-typing of strains,
- ➢ Characterizing drug-resistant strains,
- ➢ Identifying links between cases and infections,
- ➢ Linking pathogen variants to endemicity and epidemicity,
- ➢ Monitoring impact of immunization programmes,
- ➢ Monitoring the progress of disease control activities,
- ➢ Maintenance of "Gene Bank" of important disease pathogens and
- ➢ Molecular typing of drug resistant strains of bacterial pathogens etc.

- **Molecular characterization of Hepatitis C virus:** An outbreak of HCV infection was reported in the district of Anantnag, J&K. Outbreak was belonged to HCV genotype 3a.

- **Molecular characterization of dengue virus isolates targeting Cpre-M and Env/NS1 gene region during DF outbreaks:** Molecular characterization and genotyping was done for Delhi samples. DENV-1 genotype III and DENV-3 genotype III, which are relatively considered milder strains in terms of severity of disease and circulation of DENV-2 genotype IV were reported.

- **Molecular studies of Chikungunya virus:** The downward trend of disease was found in Delhi having only 2 positive samples.

- **Diagnosis of Guinea Worm:** Suspected sample for guinea worm (D.medininensis) reported from erstwhile endemic district of Rajasthan was tested for molecular characterization using 18S-rRNA & CO1 gene specific primers. Sample did not confirm to be D. medininensis.

ii) Specialized Training:

a. Specialized training imparted to **>25 M.Sc./B.Tech** students perusing from various **Indian Universities** and nominees of Indian Academy of Sciences.

b. Four students pursing *Ph.D. degree* from various Indian Universities.

c. Imparted training and teaching to students of perusing MPH course at NCDC under GGSIP University, New Delhi.

iii) Applied Research in genomics of important epidemic-prone diseases.

- **Sequence-based genomic characterization of circulating strains of influenza A with special reference to 2009 Pandemic H1N1 virus.**

  DNA sequencing of HA and NS gene of influenza A was carried out and data was analyzed for factors related to increased virus virulence, pathogencity, severe infection and drug resistance. Data generated from sequencing was also analyzed by different bio-informatics tools to determine phylogeny of circulating strain.

- **Targeted characterization of 65kDa heat shock protein gene (DNA) and of 85B antigen gene (mRNA) of M. tuberculosis in endometrial biopsies from infertile women undergoing *in-vitro* fertilization.**

  Endometrial samples were amplified for 740 bp region of the DC-Sign promoter region present in CD209 gene of humans to check for susceptibility to tuberculosis infection in these patients due to presence of the two known SNP's namely, -871 and -336.

- **Genotypic characterization of nef gene from HIV-1 infected Rapid progressors.**

  Analysis of HIV-1 nef gene was carried to unveil important genomic changes in rapid progressors and long term non-progressors. Some striking amino acid changes were observed which may serve as predictors for the two above categories of AIDS patients.

- **Computational and molecular analysis of HIV release by 'Viral Protein-U' (vpu) at the time of pregnancy.**

  Genetic characteristics of the trans-membrane and cytoplasmic domain of the vpu protein of HIV during pregnancy was done. In addition we also studied BST-2 m-RNA expression at the time of pregnancy and post-partum.

- **Genetic characteristics of the hypervariable region (V3-V5) of env gene of HIV-1 distinguishing Subtype C from B.**

  Molecular characterization of the hyper-variable region (V3-V5) of the envelope (env) gene of HIV-1 and compared them with subtype B sequences retrieved from database to determine Subtype C distinguishing genetic characters that may possibly account for its high pathogenicity.

H. Division of Malariology & Coordination: The division has a malaria laboratory to check/cross check blood smears of clinically diagnosed cases for the presence of malarial parasites, referred by various hospitals of Delhi and surrounding districts of Uttar Pradesh and Haryana state. During the year 2013 upto 30th September, 2013 a total of 632 blood smears were examined, of which 58 were found to be positive **51 for P.vivax and 7 for P. falciparum**.

A total of 554 students from different institutes were given short term training in orientation of NCDC and Communicable Diseases. The details are as below:

S. No.	Date	Institutions	No. of participants
1	7-1-13 to 11-1-13	Post Graduate (MD) students of Deptt. of Microbiology, RML Hospital, New Delhi	3
2	16-1-13	B.Sc. Nursing students of St. Andrews College of Nursing Shukarwar Peth, Wadia hospital campus, Pune	56
3	4-2-2013	B.Sc. Nursing students of Mahatama Gandhi Mission's Mother Teressa Nursing college, Aurangabad	23
4	5-2-2013	Veterinary Doctors of NDEHMS-39 course from RVC Centre & College, Meerut Cantt	8
5	5-2-2013	Participants of training programme in Diploma in Health Promotion Education and Diploma in community Health care for paramedical Health workers from family welfare and training centre, Mumbai	29
6	19-2-13	2nd Year B.Sc. (N) students of RML Hospital, New Delhi	50
7	21-3-13	Final Year BHMS students of Dr. Padiar Memorial homoeopathic College, Chottanikkara P.O. Ernakulam, Kerala - 682312	42
8	1-4-13	IV year B.Sc. Nursing students of College of Nursing, St. Philomena's Hospital, Bangalore	45
9	4-4-13	GNM 1 year and B.Sc Nursing III year students of Rufaida College of Nursing, Jamia Hamdard, New Delhi	45
10.	9-4-2013	4th year Basic B.Sc. & 2nd Year Post Basic B.Sc Nursing Students of Hiranandni College of Nursing ,Hiranandni gardens, Powai, Mumbai	44
11	25-4-2013	Senior Medical Officers from BSF Gwalior	22
12	26-4-2013	B.Sc. Nursing students from St. Ann/s College of nursing, Mulki, Mangalore	45
13	29-7-2013	M.Sc Public Health Entomology students of VCRC Pondicherry	10
14	29-8-2013	Air force warriors from NBC protection, AF station, Arjangarh, Air Headquarters (Offensive), New Delhi	62
15.	11-9-13	2nd Year B.Sc. (H) Nursing students, from R.A.K. College of Nursing, Delhi	70
			554

I. Centre for Medical Entomology and Vector Management: Centre for Medical Entomology and Vector Management is reorganized to develop it as a National Centre par excellence for undertaking research, providing technical support and to develop trained manpower in the field of vector - borne diseases and their control. The centre provides technical guidance, support and advice to various states and organizations on outbreak investigations and entomological surveillance of vector-borne diseases and their control. Major achievements are highlighted below:

Major achievements:

1. Based on the detection of dengue virus antibodies in vector mosquitoes warning signals were issued to Municipal Health Officer, MCD, Delhi for possible outbreak of dengue.
2. First time map for distribution of presence of infected Aedes mosquitoes in Delhi was prepared. List of high-risk localities was communicated to Municipal Corporation of Delhi and NVBDCP for action taken.
3. Dr. R. S. Sharma attended Expert group meeting on Malaria Vector Control, from 24-26 Feb. 2014 at Geneva.
4. Entomological Surveillance of vector of Yellow Fever, Dengue and Chikungunya mosquitoes in and around Amritsar airport, Kandla seaport, Goa airport.
5. Provided training to health official at Goa Port Health Organization.

Paper published:

1. Roop Kumari et al., Mapping of dengue virus and dengue vector in Delhi. Published in Dengue Bulletin. 2013, Vol. 37

Ongoing Research Projects

1. Studies on the presence of dengue/JE virus in vector mosquitoes.
2. Japanese Encephalitis/ Dengue virus detection in mosquitoes of some endemic areas.
3. Entomological surveillance of vector of Yellow Fever. Dengue and Chikungunya mosquitoes in and around international airports and seaports and vector control measures thereof.
4. Studies on rodent-flea association at major Sea Ports of India.
5. Entomological surveillance of vectors of scrub typhus in selected urban, peri-urban and rural set up of Delhi, NCR and other parts of the country.

J. Epidemiology Division:

i. Activities of the Division:

1. Organization and coordination of training courses in Epidemiology to develop trained health manpower. Development of teaching materials such as Modules, Manuals etc. on disease surveillance and outbreak investigation of epidemic prone communicable diseases.
2. Investigation of outbreak of diseases of known/ unknown etiology and recommend measures for its prevention and control to the States/UTs of the country. Provision of technical support to State government for investigation and control of disease outbreaks.
3. Provision of administrative and technical supervision to three branches of the Institute viz., Alwar (Rajasthan), Jagdalpur (Chhattisgarh) and Conoor (Tamil Nadu).
4. Provision of technical support to various National Health Programmes in the form of developing guidelines for control, manpower development, evaluation of different components/indicators.
5. Assisting the Director for publication of monthly Bulletin "CD Alert".
6. Carry out field research on different aspects of communicable diseases.

ii. Outbreaks Investigated/Rapid Health Assessment: During the period, officers from the division of Epidemiology carried out investigations of outbreaks in the country and suggested containment measures to the authorities. Officers of Epidemiology division mentored outbreak investigations carried out by EIS Officers.

iii. **Manpower Development:** National Centre for Disease Control (NCDC), Delhi is a WHO Collaborating Center for Epidemiology and training. The division of Epidemiology conducts regular training programmes and numerous other short-term training activities every year. The course curricula of these training programmes are designed and tailor-made to develop the necessary need-based skills for the health professionals. The participants to these courses come from different States/Union Territories of India. In addition, trainees from some of the neighbouring countries like Nepal, Bhutan, Sri Lanka, Thailand, Timor Leste, Maldives and Indonesia also participate in some of the training programmes.

iv. **The Training courses organized during the reported period:**

1. Three months Regional Field Epidemiology Training Programme for the health personnel of South East Asia Region started from 24th June to 20th September, 2013. A total of 15 participants from 6 countries.

2. 9th batch of MPH (FE) was inaugurated on 1st Aug 2013 in which 5 students joined.

3. Second batch of India EIS training has been started on 16th September 2013. A total 7 officers are currently undergoing the training in the second cohort.

v. **Global Disease Detection-India Centre:** Global Disease Detection-India Centrein collaboration with CDC Atlanta started functioning at NCDC in 2012. The objectives of GDD India Centre are to build epidemiological and laboratory capacity for detection and response to Emerging and Remerging infectious diseases. The focus will be on development of human resources, both in epidemiology and laboratory and sharing best practices for detection and response to emerging infections, wherever required.

vi. **Epidemic Intelligence Services (EIS):** The second cohort of the India EIS training was launched on 15th September 2013 with the initiation of one month inception course for EIS trainees was held at NCDC from 16th September to 15th October 2013. It is a Govt of India initiative in collaboration with US Centres for Disease Control, Atlanta. A total of 14 officers (seven in each cohort) are attending the training programme.

vii. **CD Alert:** A bulletin on communicable diseases and an important tool for Rapid Dissemination of Information towards Control of Diseases is published by the National Centre for Disease Control, Delhi. It is widely circulated to different parts of the country including Directorates of Health Services of different States, Districts, Primary Health Centres, Medical Colleges and individuals.Many a times, the important topics covered in CD Alert have been reproduced, in part or whole, by Indian Medical Association for dissemination of knowledge. The first issue was published in August 1997 on emerging and reemerging diseases and a total of seventy five issues have been published so far. Issues have been published on commonly known topics which have also been updated from time to time.The CD Alerts give an inside view of the disease including the global scenario, Indian scenario and also the diagnostic facilities of the particular disease within our country. The CD Alert becomes a handy tool for the Rapid response Teams for management and containment operations in outbreak/epidemic situations.

viii. **NCDC Newsletter:** It is a quarterly publication of the National Centre for Disease Control (NCDC) and the first issue was released on 4th October 2012 by Hon'ble Secretary, Ministry of Health and Family Welfare, Government of India. The purpose of this newsletter is to provide a forum for sharing information on outbreaks, programme updates from various departments at NCDC, technical and programmatic news and updates including capacity building and information on selected documents and guidelines, forthcoming conferences, world days and monitoring of disease trends. So far, six issues have been successfully published and widely circulated.

15.23 LADY READING HEALTH SCHOOL, DELHI

Lady Reading Health School, Delhi is considered as one of the pioneer institutions and first of its kind for training Health Visitors. It was established in 1918 under the Countess of Dufferin Fund for training Nursing personnel for M.C.H. service programme. In 1931, it came under the administrative control of the Indian Red Cross Society (Maternity & Child Welfare Bureau). In 1952 the Government of India took over the school and attached Ram Chand Lohia MCH Centre to it. Total capacity of the school was 24 Health Visitors trainees from all over India, even these candidates were not available at that time. Duration of the course was one and a half year for matriculates who were qualified midwives, which was replaced by two and half years integrated course for health visitor in 1954.

The School aims at providing training facilities to various categories of Nursing Personal in community health as well as M.C.H. and family welfare services through the attached Ram Chand Lohia MCH and Family Welfare Centre.

The institution is imparting the following courses at present:

1. **Auxiliary Nurse-cum-Midwife Course:** The last batch of 40 students under CBSE appeared in final examination in March, 2013 and all candidates passed out. Now this course is under Indian Nursing Council and eligibility criteria for the course is 12th pass. This year 40 students have been admitted for session 2013-15. Total number of students are 80 i.e. 40 students each for 2012-14 and 2013-15.

2. **Certificate Course for Health Workers (Female) under Multipurpose Workers Scheme:** This course is of six months duration. Students are admitted twice a year i.e. in January and July every year with admission capacity of 20 in each batch. 20 students were selected for January, 2013 to June, 2013 batch. But only 15 candidates joined the course and all passed out in June, 2013. 30 candidates were selected for July, 2013 to December, 2013 batch and out of them 28 joined the course. These students will appear for final exam in December 2013.

3. **Diploma in Nursing Education and Administration (DNEA) (Elective in Community Health Nursing):** This course is of 10 months duration which started on the 15th July 2013 with total admission capacity of 30 students. 4 students appeared in Final Examination in May, 2013 and all passed out the examination.This is the last batch of DNEA Course as per the INC resolution. This course is to be stopped and Post Basic B.Sc. (Ng.) to be started to upgrade Lady Reading Health School to a College.

4. **Post Basic B.Sc. (Nursing):** Administrative approval of the Ministry has been granted for conducting Post Basic B.Sc. (Nursing) at this institution.

5. **Hostel:** At present total 80 ANM students are under training require hostel facilities.

6. **Clinical Experience:** The students are sent for their clinical experience in Rural and Urban Health Centre, different Hospitals like Safdarjung Hospital, RML Hospital, Lady Hardinge Medical College and Kalawati Saran Children's Hospital in Delhi and out of Delhi. Students are also posted for Rural Field Experience at Rural Health Training Centre, Najafgarh & Rural Field Training Centre, Chhawla. Students are also posted to different MCH Centres of Municipal Corporation of Delhi within 2 Km radius of school.

7. **Ram Chand Lohia MCH and Family Welfare Centre** under Lady Reading Health School provides field practice area for Urban Health experience for the students. It gives integrated Maternity and Child Health & Family Welfare Services to over 40,000 population. Weekly clinics like Antenatal Care, Post Natal Care, Well Baby Immunization and Family Planning Clinics, door to door services are also imparted to the community by the students and staff. Exhibition and Health education are also organized in the community by MCH centre through students & staff.

   Programme like regular surveys are conducted to find out the latest status of Immunization and number of target couple in the community under Ram Chand Lohia Maternity Child Health &Infant

Welfare centre of Lady Reading Health School. The target couple detected during the period was 7054 which gives approximately 70% coverage of family planning and it is also found that there is 100% coverage of all immunization.

8. **Other Activities:** Health Education Programme is organized in the school, centre as well as in the community by different approaches i.e. Film shows, Baby shows, Magic show, Cultural programme, Puppet show, Role play, followed by group exhibitions and Speech competition.

9. **Budget:** The total budget for the institution and family welfare staff is Rs. 3,55,00,000 (Rs. Three crore fifty five lakh only) for the year (2013-14) and the budget is utilized in the designated area.

15.24 PASTEUR INSTITUTE OF INDIA (PII), COONOOR

Pasteur Institute of India, Coonoor started functioning as Pasteur Institute of Southern India, on 6th April 1907 and the Institute took a new birth as the Pasteur Institute of India (registered as a Society under the Societies Registration Act 1860) and started functioning as an autonomous body under the Ministry of Health and Family Welfare, Government of India, New Delhi from 10th of February, 1977. The affairs of the Institute are managed by the Governing Body.

Present Activities:-

- Production of DPT and Tissue Culture Anti (TCAR) vaccine in compliance with the revocation of suspension of production license by the Ministry of Health and Family Welfare, New Delhi.
- Establishment of cGMP (Current Good Manufacturing Practice) compliant DPT vaccine laboratories is underway.
- Academic programmes like Ph.D. Microbiology, Biochemistry and Biotechnology (Part time & Full time) affiliated to Bharathiar University, Coimbatore.
- Breeding of Mice and Guineas pigs for Experimental purpose like Quality Control of DPT group and TCAR vaccines.
- This Institute has Rabies Diagnostic Lab and Anti Rabies treatment center to cater to the need of the general public.

Activities Undertaken in respect of establishment of Green Field Manufacturing GMP (Good Manufacturing Practice) facility for Production of DPT Vaccine:-

- The Ministry has proposed to create Green Field GMP facility for manufacturing DPT group of vaccines at PIIC. HLL Life Care Ltd., Trivandrum has been engaged to carry out the Project for an estimated expenditure of Rs. 149.16 crores.
- After the approval on relaxation for the restriction of building height from Govt. of Tamil Nadu and construction of proposed building from the Coonoor Municipality, the construction work is in progress. HLL is likely to complete the civil construction of GMP facility by October, 2014.
- The technical bid evaluation for the procurement of critical equipments as per user requirement specification has been finalized.
- After that Equipment Installation, Validation and Process validation the new facility will supply 130 million doses (DPT-60Mid; TT-55 Mid; DT-15 Mid) annually.

15.25 ALL INDIA INSTITUTE OF PHYSICAL MEDICINE AND REHABILITATION (AIIPMR), MUMBAI

All India Institute of Physical Medicine and Rehabilitation, established in 1955, is an apex Institute in the field of Physical Medicine and Rehabilitation under, Ministry of Health and Family Welfare, Government of India.

Objectives:

- To provide need based Medical Rehabilitation Services, including provision of Prosthetic & Orthotic appliances, for persons with neuro-musculo-skeletal (locomotor) disorders.
- To provide training at Under Graduate and Post Graduate level to all categories of Rehabilitation professionals.

- To conduct research in the field of Physical Medicine and Rehabilitation (P.M.R.).
- To provide and promote community based programmes of Disability Prevention & Rehabilitation for the rural disabled.

Training of Rehabilitation Professionals: Graduate and Post Graduate Courses in Medical and Paramedical Courses are conducted by a team of highly qualified and dedicated Faculty. Health functionaries at the community level are also trained. The Institute has comprehensive facilities for research and teaching. In the field of Rehabilitation and Allied Sciences, AIIPMR is in the lead having numerous publications and presentations to its credit. Collaboration and co-ordination with government and NGOs is done to provide consultative services to formulate improvement and monitor rehabilitation services from time to time.

Annual Statistics (April 2012-March 2013)

- **Medical:**

I) Out Patient Department:

Services: Number of PWDs managed through Out Patient Department:

New Persons with Disabilities registered	-	11875
Follow-up PWD	-	19285
Total No. of PWDs	-	31160
No. of Disability Certificate issued	-	1139
No. of Railway Concession issued	-	726
No. of Driving Certification	-	683
No. of Special Certificates	-	29

II) In Patient Services:

Admissions in ward for reconstructive Surgery and inpatient rehabilitation	-	781
Major reconstructive surgical procedure	-	519
Minor Surgeries	-	2034

III) Audiology & Speech Therapy Department:

No. of PWD for speech and language disorder registered in the department	-	762
No. of audiometry tests and other hearing tests	-	208
Home exercise programme and counseling	-	143
Cases attended Therapeutic Treatment	-	1218

IV) Prosthetic & Orthotic Workshop:

(a) Registration of Supply of Orthoses to PWDs:-	-	3339
(b) Registration of Supply of Prostheses to PWDs:	-	571
(c) Maintenance and Services of Orthotics and Prosthetics: Total number of Jobs Executed	-	3910

V) Physiotherapy Department

New Patients	-	7252
Old Patients	-	8018

VI) Occupational Therapy Department

Total number of PWDs	-	15236
Mobility Devices/Aids Delivered:	**-**	**1651**

VII) Vocational Guidance Department:

No. of PWD evaluated for pre job counseling and job placement	-	200
No. of PWD for evaluated for Intelligence and development test	-	561
Counseling of PWD for inclusive education, special education, self-employment& other benefits	-	765

VIII) Vocational Training Workshop:

Number of candidates assisted for self & open employment	-	120
No. of physically disabled for job environment evaluation and suitability for the job.	-	75
Number of physically disabled enrolled for Vocational Training in various trades	-	25
Placement of the PWD's done in the various private sector with the help of NGO from New Delhi and local Employment Exchange.	-	24

IX) Medical Social Work Department:

Total donation received from individual and corporate offices.	-	76,121.00
Amount spent for subsidy for patients belonging to below poverty line.	-	46,322.00
Total Number of PWDs for financial assistance for medical expenses during the hospitalization, free aids and appliances i.e. special C.P. chairs, wheel chairs, crutches, walker and rollators etc. through Institute funds, social welfare funds.	-	15

X) Radiology Department:

No. of Digital X-Ray Investigations	-	7722
No. of PWD's attended	-	7890
USG and Color Doppler	-	690

XI) Pathology Department:

Investigations in Clinical Pathology	-	10560
Investigations in Bio-Chemistry	-	11040
Investigations in Serology	-	2304
Total number of Pathological Investigations	-	23904
Average number of investigations per day	-	92

Augmentation of capacity

➢ **Physical Medicine and Rehabilitation (PMR)**

- PMR Department is involved in patient care-both indoor & outdoor, teaching at Post Graduate level and conducting research.
- New gymnasium for indoor patients constructed and made functional.

➢ **Prosthetic & Orthotic Department**

- Dynamic positioning and stretching plastic AFO/ KAFO's have been tried upon and being employed in regular clinical practice. Twenty five patients have been fitted till date, follow-up report and feed back is awaited.
- These splints have replaced the conventional static splints which were prescribed earlier and initial clinical results are heartening.

Physiotherapy Department

- **Gait & Motion Analysis Laboratory**

  Total number of subjects assessed - 92

- **Isokinetic assessment and training muscle of performance**

  Total number beneficiaries - 64

  Total number of sessions - 245

- **Balance assessment and training -** Assessment of static and dynamic balance is carried out using clinical test batteries which are indicative intervention.

  Number of beneficiaries -

  Balance assessment - 190

  Training/Session

Turnbuckle Orthosis for Angular Deformities of the Knee Joint

Otherapy Department

Scientific Publications & Research

Sr. No.	Department	Staff Guided Research				
		Papers Presented	Papers Published	Dissertation Completed	Invited Lecturers	Conference/Workshop/ Seminars/Attended
1	Medical					
	a) PMR	11	04	--	--	07
	b) Radiology	01	--	--	--	--
2	Physiotherapy Department	--	--	12	--	--
3	Occupational Therapy	02	--	07	--	03
4	Prosthetic & Orthotic	--	--	16	--	--

Institute is taking initiative in building up capacity further by building up infrastructure and manpower by starting satellite center in the District hospitals so as to reach large number of Person with disabilities.

15.26 ALL INDIA ISTITUTE OF SPEECH AND HEARING (AIISH), MYSORE

The All India Institute of Speech and Hearing (AIISH), Mysore is the leading organization in the country in providing training, research, clinical care and public education pertaining to communication disorders. Founded in 1965 as an autonomous institute under the Ministry of Health and Family Welfare, Government of India, AIISH has been successfully carrying out its activities for the last 48 years. The activities carried out by the institute from 1st April to 30th September, 2013 are given below:

Education and Training: The institute offered 14 academic programmes pertaining to communication disorders ranging from certificate to post-doctoral level and totally 561 students were admitted to various programmes. Also, the Institute organized four guest lectures by eminent personalities, 44 orientation/short-term training programmes and 14 workshops/seminars/ symposia on various aspects of communication disorders during the period. In addition, the Institute underwent assessment for accreditation by the National Assessment and Accreditation Council (NAAC), Bengaluru.

Research Activities: Totally, 20 funded research projects were completed and 15 projects were newly initiated at the institute during first April to September, 2013. Also, 45 projects were progressing in different departments. The funding for the research projects were sponsored by organizations such as the Department of Science and Technology, Govt.of India and Indian Council of Medical Research, in addition to the funding given by the Institute.

Other major research initiatives of the Institute during the period include the setting up of Centre for Neuropsychological Research and Rehabilitation to cater to the persons with brain damage or dysfunction having communication disorders, Electrophysiological Laboratory to promote basic and applied research in the area of auditory electrophysiology and Human Genetics Unitto construct pedigrees to determine the pattern of genetic inheritance in persons with communication disorders in Indian population.

Also, an **Epidemiology Unit** was established as a centralized data bank for all activities of prevention and early identification of communication disorders and to promote epidemiologic research in the area.

Clinical Services: The institute offered a wide variety of clinical services to a total number of 26,897 persons with various types of communication disorders, from 1st April to 30th September, 2013. The clinical services offered include assessment and rehabilitation pertaining to speech, language and hearing disorders, psychological disorders, and otorhinolaryngological disorders. In addition, specialized clinical services were also rendered on augmentative and alternative communication, autism spectrum disorders, cleft lip palate and other craniofacial anomalies, fluency, learning disability, listening training, motor speech disorders, professional voice care, voice disorders and vertigo. The detailed clinical statistics during the period 1st April to 13th September, 2013 are given.

Clinical Services	No. of Clients Assessed	Therapy Sessions/ Surgery
Augmentative and Alternative Communication	120	701
Autism Spectrum Disorders	646	2903
Adult & Elderly Persons with Lang. Disorders Assessment	4	-
ENT Examination	12149	-
Fluency Assessment	259	1140
Hearing Evaluation	7180	-
Learning Disability Assessment	468	-
Listening Training	1611	9561
Mapping for Cochlear Implants	-	52
Medical Speciality	747	-
Motor Speech Disorders	15	19
Neuropsychological Assessment	12	38
Physiotherapy	411	3394
Pre-School Services	213	-
Psychological Assessment	3372	
Speech and Language Assessment	4277	35937
Structural Craniofacial Anomalies Assessment	107	413
Vertigo Assessment	110	-
Voice Disorders Assessment	311	-

Outreach Clinical Services: The major outreach activities of the institute during the period include the diagnostic services at its outreach clinical centers, tele-intervention service and infant screening for communication disorders in various hospitals and industrial screening.

The institute formally launched the New Born Screening (NBS) programme for screening new-borns for communication disorders on 9th August, 2013. This will help in detecting the condition in the beginning stages of the child's development.

Public Education: A number of public education activities pertaining to communication disorders were carried out such as organization of six public lectures on various aspects of the disorder, six screening camps on communication disorders and preparation and dissemination of public education materials related to the prevention and control of communication disorders in print and electronic format.

Infrastructure Development: The Institute installed a Digital EPBAX System which features state-of-the-art voice communication system. The system facilitates linking of all the remote centers of the Institute with the AIISH Intercom network. Other major infrastructure development includes the initiation of civil work for Centers of Excellence.

Other Activities: The other major activities and events took place at the institute during the period include the following.

a. Right To Information- The details of the information requests and the decisions taken under the RTI Act, 2005 are given below.

	Opening balance	No. of applications received as transfer from other PAs u/s 6(3)	Received (including cases transferred to other PAs)	No. of cases transferred to other PAs u/s 6(3)	Decisions where requests/ appeals rejected	Decisions where requests/ appeals accepted	Registration Fee Collected (in Rs.) u/s 7(1)
Requests	8	9	28	0	1	44	Rs. 200
First appeals	0	N/A	2	N/A	0	1	

b. Official Language Implementation (OLI) - Various activities such as Hindi training for staff members, organization of workshops, displaying of Word a Day in Hindi and translation of materials in Hindi were carried as a part of Official Language Implementation. Also, Hindi Week was celebrated on 12-18 September, 2013.

Capital Work- Capital works cost Rs. 37.58/- lakhs were completed and works cost Rs. 2601.87/- lakhs were going on at the institute campus during the period.

Financial Status- The financial status of the institute during the period is given.

(Rs. in lakhs)

Type of grant	Amount allocated for 2013-14	Amount released
Plan		
Grant- in-Aid General	1614.00	807.00
Grant- in-Aid Capital	4970.00	1639.22
Grant- in-Aid Salaries	1530.00	704.86
Non-Plan		
Grant- in-Aid General	556.00	241.30
Grant- in-Aid Salaries	794.00	380.46
Total	**8114**	**3151.08**

15.27 CENTRAL INSTITUTE OF PSYCHIATRY (CIP), RANCHI

The Central Institute of Psychiatry (CIP), Ranchi established in 1918 functions under the aegis of the Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India. Initially it had a bed capacity for 174 patients (92 male, 82 female). In 1922, the hospital was rechristened as European Mental Hospital. In the same year, the hospital was affiliated to the University of London for Diploma in Psychological Medicine Examination, earning it the distinction of being the first institute in India to impart post-graduate training in psychiatry. In 1948 the hospital was renamed as Inter-Provincial Mental Hospital and in 1952, as Hospital for Mental Diseases. In 1954, the management of the Institute was taken up by the Government of India. In 1977 the hospital was given the status of an institute and was renamed as the Central Institute of Psychiatry.

The Institute campus is spread over 210 acres and has a current capacity of 643 beds. Some beds are reserved for patients sponsored by the Central Government, State Governments, Coal India and the Railways. The Institute has 17 wards: 9 male wards, 6 female wards, an emergency ward and a family unit. Patients are not kept confined and can walk about within the hospital campus. Along with drug therapies, psychotherapies, behavioral therapy, group therapy and family therapy are also administered to the patients. The patients are also encouraged to take part in regular physical exercises, yoga, outdoor as well as indoor games to keep them physically fit. Patient care, research and manpower development remain the major objectives of the Institute.

The Institute has been providing patient care through Adult in-patient services, Erna Hoch Centre for Child and Adolescent Psychiatry, SS Raju Centre for Addiction Psychiatry, Charak Outpatient Department, Outreach programmes and Special Clinics. 3,233 patients (2,671 male and 562 female) were admitted between January and September 2013. 3,216 patients were discharged (2641 male and 575 female). The average bed occupancy during the period was 79.8%.

The child guidance clinic and the 50-bedded child psychiatry unit impart training to resident doctors and postgraduate students in the field of child and adolescent mental health. It caters to the needs of psychotic children, children with developmental disorders and with mental retardation. During the period January-September 2013, 5454 patients (1487 new cases and 3967 follow-up cases) attended the out-patient department (OPD) for treatment. There were a total of 134 admissions and 125 discharges during the period under report.

The Institute has a modern De-addiction Centre with a capacity of 57 patient beds for treatment of persons suffering from alcohol & drug related problems. It is also the nodal centre in eastern India for manpower training and research in the field of alcohol and drug abuse. During the period January-September 2013, 927 patients were seen in the OPD in the De-addiction Clinic; 566 patients received admission in the De-addiction Centre while 586 were discharged.

The total number of cases seen on an outpatient basis during the period January-September 2013 was 56,274 (20,109 new cases & 36,165 follow-up cases) [including all psychiatry cases (Adult & Child), Staff OPD, Extension Clinics, Skin Clinic, School Mental Health Programme & Psycho-Social OPD]. The total number of new psychiatry cases seen were 11,033 (7571 male & 3462 female) while 34,042 psychiatry follow-up cases were seen during this period (26724 male & 7318 female).

The Institute runs Extension Clinics which include the General Psychiatry Clinic at West Bokaro, Hazaribag and Epilepsy Clinic at Deepshikha, Ranchi. Regular

camps, awareness programmes, workshops with teachers and parents are also conducted at the extension clinics. School mental health programmes are being run in two schools through the outreach programme. The case-load in the extension clinics during the period January-September 2013 was 1585.

The Institute runs a number of special clinics: the Chronic Schizophrenia Clinic, Skin & Sex Clinic, Neurology Clinic, Sleep Clinic, Epilepsy Clinic, Staff OPD, Headache Clinic, De-addiction Clinic, Child Guidance Clinic, Mood Clinic & Obsessive-Compulsive Disorder (OCD) Clinic. Total attendance of patients in special clinics during the period January-September 2013 was 15,379.

Psycho-Social Unit (PSU)-The Outpatient Wing of the Department of Clinical Psychology

The Clinical Psychology Department at the Institute is the oldest independent Department of Clinical Psychology in India. In 1962 a teaching course in Clinical Psychology-Diploma in Medical and Social Psychology-was started (this course is now known as M.Phil. in Clinical Psychology). The course of Ph.D. in Clinical Psychology was started in 1972. At present, there are 18 seats in M. Phil (Clinical Psychology) and 4 seats Ph.D. (Clinical Psychology).

There is a separate out-patient unit of the Department called the Psycho-Social Unit (PSU). The PSU caters to the needs of those patients who suffer from minor psychological problems and who can be managed exclusively by psychological methods such as counseling, behaviour therapy, biofeedback, relaxation therapy etc. 935 patients were assessed and 1635

The Bhaskaran Rehabilitation Centre

therapies were carried out by the Department during the period January-September, 2013.

The clinical psychology laboratory (a first in the country), is equipped with various psychological tests, rating scales, instruments and apparatus which aid in the diagnosis and assessment of patients. Research is an integral part of the Department an Research papers are published in various international and national journals.

The department of psychiatric social work came into existence in the 1950s although family psychiatry can be dated back to 1922.

The Institute began the course of Diploma in Psychiatric Social Work (DPSW) in the year 1970. In 1985 this course was upgraded to M.Phil. in Psychiatric Social Work. At present, 12 seats are available for M. Phil. trainees. The Department is actively engaged in academic and research activities in the field of mental health.

The Department of Nursing Service provides quality nursing care to in-patients as well as out-patients. The Nursing Education section of the Institute is responsible for training nurses to obtain the Diploma in Psychiatric Nursing (DPN) and giving clinical nursing experience to visiting nurses. One nursing student enrolled in the DPN course in 2013. The number of visiting nurses who received training during the period January-September 2013 is as follows:

M.Sc. in Psychiatric Nursing	–	46
B.Sc. Nursing	–	69
General Nursing and Midwifery (GNM)/ Auxiliary Nursing and Midwifery (ANM)	–	40

The Institute currently offers occupational therapy to adults as well as child and adolescent in-patients with either acute psychiatric illness or severe and enduring mental health problems. About 50-60 male patients and 35 female patients attend OT daily. The department also has a well-equipped and modern physiotherapy unit. The OT department is also involved in training medical as well as non-medical professionals such as psychiatry residents, clinical psychologists, psychiatric social workers and psychiatric nurses in various aspects of occupational therapy and rehabilitation.

The Centre for Cognitive Neurosciences was originally established in 1948, when it was known as the Electroencephalography (EEG) Department. The EEG Department initially had a 6 channel and then an 8 channel electro encephalograph machine. It is now called the Centre for Cognitive Neurosciences.

The Centre has two sections - a clinical section and a research section. The clinical section possesses a 21 channel paper electroencephalogram, a 32 channel quantitative electroencephalogram and a 40 channel video electro encephalogram and other equipments. The research section possesses Dense Array EEG acquisition systems (64, 128 and 192 channels), Evoked Response Potential (ERP) acquisition units (40 channels), a 40 channel poly somnography (PSG) unit and a repetitive Transcranial Magnetic Stimulation (rTMS) unit. The Centre has acquired advanced signal processing software such as Advanced Source Analysis (ASA), Brain Electrical Source Analysis (BESA) etc.

The Centre also runs a weekly Epilepsy Clinic in the Out-patient Department of the Institute (Thursdays) and at Deepshikha, ICD&MH, Ranchi (Wednesdays). The Centre also carries out regular group therapies, public awareness programmes and rural camps at Ramkrishna Mission, Baripada and Pakur (Odisha) for case-identification and management. For more than a decade now, a self-help group for epilepsy patients has been running under the guidance of the Centre.

The Department of Pathology and Biochemistry was officially renamed as the S. D. Sharma Centre for Investigation Medicine in December 2011. The Centre is equipped to perform tests of clinical pathology, microbiology, bacteriology, biochemistry, serology and immunology. The Centre performs these tests for both clinical as well as research purposes.

rTMS Session in Progress at the Centre for Cognitive Neurosciences

The Olympus Au400 Automated Biochemistry Analyzer

rTMS Session in Progress at the Centre for Cognitive Neuroscience

Achievements in 2013

- 210 bedded men hostel & 15 married resident flats have been added.
- 67 candidates were admitted for various courses conducted by the Institute in the session starting from 1st May, 2013.
- Installation of underground electric cables and development of lawns in the Institute has progressed apace.

- 308 Print Journals, 650 e-Journals have been subscribed and 6295 books have been purchased for the Central Library (1258 books in Hindi).
- Sixteen more CCTV cameras have been installed in the Ibn Sina Central Library.
- SAN System back-up storage server has been installed in the Central Library.
- Alitomatch Hematology analyser & Chamilusent analyser have been installed in the Deptt. of Pathology & Biochemistry.
- Neuro-Navigational system for rTMS has been installed for patients care services.
- Several latest software have been procured for the K. S. Mani Centre for Cognitive Neurosciences.

Budget Provision for the Financial Years 2013-14

(Rs. in thousands)

Financial Year		Plan				Non-Plan			
		Budget Estimate	Revised Estimate	Final Estimate	Expenditure	Budget Estimate	Revised Estimate	Final Estimate	Expenditure
2012-13	Revenue	119000	119000	114600	114333	300000	290000	306476	306154
	Capital	338400	319000	159000	112400	- -	- -	- -	- -
Total		**457400**	**438000**	**273600**	**226733**	**300000**	**290000**	**306476**	**306154**
2013-14 (Up to Sep. 13)	Revenue	160000	--	--	81858	310000	--	--	169926
	Capital	340000	--	--	79500	--	--	--	--
Total		**500000**	**--**	**--**	**161358**	**310000**	**--**	**--**	**169926**

15.28 CENTRAL RESEARCH INSTITUTE (CRI), KASAULI

Central Research Institute was established on 3rd May, 1905 as Pasteur Institute for North India. It is a subordinate office of Directorate General of Health Services, under the Ministry of Health & Family Welfare of India. Currently the institute is engaged in (i) large scale production on Bacterial and Viral vaccines & Sera. (ii) Research and Development in the field of immunogly and vaccinology. (iii) Teaching and training. (iv) Quality Control of vaccine and Sera.

Staff Strength:- There are 725 sanctioned posts in CRI-Kasauli. The number of sanctioned posts of group A, B and C are 51, 86 and 588 respectively. The total staff in-position is 516. The staff in-position of group A, B, and C are 16, 76 and 424 respectively.

Performance during the Current Year:-

- Manufacturing of Diphtheria- Pertussis- Tetanus (DPT) group of vaccines has been started in existing facilities.

Details of batches started, quantity manufactured, demand received and quantity released are given.

Production, Demand and Supply of the Vaccine and Anti-Sera

(Quantity in Lakh of Doses)

S.No.	Vaccine & Anti-Sera	Installed Capacity	Production	% Produced	Demand	Supplies	% Supplied
1	DPT	255	28.99	11.37	158.50	29.00	18.30
2	DT	200	0.00	0.00			
3	TT	300	11.86	3.95	133.70	8.00	5.98
4.1	YFV(CRIK)	0.35					
4.2	YFV(IMPORT)		1.28		0.16	0.095	59.38
5	ARS	2.50	0.2279	9.12	0.26	0.26	100.00
6	ASVS	3.00	0.0662	2.21	0.14	0.09	63.80
7	DATS	0.80	0.0359	4.49	0.0040	0.0030	75.00
8	NHS	0.004	0.0036	0.00	0.000	0.000	
9	DR	2.75	0.3820	13.89	0.18	0.29	160.39

Significant Achievements during the Current Year:-

- Ministry of Health & Family Welfare has engaged M/s HLL for renovation and up-gradation of DPT facility at CRI, Kasauli to make it cGMP (Current Good Manufacturing Practice) compliant at an estimated cost of Rs. 49.83 Crores.
- DPT facility at CRI, Kasauli is updated. The civil work and installation qualification, NRA inspection and Validation of equipments and production process are completed. Documentation SOPs is in progress. Trial batches have been initiated in the diphtheria, pertussis and tetanus blocks.

15.29 VALLABHBHAI PATEL CHEST INSTITUTE (VPCI), DELHI

The Vallabhbhai Patel Chest Institute (VPCI) is a unique post graduate medical Teaching and Research institution devoted to the study of chest diseases and allied sciences. It is a University of Delhi maintained institution under ordinance XX (ii). The Institute is administered by a Governing Body constituted by the Executive Council of the University of Delhi and is funded entirely by Grants-in-Aid from the Ministry of Health and Family Welfare, Government of India. The Institute fulfils the national need for providing relief to large number of patients in the community suffering from Respiratory Diseases. It has eminently discharged its role and has earned a unique place in the field of Chest Medicine.

Aims and Objectives

The main objectives of VPCI are to conduct research on basic and clinical aspects of Chest Medicine, to train post graduates (DM, MD, DTCD and Ph.D.) in Pulmonary Medicine and allied subjects, to develop new diagnostic technology and disseminate scientific knowledge related to Chest Medicine to other institutions in the country as well as neighboring SAARC countries and to provide specialized clinical and investigative services to patients.

Media Achievements

- The National Centre of Respiratory Allergy, Asthma and Immunology (NCRAAI) website (www.ncraai.org) was launched.
- Dr. Anita Kotwani, Department of Pharmacology, Research work on antibiotic use in the community was quoted in India Today in the article, "Your antibiotic is sick", 18th March, 2013.
- Dr. Anita Kotwani, Department of Pharmacology, gave an interview to BBC Radio on "Antibiotic

Use, Resistance and Antibiotic Policy", on 20th March, 2013.

Research

- The Institute has been identified and approved for the establishment of centralized Multi-disciplinary Research Unit (MRU) for promoting health research by the Govt. of NCT of Delhi. Under this scheme, the Department of Health Research (DHR), Ministry of Health and Family Welfare, Govt. of India under the aegis of the Indian Council of Medical Research (ICMR).
- The Research Cell was constituted to facilitate research activities and to organize and conduct CME's and other research oriented workshops in the institute.
- The Institute continued its research activities in Respiratory Diseases and allied sciences. These research projects were sponsored by different agencies of Government of India, World Health Organization, Asia-Pacific Alliance for the Control of Influenza, etc. Presently, 30 extramurally Research Projects are ongoing.

Patient Management Services

The Viswanathan Chest Hospital (VCH), is the hospital wing of the Institute which provides the patient management services with the following facilities; Outpatient Department, Inpatient Facility with 128 beds, 24 hours Respiratory Emergency, 8 bedded Respiratory Intensive Care Unit (with 7 ventilators), Sleep Laboratory, National Centre of Respiratory Allergy, Asthma and Immunology (NCRAAI), Tobacco Cessation Clinic, Yoga Therapy and Research Centre, Cardio-pulmonary Rehabilitation Clinic, Picture Archiving and Communication Systems (PACS), Medical Records Section, Oxygen Plant.

During the year 2012-13 the VCH enrolled 10311 new patients, 52867 old patients. A total number of 3873 patients were admitted as Indoor cases. A total number of 15679 were provided 24 hours Respiratory Emergency Services and 492 patients were provided ventilator (invasive and non-invasive) treatment in ICU. Specialized investigations done were as follows: Pulmonary function tests: 18381, Arterial blood gases: 7443, Bronchoscopy: 212, Bronchoalveolar lavage: 33, CT scans: 2934, Ultrasound examinations: 236, X-rays: 21708, Electrocardiograms: 7912, Polysomnograms: 69, HIV testing: 350, Serum IgE tests: 3268, Skin tests: 1336, Clinical biochemistry: 39910.

Post Graduate Teaching and Training

At present, 5 DM students (1 for the academic year: 2011-14 and two each for the academic year: 2012-15 & 2013-16), 23 MD students (8 for academic year 2011-14, 5 for academic year 2012-15 & 10 for academic year 2013-16) and 11 DTCD students (6 for academic year 20012-14 & 5 for academic year 2013-15) are pursuing their studies. In addition, a total number of 28 research scholars are pursuing their Ph.D. programmes.

Besides that, the Institute conducts various conferences/ workshops/training programmes/public lecture series related to chest diseases and allied sciences to disseminate the knowledge to the doctors and general public of the society.

Publications

The Institute has been publishing a quarterly periodical, The Indian Journal of Chest Diseases and Allied Sciences and continues its effort to disseminate the recent advances in Chest Diseases and allied sciences. It is available online at the website address; <http://www.vpci.org.in>.

Further, 80 research papers authored by Institute's faculty members were published in reputed national and international journals and book chapters during the year 2012-13.

Moreover, the Institute is also responsible for documentation and dissemination of research output through Annual Report and other publications of the institute.

The Institute's Website <www.vpci.org.in> which almost covers most of the activities of the Institute is an additional information tool for all the concerned public.

Budget during the Year 2013-14

Plan	Rs. 16.94 crores (Budget Estimate)
Non Plan	Rs. 25.60 crores (Budget Estimate)

15.30 CENTRAL BUREAU OF HEALTH INTELLIGENCE (CBHI)

Central Bureau of Health Intelligence (CBHI), established in 1961, is the health intelligence wing of the Director General of Health Services in the Ministry of Health & Family Welfare, Government of India with the vision to have "A strong Health Management Information System in entire country". This national institution is headed by a SAG level medical officer with specialization in public health administration of Central Health Services (CHS), supported by officers from Indian Statistical Services as well as CHS and through its field survey and training units.

The Mission of CBHI is "To strengthen Health Information system in each of the district in the country up to facility level for evidence based decision making in the Health Sector"

The Objectives of CBHI are:

- To Collect, Analyze & disseminate Health Sector related data of the country for evidence based policy decisions, planning and research activities,
- To identify & disseminate innovative practices for Health Sector Reforms,
- To develop Human resource for scientifically maintaining medical records in both Government & private medical Institutes in India,
- To Carry Out Need Based Operational Research for Efficient implementation of Health Information System & use of Family of International Classifications in India,
- To sensitize & create a pool of Master Trainers in Health sector for implementation of Family of International Classification in India,
- To collaborate with National & International Institutes for imparting knowledge & skill development,
- To Collect & disseminate indicators for Health related Millennium Development Goals,
- To act as a resource centre for implementation of Electronic Health Record in India and
- To function as collaborating centre for WHO FIC in India & SEAR countries.

Organization:

a) In Dte.GHS/Govt. of India, the CBHI headed by a Director has three divisions viz. (i) Policy, Training and Co-ordination, (ii) Information & Evaluation, and (iii) Administration.

b) Six Health Information Field Survey Units (FSUs) of CBHI are located in different Regional Offices of Health and Family Welfare (ROHFW) of Govt. of India at Bengaluru, Bhopal, Bhubaneswar, Jaipur, Lucknow & Patna; each headed by a Dy. Director with Technical & Support staff, which functions under the supervision of Sr./Regional Director (Health & Family Welfare/Govt. of India).

c) Regional Health Statistics Training Center (RHSTC) of CBHI at Mohali, Punjab (near Chandigarh), CBHI-FSUs and Medical Record Department & Training Centers (MRDTC) of Safdarjung Hospital New Delhi & JIPMER Puducherry; conduct various CBHI In-service Training Courses.

Major Activities of CBHI:

- CBHI collects primary as well as secondary data on various communicable and non-communicable diseases, human resource in health sector and health infrastructure from various Government Organizations/Departments to maintain and disseminate Heath Statistics through its annual publication "National Health Profile" which highlights most of the relevant health information under 6 major indicators viz. Demographic, Socio-economic, Health Status, Health Finance, Health Infrastructure and Human Resources.
- CBHI collects the information on reform initiatives for Health Sector Policy Reform Option Database (HS-PROD). [www.hsprodindia.nic.in]
- Though States/UTs of India have reforms in the health sector, a lot of this goes unnoticed and hence not documented. Thus, Ministry of Health and Family Welfare/Govt. of India under its Sector Investment Programme (SIP) is funded by the European Commission, entrusted CBHI to develop and maintain HS-PROD. It is a web-enabled database that documents and further creates a

platform for sharing of information on good practices, innovations in health services management while also highlighting their failures that are very important for the success of NRHM. More than 250 such initiatives under 16 key management areas have been taken from a varied range of stakeholders like all the 35 State/UT governments, development partners, non-government organizations etc.

- Sense of ownership and pride is to be taken in an effort like HS-PROD by all public health professionals.

Millennium Development Goals

CBHI publishes a concise list of all MDGs and comprehensive list of Health related MDGs i.e. Goal-4 (Reduce Child Mortality) and Goal-5 (Improve Maternal Health) and Goal-6 (Combat HIV/AIDS, Malaria and Other Diseases) in its annual publication "National Health Profile".

National Level In-service Training programme per year

S.No.	Name of the Training	Batch	Duration	Training Centre
1.	Medical Record Officer	2 (at each training centre)	6 months	1. Medical Record Deptt. & T.C. at Safdarjung Hospital in New Delhi 2. JIPMER, Puducherry
2.	Medical Record Technician	2 (at each training centre)	6 months	1. Medical Record Department & T.C. at Safdarjung Hospital in New Delhi 2. JIPMER, Puducherry

With a view toCapacity Building & Operation Research for Efficient Health Information System (HIS) including Family of International Classification (ICD-10 & ICF) use in India and South East Asia Region, CBHI is conducting National Level training course on Master trainers on ICD-10 & ICF at RHSTC at Mohali, Chandigarh. It is also organizing sensitization work shop on ICD-10 & ICF in big Govt./Private Hospitals.

S.No.	Name of Training	Batches/ year	Training Duration	Training Centre
1.	Training Course on Master Trainers On (ICD-10 & ICF)	2	5 days	RHSTC Mohali
2.	Orientation training course on Health Information Management (For Officers)	14	5 days	RHSTC Mohali & 6 FSUs
3.	Orientation training course on Health Information Management (For non medical personnel)	14	5 days	RHSTC Mohali & 6 FSUs
4.	Orientation training course on Family of International classification (ICD-10 & ICF) (For Non-Medical Personnel)	14	5 days	RHSTC Mohali & 6 FSUs
5.	Orientation training course on Medical Record & Information Management for Non-Medical Personnel	7	5 days	RHSTC Mohali & 6 FSUs

On regular basis, 48 batches of Training Courses covering more than 960 candidates are held every year. In addition, special batches of National/International Training Courses are conducted on request of States/ UTs & various organizations like IRDA, WHO etc.

Training Calendar, Eligibility Criteria, Guidelines and Application Forms for all the above courses can be downloaded from the CBHI website: www.cbhidghs.nic.in

During 2013-14 (up to 31.10.2013), 401 personnel from all over the country have been trained in various in-service training courses viz. Medical Record Officer, Medical Record Technician, Health Information Management for Officers, Health Information Management for Non-medical Personnel, Family of International Classification (ICD-10 & ICF) for Non-medical Personnel, Master Trainers on Family of International Classification (ICD-10 & ICF) and Medical Records and Information Management through CBHI Training Centres and 16 batches of trainings are still to be conducted up to 31st March, 2014. In 2013-14, 40 batches of in-service training courses are expected to train more than 800 functionaries.

Operational Research & Reviews

CBHI (Hqrs) and it's the six FSUs located in Regional Offices of Health & Family Welfare/Govt. of India at Bengaluru Bhubaneswar, Bhopal, Jaipur, Lucknow and Patna help CBHI in getting the validated health information from States/UTs and facilitate in capacity building of health care delivery functionaries as well as operational research keeping in view the objectives of CBHI. The CBHI regularly undertakes half yearly meetings to review functioning of all the FSUs and Training Centres. During 2013-14, 19th half yearly review meeting was held during 8-9 July 2013 at FSU, Bengaluru and 20th such meeting is tentatively to be organised by MRD, SJ Hospital, New Delhi during February, 2014.

CBHI is playing an important role for implementation of Electronic Health Record in India. It is identified as Resource Centre for implementing and maintaining the licensing of SNOMED CT in the country.

CBHI as WHO Collaborating Centre on Family of International Classification (FIC) for disease, mortality, morbidity and related health aspects function at disabilities as well as health interventions (ICD, ICF & ICHI) in India.

CBHI with due approval by the Ministry of Health & Family Welfare (Govt. of India) has been functioning as "WHO Collaborating Centre on Family of International Classifications (ICD-10, ICF & ICHI)" w.e.f. September, 2008 for coding morbidities, mortality, related health aspects, function and disabilities in India, while closely, linking with South East Asian Asia Pacific regional network on FIC and its main functions.

CBHI as WHO Collaborating Centre on Family of International Classifications (ICD-10 & ICF) in India are to:

(1) To promote the development & use of the WHO Family of International Classifications (WHO-FIC) including the International Statistical Classification of Diseases and Related Health Problems (ICD), the International Classification of Functioning (ICF), Disability and Health and other derived and related classifications and to contribute to their implementation and improvement in the light of the empirical experience by multiple parties as a common language.

(2) Contribute to the development of methodologies for the use of the WHO-FIC to facilitate the measurement of health States, interventions and outcomes on a sufficiently consistent and reliable basis to permit comparisons within and between countries at the same point in time by:

- Supporting the work of the various committees and work groups established to assist WHO in the development, testing, implementation, use, improvement, updating and revision of the member components of the WHO-FIC.
- Studying aspects related to the structure, interpretation and application of contents those concerning taxonomy, linguistics, terminologies and nomenclatures.
- Participating in the quality assurance procedures of the WHO-FIC classifications regarding norms of use, training and data collection and application rules.

(3) Networking with current and potential users of the WHO-FIC and act as reference centre by:

- Assisting WHO Headquarters and the Regional Offices in the preparation of member components of the WHO-FIC and other relevant materials.
- Participating actively in updating and revising the member components of the WHO-FIC.
- Providing support to existing and potential users of the WHO-FIC and of the data derived in India and SEARO Region. Linkage will also be made with other countries of Asian Pacific Region for seeking status on FIC implementation.

(4) Work in at least one related and/or derived area of the WHO-FIC: Specialty- based adaptations, primary care adaptations, interventions/ procedures, injury classification (ICECI).

Maintenance of three Web Sites

CBHI with the assistance of NIC has recently redesigned & reformatted its three websites viz. (i) www.cbhidghs.nic.in (ii) www.hsprodindia.nic.in (iii) www.cbhighf.nic.in, for online data transmission and public viewing.

Major Publications of CBHI during 2013:

- National Health Profile (NHP) 2012
- National Health Profile (NHP) 2013 is in the final stage of publication

CBHI - On Line Data Entry System through website www.cbhidghs.nic.in

State/UT Health and Family Welfare Directorates are responsible for punctually and regularly furnishing the (i) Monthly Communicable Diseases (ii) Monthly Non-Communicable Diseases and (iii) Annual Data on Medical/Nursing/Para-Medical education & infrastructure in the prescribed formats to CBHI/ Dte.GHS. Based on this information from all the States/ UTs and other reporting agencies, provide up-to-date data related to morbidity & medical/health infrastructure for framing reply to the Parliament Questions. CBHI also brings out annual publication "National Health Profile" which serves as National Reference Document for policy, planning and evaluation now of health related activities in the country. The above requisite health information are being sent by the States/UTs On-line through CBHI website **www.cbhidghs.nic.in**.

CBHI Linkages and Coordination:

1. All 35 States/UTs of India;
2. All 20 Regional Offices of Health & Family Welfare of Govt. of India;
3. National Rural Health Mission (NRHM) and National Health Programmes in India;
4. Medical, Nursing & Paramedical Councils & Educational Institutions;
5. Public Health/Medical Care Organizations and Research Institutions under Department of Health Research including ICMR and various other Ministries;
6. Census Commissioner & Registrar General of India;
7. Planning Commission, Government of India;
8. Union M/o Statistics & Programme Implementation;
9. Union Ministries of Railways, Labour, HRD, Rural Development, Communication & Information Technology, Shipping Road Transport & Highways, Home Affairs, Defence, Social Justice & Empowerment etc.;
10. Non-Government Organizations in Health & related sectors in India;
11. WHO and other UN Agencies Concerned with Health and Socio-economic Development and
12. All the WHO-Collaborating Centres on Family of International Classification (FIC) in the world, Asia Pacific Network on FIC and countries of South East Asia Region of WHO.

Budget

CBHI, under the budget head "Health Information and Monitoring System" has been allocated an amount of Rs. 1.15 crores (Rs. one crore 15 lacs only) during the financial year 2013-14 in the plan budget.

15.31 NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH AND MEDICAL SCIENCES (NEIGRIHMS), SHILLONG

NEIGRIHMS is a super specialty teaching institute under the Ministry of Health & Family Welfare established in 1987 under the Meghalaya Regulation of societies Act 1983.

The objective of the institutes to provide advanced and specialized medical facilities of the highest level in the selected specialties and to serve as a regional referral service centre for comprehensive health care. The Institute is also conducting both the Post Graduate and Under Graduate courses in medical sciences. The B.Sc. Nursing programmed started by the Institute is the first technical graduate progrmme in the State of Meghalaya.

The Institute at present is having 467 beds. The number of beds will be increased to 500 with opening of new Department. The institute at present is offering super specialty services in Cardiology, Neurology, CTVS, Urology and Gynaecology, ENT, Orthopaedics and Ophthalmology. These Departments are very well supported by the Department of Radiology, Anaesthesiology, Pathology Microbiology, Forensic Medicine and Biochemistry.

MD/MS Programme in NEIGRIHMS

The Ministry of Health & Family Welfare has approved starting of MD/MS course in four disciplines i.e. Anaesthesiology, Obstetrics & Gynaecology Pathology and Microbiology with two seats in each respective Department. The MD/MS courses in these Departmenthas started in the current academic year.

A sum of Rs. 106.25 crore has been released to NEIGRIHMS during the year 2013-14.

The major projects of NEIGRIHMS are as under:

i) Expansion of Nursing College and Hostel at a total cost of Rs. 61.89 crore was approved by the Standing Finance Committee (SFC) in its meeting held on 30-10-2013 under the chairmanship of Secretary (H&FW) and also approved by Hon'ble HFM. Administrative approval of the Competent Authority (HFM) has been conveyed to NEIGRIHMS on 16-01-2014. The institute has already initiated the process.

ii) Two EFC proposals that is (i) Establishment of Under Graduate Medical College with Hostel and (ii) Setting up of Regional Cancer Centre at an estimated cost of Rs. 377.16 crore is under pipeline.

15.32 NATIONAL INSTITUTE OF BIOLOGICALS (NIB), NOIDA

The National Institute of Biologicals (NIB) has been performing Quality Evaluation of Biological and Biotherapeutic products including Albumin, Normal and Specific Immunoglobulin, Coagulation Factors VIII, Insulin and its Analogues, Erythropoietin, Granulocyte Colony Stimulating Factor (G-CSF), Streptokinase, Immunodiagnostic Kits (HIV, HCV, HBsAg), Blood Grouping Reagents and Glucose Test Strips in its various state-of-the-art Laboratories and Animal House by following various National/International pharmacopoeias. The Institute has performed Quality Evaluation of 1516 batches of 96 types of various biologicals during the year 2012-13.

Efforts have been initiated to establish a laboratory for evaluation of high profile novel drugs like Therapeutic Monoclonal Antibodies which are used for Hematological, immunological and oncological disorders. In this regard, standardization and validation of Rituximab has been taken up. Interferons are under process of validation. Testing of Glucose Test Strips, which are commonly used for measuring sugar level particularly in human beings suffering from the diabetes, has been fully taken up. Nucleic Acid Testing (NAT) laboratory has done evaluation of 9 kits used for monitoring of viral load in the patients. DNA sequencing of Five Isolates of HBV has been done.

Standardization and Validation of Viral Vaccines like CCRV, MMR vaccine, Live Attenuated Measles Vaccine, Rubella Vaccine, JE Vaccine, HPV Vaccine, HBIg, HRIg and Bacterial Vaccines like BCG, HibTT, Meningococcal Polysaccharide Quadrivalent, Typhoid Vi Polysaccharide are going on.

As an on-going exercise, the Institute is supplying National Reference Standard of Insulin and Reference Sera Panel of HIV, HCV, HBsAg to the indigenous

manufacturers as and when required. The Institute has successfully participated in External Quality Assurance Programme of HIV, HBsAg, HCV and Syphilis with National Reference Laboratory, Australia. Successful participation is achieved in Proficiency Testing of Protein conducted by European Directorate of Quality Medicine, France. Institute is also regularly participating in EQAS of Glucose Testing at Christian Medical College (CMC), Vellore, India.

With regard to additional manpower, the Institute has deployed 117 staff on contract basis after approval of the Ministry. A separate proposal has also been submitted for creation of 43 regular posts and same is under active consideration of Ministry.

Haemovigilance Programme has been initiated by the Institute to report Adverse Drugs Reactions (ADR) caused due to administration of blood and blood products in the country. 90 Medical Colleges has been enrolled for this programme.

Budget:

The funds of the Institute are received as Grant-in-aid from the Ministry of Health & Family Welfare. The B.E. & R.E. of the Institute are as under:

(Rs. in crores)

Year	B.E.	R.E.	Expenditure
2011-12	17.80	14.40	13.95
2012-13	17.00	19.50	19.21
2013-14	25.00*	27.00	11.02**

* Proposed

** Upto September, 2013

15.33 BCG VACCINE LABORATORY, GUINDY

The BCG Vaccine Laboratory, Guindy, Chennai was established in 1948. The major activities of the Institute are:

- Production of BCG Vaccine (10 doses per vial) for control of childhood Tuberculosis and supply to Expanded Programme of Immunization (EPI).
- Production of BCG Therapeutic (40 mg.) for use in Chemotherapy of Carcinoma Urinary Bladder.

Staff Strength

- There are 113 sanctioned posts in BCG VL, Guindy. The number of sanctioned posts of group A, B, and C are 3, 13 and 97 respectively.

Performance of BCG Vl
(Production, Demand & Supply)

S. No.	Particulars	Quantity
1	Installed capacity per annum	800 lakh doses
2	Quantity manufactured	87.50 lakh doses
3	Quantity of demand received	87.50 lakh doses
4	Quantity of Supply Released	81.00 lakh doses

Significant Achievements

Ministry has engaged M/s HLL as Project Consultant for BCGVL revival project with a cost of Rs. 64.72 crores. Chennai Metropolitan Development Authority and Chennai Corporation has approved building plan and construction work for upgradation is in advanced stage. Till the new plant is commissioned, production of vaccine will continue from the old building with existing facilities. After completion of new facility, the production will be shifted to new facility and the existing infrastructure will be used for allied facilities. After validation of trial batches of BCG Vaccine from the new facility, the production would start in 2014.

15.34 ALL INDIA INSTITUTE OF HYGIENE & PUBLIC HEALTH (AIIH&PH), KOLKATA

The All India Institute of Hygiene & Public Health (AIIH&PH), Kolkata, is the oldest public health institute in the South-East Asia region, which was established in the year 1932. It is devoted to teaching, training and research in various disciplines of public health and allied science.

Vision, Mission & Objective

Vision: Capacity Building for Excellence in Public Health.

Mission

- To develop competent public health work force through best practices in public health teaching and training.

- To ensure universal coverage through primary healthcare in the field practice areas.
- To develop innovative approaches to strengthen public health services.
- To develop best quality of infrastructure to create conducive environment of learning.
- To develop and strengthen collaboration and networking at local, national and international levels.
- To offer technical expertise and leadership to improve public health.

Objective

1. To develop manpower by providing post graduate teaching and other training in the area of health services.
2. To conduct research directed towards the solution of various problems of health and diseases in the community.

Institutional set up

The Institute has two campuses at Kolkata. The main campus is at 110, Chittaranjan Avenue, Kolkata-700073 and the second campus is at Bidhan Nagar (JC Block, Sector-III, Salt Lake) Kolkata. There are eleven academic Departments. Besides these, the Institute also has two field practice units, one in the rural area (Rural Health Unit & Training Center, Singur, District-Hooghly) and the other in urban area (Urban Health Centre, Chetla, Kolkata) which provide hands-on-training to the students on rural and urban health problems respectively. These field practice units are utilized for community based training for other health institutes also for their field training programmes. The Institute Library is one of the few reference libraries on health sciences in the country.

Teaching and Training Activities

The Institute has been providing teaching and training in various disciplines of public health through its regular and short term training programmes. Details of various courses run by the Institute are given below:

Sl.No.	Department	Course
1	Preventive & Social Medicine (PSM)	MD (Community Medicine)
2	Sanitary Engineering	Short courses
3	Microbiology	Master of Veterinary Public Health
4	Epidemiology	• Master of Public Health (MPH) in Epidemiology • Post-graduate Diploma in Public Health Management. (PGDPHM)
5	Biochemistry & Nutrition	• M.Sc. in Applied Nutrition. • Diploma in Dietetics (Dip. Diet)
6	Public Health Administration	Diploma in Public Health (DPH)
7	Maternity and Child Health	Diploma in Maternity & Child Welfare (DMCW)
8	Occupational Health	Diploma in Industrial Health (DIH)
9	Department of Health Promotion & Education	Diploma in Health Education (DHE)
10	Statistics	Short Courses & Assistance to other courses
11	Public Health Nursing	Short Courses

Short Term Training Programme during the year 2013-14

- Training course on "Calcium Metabolism and Bone Health" for Medical Officers, Nursing Personnel and PG Students of the institute;
- Ttraining programme for M.Sc. Nursing (Community Health);
- Short duration courses on Basic and Health Statistics;
- Computer applications in health data analysis using packages like SPSS, Epi Info. etc.;
- Two week FETP(IDSR) for the state surveillance Officer of Sikkim, Nagaland, Mizoram, Tripura and West Bengal and
- In service training on AFP & Measles Surveillance & IPPI Reorientation Training.

Research activities, other training and seminars

- Seminars of different topic of "Zoonoses" are held regularly;
- UGC sponsored National Seminar on "100 years for the Hypothesis of Vitamin Deficiency Diseases "was organized by Biochemistry and Nutrition Department, AIIH & PH in collaboration with Dept. of Food and Nutrition, Prasanta Chandra Mahalanobis Mahavidalaya at Kolkata on 25th and 26th September 2013;
- An epidemiological study of Chronic Obstructive Pulmonary Diseases (COPD) in an urban slum area of Kolkata;
- Cross sectional study of association of adverse perinatal outcome with indoor air pollution and parental occupation;
- Study on occupational stress and hazard of EMU local train drivers in Eastern Railway;
- Community based research works/projects on MCH/RCH and related fields sponsored by ICMR;
- Seminar on National programme of prevention and control of diabetes, cardiovascular disease and stroke (NPDS) & mid-day meal programme-current status, critical review;
- Seminar on Management of biomedical waste and hospital acquired Infections;
- Seminar on WHO multicentre growth reference study and new WHO growth curves for assessing growth & development;
- Seminar on Public-Private partnership in health care system in India;
- This Institute provided consultancy to other organization in the area of Public health services like professional development course of IISW&BM, Kolkata; M. Sc. Nursing, Asia Heart Foundation; Training Course on RCH, ATI, Kolkata etc.;
- The 100th Science Congress-Medical Seminars/ Poster Sessions round the clock Medical Unit was set up in the Campus and
- Regional Training of Senior Level Medical Officer of Central Government Health Scheme.

Monitoring of NRHM, West Bengal

The Implementation of NRHM in West Bengal is monitored on quarterly basis as per the Ministry's instruction. This year four districts have been covered. The monitoring team submits the analytical reports and suggestions for improvement to the State Government and the Ministry. It provides supportive supervision to the state health system by actually showing as to how the gaps in the system may be removed (like documentation, HMIS, Financial aspects etc). This has led to improvement in grievance redressal system, documentation, mode of JSY payment, IEC etc.

Other important activities undertaken during the year

- EMR duties attended by the officials of this Institute in the State of Uttarakhand and Odisha.
- Yellow Fever Vaccination was given to 780 persons by the department. 1070 and 530 doses were supplied to Port Health Organization and Airport Health Organization respectively
- 244 water samples were tested for portability of which 55 were not found fit for human consumption. 153 & 122 samples were processed in the section of Bacteriology & Parasitology respectively.

- Health care services in RHU&TC service area is being provided by two Union Health Centres (UHC) through OPD, Indoor and Field Services. General OPD & MCH clinic run by Medical Officers at Nasibpur UHC, Anandanagar UHC and Paltagarh Sub centre, Nasibpur, Balitipa sub--centres. Immunization sessions are conducted at all sub centers. DOTS for TB patients are also provided. Health care services are also supported by Public Health Laboratory, Bio-chemistry Laboratory and Sanitary Engineering Workshop at RHUTC, Singur.
- The Urban Health Centre (UHC, Chetla) covers an area of 3.9 Sq. Km. with population of 1.2 lakh comprising of a slum population around 35,000. The centre also provides primary health care services for the beneficiaries and specialist clinic services on MCH, Gynecology & Obstetrics, Skins & VD, Occupational Health, RNTCP, NCD, School Health, Nutrition & Public Health Laboratory Services.

Implementation of official language and policy

- As part of implementation of official language policy, Hindi Cell of the Institute organized Hindi workshops in the Institute. Hindi Pakhawara was also organized for the officers and other staff members in the month of September, 2013.

Right to Information

The Institute has received a total number of 61 RTI applications during the year 2013.

Budget allocation (2013-14)

Details of the budget allocated for the financial year 2013-14 are given below:

Plan	Non-plan	Total
17.60 crore	33.85 crore	51.45 crore

15.35 CENTRAL LEPROSY TEACHING AND RESEARCH INSTITUTE (CLTRI), CHENGALPATTU

The Central Leprosy Teaching and Research Institute (CLT&RI), Chengalpattu was initially established in 1955 by the Government of India under a Governing body by taking over Lady Wellington Leprosy Sanatorium established in 1924. Later, in 1974, Govt. of India had made CLT&RI as a subordinate office of Directorate General of Health Services, Ministry of Health & Family Welfare with an objective to provide diagnostic, treatment and referral services to leprosy patients, trained manpower development for leprosy, control/elimination, research on applied aspects of leprosy and its control.

Objectives

- To undertake research in basic problems relating to the occurrence and spread and complication of leprosy.
- To train manpower necessary to implement National Leprosy Eradication Programme (NLEP).
- To provide specialized services for diagnosis of leprosy, reaction, relapse and Reconstructive Surgery (RCS).
- To Monitor and Evaluate NLEP.
- To function as a pivotal center for promoting anti leprosy work in the country.

Clinical Division

It comprises of five wards and OPD, Nursing section, Sanitary Section and Central Kitchen. Hospital has Investigation ward, Main hospital, Sick room and women hospital. It is mainly used for expertise management of lepra-reactions, investigation for relapses/ drug resistance and for other general's medical conditions, management of lepra reactions by using Thalidomide in special situations.

Patient care facilities provided in the Clinical Division are:

- Out-patients care/Inpatient treatment and MDT services.
- Expert Management of Lepra reactions, relapses/ drug resistance etc.
- Training activities & Research activity.
- Study of relapse and lepra reactions cases in Leprosy.

In-patients services

Total patients treated	8452
Total Discharges	0677
Patients remains at the end of the year	074
No. of Deaths	003

Out -patients services

Total No. of New case of Leprosy	089
Total patients treated	8690

Surgical Division

The Surgical Division comprises the Operation Theater for RCS, Physiotherapy section, Artificial limbs and Footwear section, X-Ray Section and Micro-Cellular Rubber (MCR) sheets manufacturing unit. The functions are:

- Reconstructive Surgery (RCS), DPMR activity.
- Support in Training Programmes.
- Camp based RCS Surgery in Tamil Nadu.

Patient care Activities

This division provides treatment in the areas of deformities and deformity prone conditions are extended. Prevention disability and correction of deformity is main objective.

Reconstructive Surgery: Major Surgeries 16 and Minor Surgeries 17.

Physiotherapy Section

It provide Physio services and counseling of patients by imparting health education in the care of insensitive hands and feet and support training activity and nodal in Physiotherapy Technician Training.

Micro Cellular Rubber (MCR) Mill

The Micro-Cellular Rubber Mill is a small production unit manufacturing MCR sheets of the quantity needed for use in the manufacturing of footwear for leprosy patients. Quality Assurance of MCR Production has been initiated at 2012. Installation of Dispersions Kneader to the production capacity with help of Central Leather Research Institute, Chennai . We are providing MCR sheets to various State Leprosy Society.

MCR Sheet Production	790/year
MCR Footwear Produced	850pairs/year

Division of Laboratories

It has Microbiology, Myco-bacteriology, Serology and Clinical Pathology, Skin Smera, Histopathology, Molecular-biology Hematology Biochemsitry, Immunology and Animal House. This division has been upgraded with the basic facilities for the isolation of DNA, PCR amplification and Gel documentation. Animal House with different animal colonies with provisions for animal experimental investigations including Mouse Foot Pad (MFP) inoculation for the viability and drug susceptibility tests for M. leprae is also available.

Annual performance of Laboratory Division

Clinical Pathology & Skin Smear	1294
Hematology & Serology	3741
Bacteriology	0148

15.36 REGIONAL LEPROSY TRAINING AND RESEARCH INSTITUTE (RLTRI), RAIPUR

Regional Leprosy Training and Research Institute (RLTRI), Raipur established in the year 1979 with the aim to provide training, research and treatment for the leprosy affected persons under administrative control of Central Leprosy Division of DGHS.

The Institute is having 75 beded indoor patient services and is daily OPD services. It is also having well equipped Laboratory and well trained technical manpower in the laboratory for skin smear examination and other laboratory investigation. Institute also carry out Polio Surgery in the hospital. RLTRI also provide technical guidance as and when required.

Institute organize following Training Programmes routinely in the filed of leprosy.

- National Level SLO/DLO/BMO Training(1 week duration)

- BPT Interns training (1 week duration)
- Final year MBBS students orientation training in Leprosy (1 day)
- Physiotherapist Training(1 week)
- Skin Smear Technician Training (1 week)

RLTRI has been assigned additional responsibilities of Regional Office of Health and Family welfare (ROHFW) for the State of Chhattisgarh to monitor various National Health Programmes including NLEP at State and District level and cross checking of beneficiaries like JSY, immunization status of children, ANC/PNC follow up, eligible couple using different contraceptive methods, work of ASHA (Mitanin) at different level.

RLTRI Activity

OPD Services

New Leprosy Cases detected	732
No. of MB cases in newly detected cases	435
No. of PB cases in newly detected cases	297
No. of old cases provided treatment	3661

IPD Services

No. of patients admitted for RCS & Physiotherapy	191
No. of patients admitted having Ulcers	170
No of patients admitted having ENL reaction	174
Total No. of patients admitted in the wards	553

Lab services

No. of Microbiological investigation undertaken	1818
No. of clinical pathological investigation undertaken	1245
No. of bio-chemical investigation	362
Total No. of investigation done	3425

Physiotherapy Services

No. of patients given wax bath therapy	63
No. of patients given oil message, hydro-oiling therapy	233
No. of patients given Active & Passive Exercise	652
No. of patients given Electric Vibrator massage	3
No of patient given short wave diathermy	1
No. of patient given I.R.	6
Others	34
Total No. of patients provided Physiotherapy	992

Training Conducted

National level DLO /BMO/MO Training	4 batches	32 Nos
imparted to Medical College students	5 batches	80 Nos
Training imparted to BPT Intern students	16 batches	53Nos
Training of Physiotherapist	1 batch	6 Nos

Reconstructive Surgery for Leprosy patients

No. of surgeries conducted at RLTRI	52
No. of surgeries conducted outside RLTRI (at district level)	64

Surgery for Polio Cases

No. of Polio Surgery conducted at RLTRI	25
No. of procedures	36

Special Activities under RLTRI

Technical supervision of NLEP activities in the ten districts: During the year ten districts were covered for assessment of the NLEP programmes.

Sl No.	District	DHs	CHCs	PHCs	HSCs	Total
1	Bilaspur	1	3	3	3	10
2	Jashpur	1	3	3	3	10
3	Korea	1	3	3	3	10
4.	Korba	1	2	2	3	8
5	Durg(Divided)	1	4	4	6	16
6	Bemetara	1	2	4	4	11
7.	Dhamtari	1	4	4	5	14
8.	Rajnandgaon	1	3	3	3	10
9.	Mahasamund	1	4	3	5	13
10.	Kawardha	1	3	3	3	10
	Total	**10**	**32**	**32**	**38**	**112**

Research/Project Activities in NLEP

ICMR sponsored extramural project-A study on endemicity of leprosy and utilization of health services in two districts of Chhattisgarh i.e. Mahasamud and Sarguja.

Under the project samples were collected from patients of selected villages and also collected environmental samples (water and soil) also by the team of this Institute and sent to JALM, Agra for further investigation.

15.37 REGIONAL LEPROSY TRAINING AND RESEARCH INSTITUTE, ASKA

This institute was established in the year 1977. At present there is 38 (Gr.A-2, Gr.C-22, Gr.C(MTS)-14) staff in position out of 67 sanctioned posts. It has a 50 bedded hospital and average bed occupancy is about 43.3%. The institute provides both Out-door and In-door services to leprosy patients. The institute also works as a referral center for management difficult to diagnose leprosy cases, Skin smear examination and problematic, complicated and intractable cases of reaction and ulcers. Thalidomide is also given to intractable recurrent ENL reaction cases. Physiotherapy measures and MCR chappal are provided to the needy patients. Amputation and various others surgical procedures are carried out regularly and RCS (Reconstructive Surgery) camps have been done in the past.

It also works as a nodal training and research center for the cause of leprosy elimination.

Brief activities performed by the Institution

- OPD Attendance-1604(Leprosy-1211, Non Leprosy-393)
- Indoor-Total admission-209
- Reaction cases Managed-80 (In 348 episodes of reaction Type I-302 & Type II-48 in 80 patients) and Thalidomide course was given to 2 patients of recurrent ENL Reactions.
- Major surgeries-29
- Lab- Total Inv-628(Clinical-242 Bio-Chem-07)
- Training-Faculty of this institute is going as resource person to impact modular trainingin NLEP to doctors and paramedical staffs of State.

A total of 108 MOs and 35 AYUSH MOs of different district of Odisha trained in 3 days modular training in 5 batches organized by Govt. of Odisha. Faculty of this institute also participates in NLEP review and planning meeting of States and monitoring of NLEP activities of different district of allotted States.

15.38 REGIONAL LEPROSY TRAINING AND RESEARCH INSTITUTE, GOURIPUR

Regional Leprosy Training and Research Institute, Gouripur, Bankura, in short RLTRI, Gouripur, a 50 bedded leprosy hospital under Central Leprosy Division of Ministry of Health and Family Welfare has been set up by Govt. of India in 1984 with the aims & objectives of (a) creation of sufficient trained man-power for better implementation of NLEP in different Indian States, especially, the north-eastern zone states to eradicate leprosy and for (b) operational research on leprosy. The institute is located at a village named Gouripur which is well connected with the district town Bankura and the neighbouring Jharkhand State by roads and rails.

In the changing scenario of NLEP management, presently the institute has been conducting 'Training of Trainers'(TOT) course for senior officers (DLOs & BMOs) on leprosy throughout the year, catering OPD services 3 days a week and running an indoor ward of 30 beds for ulcer care and reaction management of leprosy patients. For diagnosis of difficult cases and to provide quality care to deformed/complicated leprosy cases, the institute runs one laboratory unit, one X-ray unit & one physiotherapy unit. In addition, there is one field unit that carries out IEC activities regularly throughout the year in its' field area covering 300000 population to increase voluntary case reporting for early case detection and prevention of deformity. A significant numbers (45%) of OPD patients of RLTRI, Gouripur, belongs to SC/ST categories of people because of dominance of habitation in the area.

Apart from TOT programme, the institute is having an excellent atmosphere for carrying out of short course training programme on leprosy for Para/Non-Medical personnel. Last but not the least, the institute can be an ideal place for epidemiological studies considering its' location and resources.

Performance report up to 31st October, 2013 during the year 2013-14 is as detailed below:

- **Training -** TOT Programmes -2 nos. (11 + 11 = 22 nos.) Candidates attended in two TOT programmes. In addition, one day orientation Training imparted to 50 nos. of B.Sc. Nursing Students.
- **Indoor -** Admission -122 nos., Discharge -126 nos.
- **O.P.D. -** New Case- 40 Nos., Old Cases -1565, MDT given-252 no, RFT-04 nos., Relapse -5 nos.
- **Field/IEC activities-** Group Discussion-251, Leaflet Distribution-1754 nos., IEC Programme-50, Villages covered-50 nos.
- **Laboratory Unit-** Slit Skin Smear-585 nos., Bio-chemistry-184 nos., Clinical Pathology-111.
- **Physio. Unit-** Plaster-14 nos., Exercise-1231, Muscle stimulation-395, Wax Therapy-146, Infra Ray-78.
- **Special Activity-** Dr. B. C. Mandal, Director has composed and published a book entitled- "ANTARDEEPAN" during the year on health awareness including leprosy and on other social issues of national interest for the mass awareness.

15.39 NATIONAL MEDICAL LIBRARY (NML), NEW DELHI

National Medical Library (NML) provide valuable library information services to support the academic, research and clinical work Health science professionals in the country. It occupies important position in country's health care information delivery system. Some of the significant services provided by NML are:

Activities and Services

Reference Services & Collection Building: One of the greatest strengths of NML is its richest collection of books, reports, serials, bound volumes of journals and computer databases. This invaluable treasure of biomedical and health science information, which is often the only source, is widely used by professionals from all parts of the country. It has collection of over 1.35 lakhs books and over 5.2 lakhs bound journals. The Library subscribed 1524 (Titles) print journals worth Rs. 16.04 crore in 2012-2013. The books and journals acquired during the year have been classified and catalogued by using LIBSYS library software package.

Local Area Network (LAN) and Online Public Access Catalogue (OPAC): Servers and computers in the library are networked to form a LAN having an integrated Library Management Software Package-LIBSYS. About 41,350 records of books are now available through OPAC computer search by library users. Leased lines of (2 mbps) and broad band internet facility is available to provide internet services including access to full-text of the journals.

Information Retrieval Services: NML has been offering the service using MEDLINE since 1990. Besides, it has about 500 CDs on different subjects. The biomedical information sources available on Internet, namely PUBMED, PUBMED Central, ERMED etc. were also accessed to meet the requirement of library users. Many articles were searched through MEDLINE service for getting references and abstracts for research scholars during the year. A work station having the facility of 10 terminals fitted with CD writer is being developed for on-line access of foreign medical journals. Scheme to "Inter-linking of Government Medical College Libraries with the NML".

Government colleges are provided with financial assistance to acquire hardware, software, Internet connectivity and to hire contractual staff. This scheme has already covered 78 medical college libraries. The project aims to develop information communication technology capability among the participating colleges to be able to access the online information resources available in NML.

Reference and Documentation Services: The library remains open on 359 days of the year from 0900 - 2000 hrs on weekdays and from 0930 - 1800 hrs on holidays. Over 150 users visit the library every day for reference, consultation, obtaining photocopies of required articles and information retrieval service. Library has been visited by information seekers to avail following services:

- Queries answered 1276
- New Membership 45
- Issue/return of documents 233
- Inter Library loan (Print documents) 08

Library developed database of over 6000 medical thesis/ dissertation submitted to medical colleges across the country. The same is available at < Search Medthes> at www.nml.nic.in. The library also developed a database of over 4000 medical articles published in Indian Medical journals in the country in MARC21 software under the **"Index Medicus-India"** project. The library also developed the database of over 6000 medical thesis submitted to different medical colleges across the country. The database is widely used through the NML website. Library brings out a quarterly List of New books Added to NML. It is also bringing out a weekly **"Indian Press Index on Health"** which covers important press release on topics related to health science in prominent Indian newspapers.

Document Delivery Service: The Document Delivery Service provides access to the full text of documents needed by various medical specialists. This service is in fact used more widely than any other service of the library and caters predominantly to requests for copies of articles in journals (current as well as back files). A large number of request for photocopy of articles are received from outside Delhi by post, e-mail and fax through Government as well as private photocopy counters. Photocopies of 496 articles has been provided to the Students/medical professionals of Institutions located outside Delhi and 50 articles were provided to NISCAIR/Medical institute located in Delhi comprises a total number of 22771 pages for which postal charges are free for delivery of articles to outside Delhi states.

ERMED-India e-Journal Consortium: Over the years the National Medical Library (NML) has been providing a wide variety of Health Information dissemination activities focused on reaching out Health Care Professionals of the country. NML disseminates over 8000 (8000 x 5 =40,000 pages) photocopy of articles from medical journals per month to medical scholars across the country. The system involves sizeable photocopy machines + man power + maintenance of back, volumes of medical journals, their shelving and repeated binding due to extensive use of journals. Despite above tedious efforts the end user does not get efficient document delivery service due to delay in postal services and human handling.

In order to cope up with the problem, NML started ERMED (Electronic Resources in Medicine) electronic journal consortium since January 2008 for 39 (28 ICMR Institutes + 10 DGHS Institutes/Medical Colleges + AIIMS), by spending Rs. 2.5 crores.

NML envisions that the availability of latest knowledge and skills through global Medical Literature to Indian Medical Fraternity. In 2010 ERMED purchased 1180 e-journals at the cost of Rs. 10.20 crores for 98 members (2 private members have made their own payment for per site e-journals). In 2011 ERMED purchased 201 e-journals at the cost of Rs. 7.50 crores for 96 members spread across the country.

Training: The Training cum Orientation programme for ERMED at National/Regional/State level had been conducted to create awareness and make the system more user friendly.

NML also provided sufficient number of "Users Manuals" and "Posters" to each participant to enhance awareness for ERMED. It is expected that the search skill of the users will be more efficient in future to make use of the ERMED resources

Consultancy services provide to following Hospitals/ Institutes

- National Institute of Health & Family Welfare, New Delhi
- Institute of Human Behaviour and Allied Sciences (IHBAS), New Delhi.
- Safdarjung Hospital, New Delhi.

Branch Library

National Medical Library maintains a branch library in the Nirman Bhawan to cater to the library and information needs of staff and officers in the Directorate General of Health Services and the Ministry of Health and Family Welfare. Steps are being taken to renovate the present library set up and to improve library collection and services at Branch Library.

Library Building

As the library building is 34 years old, several measures have been taken to repair and restore the structure and

modify it as per the modern requirement. The building needed complete renovation and repair to improve the exterior get up of the library as per its status. Necessary repairs and renovation of the building has been done. The installation of lift and the dumb waiter are in the final stage of completion.

15.40 NATIONAL INSTITUTE OF TUBERCULOSIS AND RESPIRATORY DISEASES, NEW DELHI

National Institute of Tuberculosis (TB) & Respiratory Diseases (Erstwhile L.R.S. Institute of TB and Respiratory Diseases) is an autonomous Institute under Ministry of Health & Family Welfare, Government of India.

The Institute is providing world class health care to sick and needy patients, supporting National Tuberculosis Control Programme, facilitating training, teaching and research activities. It has an extensive Out Patient Department (OPD) complex running daily OPD with computerized registration, round the clock emergency services, indoor facility comprising of 520 beds, a Respiratory Intensive Care Unit (ICU) for the critically ill patients and a state of the art MDR TB ward with international standards of infection control measures. The Public Health Department of the Institute implements the Revised National TB Control Programme for 10 lack population in South Delhi. The Thoracic Surgery Department of the Institute is one of its kind and serves patients requiring surgical intervention from all over the country and even neighbouring countries. Institute also has facilities for Human Immuno-Deficiency Virus (HIV) care including a free Antiretroviral Therapy Centre under the aegis of National AIDS Control Organization (NACO) and chemotherapy for lung cancer. The Microbiology Department of the Institute is a National Reference Laboratory and assists the RNTCP for Quality Assurance networking for laboratory services.

The Institute is also a recognized centre for post-graduate DNB (Respiratory Diseases) degree course since 1999 and has been accredited for ten DNB seats per year w.e.f. 2009. Regular teaching activities such as seminars, journal club, faculty lectures, grand case presentation, mortality meetings, pathological conference, radiological conference, and bed-side clinical rounds are routinely carried out. The Institute has been providing training to various classes of health personnel from within and even from outside the country. The Institute provided training to 345 trainees during the period from 1st April 2013 to 31st October 2013. A total number of 1630 trainees were trained in the Institute between April 2012 to 2013.

During the period from 01st April 2013 to 31st October 2013, a total number of 26730 symptomatics were newly registered in OPD. Taking follow up patients and patients of special clinics etc. into consideration, the total OPD load was 95425. A total number of 3959 patients required admission in hospital and 3151 were discharged with favourable outcomes. During the period from April 2012 to March 2013, a total number of 46210 new registrations took place under the Institute. Taking follow up patients and patients of special clinics etc. into consideration, the total OPD load was 1,51,786 patients. A total of 6635 patients were admitted and 6640 discharged during this period.

The Institute is also actively involved in research in the field of TB & Respiratory Diseases. Over the years, numerous research projects have been carried out on various sub-specialties of Respiratory Diseases within the Institute. During the period from 01st April 2013 to 31st October 2013, 11 new researches were initiated in addition to those already in progress and 8 publications took place in several reputed national and international journals and books, in addition to the regular 3-monthly publication of the Institute's newsletter.

Other Achievements/Notable developments during the period:

- The Private Ward Block was inaugurated at the Institute by the Hon'ble Union Minister for Health and Family Welfare.
- A book of Research Abstracts having a compilation of the researches carried out by the Institute faculty from 1990 to 2012 was also released by the Hon'ble Union Minister for Health and Family Welfare during the inauguration of the Private Ward Block.

The Department of Respiratory Critical Care, a new department, created on 21st February 2013 to provide

critical care to seriously ill TB and Respiratory disease patients set up a facility in Emergency ward for providing ventilation to patients of sputum positive TB. This facility, which has already served 30 patients with active TB, is rarely available even in the premier Institutes of the country. Efforts are on to:-

- expand the bed strength and the infrastructure of the department in a phased manner so as to benefit greater number of needy patients with critical illnesses.
- The Institute faculty chaired sessions, delivered lectures and participated as delegates in many Conferences/CMEs/scientific meets organized within or outside the country.
- The Institute faculty participated in various national level RNTCP Policy development meetings and trainings organised within and outside the Institute.
- The Institute faculty was on the editorial boards of many reputed national and international journals.
- A number of high end equipments were procured as follows:
  a. Fully Automated Rapid Microbial Identification and Drugs Susceptibility System
  b. Ultrasound Machine
  c. PACS Imaging System
  d. FACS Count
  e. Portable Ventilator
  f. 7 Bipap Machines
- A number of construction/renovation activities were undertaken to facilitate the patient care, diagnosis and research within Institute.

15.41 NATIONAL INSTITUTE OF MENTAL HEALTH & NEURO SCIENCES (NIMHNS), BANGALORE

The National Institute of Mental Health & Neuro Sciences, Bengaluru was registered in 1974 on amalgamation of the Government of Karnataka Mental Hospital and All India Institute of Mental Health, Bengaluru. The Central Government and State Government of Karnataka jointly finance it. The Institute is managed by NIMHANS Society with the Union Minister of Health and Family Welfare as its President, the Minister of Medical Education, Karnataka as Vice-President and senior officials of the Central Government and State Governments as Members. During the year 2013-14 a sum of Rs. 13280.00 lakhs under Plan and Rs. 10000.00 lakhs under Non-Plan (Total Rs. 23280.00 lakhs) has been allocated to the Institute as grant-in-aid by the Central Government.

The objective of the Institute is to promote the growth and development of Mental Health and Neuro Sciences and the main theme is multi-disciplinary approach in services. Teaching, research and community oriented activities are the main thrust of the Institute.

The National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru Act, 2012 to declare the Institution to be an "Institution of National Importance" and to provide for its incorporation and for matters connected therewith received the assent of the President on 13th September, 2012 and was notified vide Gazette Notification No. 45 dated 14th September, 2012. The Act has come into force with effect from 29th November, 2013.

New Facilities

- New spacious premises of the Department of Speech Pathology & Audiology in the Outpatient Block was inaugurated on 20 June 2013.
- A 12 Bedded Step Down Ward was inaugurated on 8 October 2013. This is being used to reduce the pressure on the Neuro ICU.
- Organic Waste Converter has been installed in the Institute to handle all organic solid waste (excluding bio-medical waste) and convert it into manure which could be used in the garden. This would convert all biodegradable waste generated in NIMHANS Campus (both residential and the Institute Campus) into organic manure.
- A centralized record storage facility, which is also is fireproof and pest-proof storage facility, has been created where all the old records of the

administrative sections such as Stores, Purchase, Academic, Personnel Section, Accounts are stored.

Major equipment added during the period: Several new equipment like Multi-Well Microplate Reader, Dynamic Light Scattering System, Ultramicrotome & Tissue Processor, Transcranial Magnetic Stimulator, Digital Slide Scanner, Intravital Fluorescence Microscope, Cardio Respiratory Monitors, Controlled Suction Apparatus, Electric Drills, ICP Monitoring System, Transoesophageal and Echocardiography Probe have been procured by the Institute during the current year.

Memorandum of Understanding

- NIMHANS signed a MoU with and Institute of Bioinformatics (IOB), Bengaluru, on 12 July 2013 for joint research and academic activities of mutual interests between the institutions.
- The Director of CBI and DIG visited NIMHANS and signed a MOU with the Institute on 26 November 2013. The MOU envisages providing of training to CBI staff by the Department of Clinical Psychology, NIMHANS.

Academic Activities: A total of 156 students of various courses at NIMHANS passed out during the current year. A total number of 51students were admitted in Ph.D. programmes and 25 students of Ph.D. students qualified for award of degree. 81 students were admitted in Medical PG courses and 97 students were admitted in Non-Medical PG courses at the Institute. 91 students enrolled for various undergraduate courses and 26 students enrolled for Diploma Courses at the Institute.

Training & Visiting of Students: The total number of 2509 students from Government/Private Institutions undergone short term training at NIMHANS during the period 01.04.2013 to 30.11.2013.

Patient Care Services: More than 2.60 lakhs patients have received treatment at NIMHANS in the current year and around 11000 patients have been admitted in the NIMHANS for treatment.

Awards and Honours

- Dr. P Satish Chandra received prestigious Basanti Devi Amir Chand Prize for the year 2010, an award instituted by ICMR for significant contributions to research in Biomedical Science, from Union Minister for Health and Family Welfare, on 24 September 2013
- Dr. Venkatasubramanian G, Additional Professor of Psychiatry, was presented Dr. Vidya Sagar Award (by ICMR) for the year 2010, on 24 September 2013.

Research Projects: NIMHANS has been awarded 29 new Research Projects during the current year along with 251 ongoing projects.

15.42 NATIONAL TUBERCULOSIS INSTITUTE (NTI), BENGALURU

National Tuberculosis Institute (NTI), Bengaluru is an organization under the Directorate General of Health Services, Ministry of Health and Family Welfare, established in 1959 in close collaboration with the World Health Organization (WHO) and UNICEF. The Institute was established with the objective of formulating the National TB Control Programme. The Institute is the technical arm of the Central TB Division, which is responsible for implementation of National TB Control Programme across the country. This is a premier Institute in the field of Tuberculosis control in South East Asia, which caters to the human resource needs for TB control in the region. Since 1985, the Institute has been functioning as a WHO Collaborative Centre for Training and Research. The Institute is also involved in carrying out Operational Research on various components of TB Control. The Institute has a National Reference Laboratory for External Quality Assessment in the TB Control activity supported by animal Research facilities. It also provides technical support for Intermediate Reference Laboratories for effective implementation of Programmatic Management of Drug Resistant TB across the country.

The Institute has also been identified as the nodal centre for operational research related to RNTCP. The major activities as a nodal centre are to organize workshops and dissemination of research data through publications.

The Institute has been re-organized with formation of Divisions/Units the details are given.

Divisions	Units
HRD and Documentation Division	Training and Co-ordination Unit Computer Tr. Unit Library and Documentation Unit
Laboratory Division	NRL Animal Lab ICELT
Epidemiology and Research Division	Research
M&E Division	Monitoring of RNTCP
Communication and Sociology Division	Communication Sociology
Administration Division	Directors Office Establishment Section Accounts section Stores Hostel Transport Section Civil and Electrical Works Campus Maintenance Security EPBX

Some of the important activities carried out by Divisions/ Units is given below:

HRD and Documentation Division

The HRD Division comprises of Training and Co-ordination Unit, Computer Training Unit and Library and Documentation Unit.

The Institute has pioneered in the field of Human Resources Development. It is involved in conducting the following training programmes to the TB Programme Managers positioned at different parts of the country.

Training courses conducted at NTI include:

- RNTCP Modular Training
- TB/HIV training for ART centre MOs
- Training on Managing Information for Action
- Training in drug logistics management
- Computer related training programmes related to RNTCP (Epicentre/Nikshay)
- External Quality Assessment
- Culture and Drug Susceptibility Testing-both solid and liquid
- Orientation in EQA for Directors of STDCs & STOs
- Training in preventive maintenance and minor repairs of binocular microscopes
- Line Probe Assay

Other Activities:

1. Seminars for post graduate medical students, sensitization of paramedical workers including nursing staff at the Scientific Gallery.
2. International training courses & workshops organized in collaboration with WHO, SAARC & the Union.
3. Organizing National level programme review meetings for STOs and STDC Directors.
4. Operations Research workshops.
5. WHO Regional workshops on TB surveillance, Programme monitoring & evaluation and impact assessment meetings.
6. Protocol development workshops.
7. Workshops on Leadership Skills & Management.
8. WHO Fellowship courses on various aspects of TB Control.
9. Publication Activities: The faculty of the Institute publish research papers in the leading journals on TB. Make Presentations and Poster sessions on the basis of the research studies conducted by the institute in the National Conference on TB and Chest Disease. The in-house publications of NTI Bulletin is undertaken.
10. National data base of trained manpower: It is proposed to set up an online portal which facilitates the national Institutes to update their training calendar and the participants trained.
11. Development of Model DOTS District incorporating the objectives envisaged as per the National Strategic plan 2012-17.

Laboratory Division

The Laboratory Division comprises of National Reference Laboratory, ICELT and Animal Model Research Unit.

1. Operationalise the EQA for sputum smear microscopy network in the states in conjunction with STDCs or IRLSs. Carry out NRL responsibilities of EQA such as Onsite Evaluation (OSE). Panel testing (proficiency testing of lab staff) to ten states at least once in a year for 3-4 days (including one to two districts visits), and make visits as and when required depending on the priorities/necessity to improve and help the performance of labs. Prepared slides are used for panel testing during the visits.
2. Conducting quality improvement workshops for the state level programme managers with a view to find solutions to EQA related operational and technical problems faced in the field.
3. To implement and verify Random Blinded Rechecking (RBRC) producers and improve the performance of labs based on analysis of the RBRC data in conjunction with STDCs.
4. Capacity building and strengthening the ten state level TB laboratories with respect to proficiency in culture and Drug Susceptibly Testing including second line drugs.
5. Conducting Anti-TB Drug résistance surveillances of priority states involving processing of representative sample of the states to obtain information of prevalence of drug resistance, with a view to support logistics of DOTS-Plus programme under expansion of DOTS and RNTCP and conduct/participate in National Level disease prevalence studies/surveys.
6. The Lab team of the Institute carryout on site evaluation of STDC laboratories of different states and provides necessary guidelines to establish quality laboratory to undertake EQA and DRS studies.
7. Carry out Lab based research studies using modern diagnostic techniques and tools viz., Gene expert, Genetic Analyzer, HPLC for NTMs, LPA and MGIT 960.
8. The Institute also has an Animal Model Research Unit which is responsible for maintaining homogenous stock of Guinea Pigs required for experimental purposes.
9. The Govt. of India in collaboration with FIND has established an International Centre for Excellence in Laboratory Training (ICELT) for providing trained manpower in newer diagnostic tools for diagnosing TB including Drug Resistant TB.

Epidemiology and Research Division

The research studies/projects taken up by the institute are as follows:

1. Inventory Study to find out 'Underreporting' of TB cases in Tumkur District of Karnataka State;
2. Challenges in Implementation of Diagnostic Algorithm for Patients having Symptoms Suggestive of Pulmonary TB with Smear Negative report on initial sputum examination;
3. Annual Risk of Tuberculous Infection among school children in Nelamangala Taluk, Bengaluru rural District;
4. Evaluation of diagnostic algorithm among registered new Smear Negative PTB patients under RNTCP in Karnataka State;
5. Role of additional screening by chest X-ray among persons with symptoms suggestive of Pulmonary TB smear Negative on initial sputum examination;
6. Effectiveness of community based observation of treatment for tuberculosis in Bengaluru city in 2010-11;
7. Inventory Study to find out 'Underreporting' of TB cases in Tumkur District of Karnataka State and
8. Improving TB case finding efficiency and management of TB cases in private health care facilities in Bengaluru city.

Monitoring & Evaluation Division

With full coverage of RNTCP in the country, the Institute is not compiling the reports on NTP. At present, the monitoring activity is being carried out by the

Central TB Division under DGHS. Currently one CSO, one Statistical Assistant and one Computor are posted the M & E division and are supporting CTD for monitoring.

Communication and Sociology Division

1. The Scientific Gallery has been established to disseminate the general information on TB the evolution of the programme and achievements of the Institute since its inception. Considering the needs of various categories of trainees, two methods of display units viz., Photo Display and Projection facility and Information Kiosk are available.
2. One day Awareness Programmes are held by the Division for the Medical and Para medical students from different institutions of the state and neighbouring states, orientation to students of medical colleges and other teaching.
3. The Division is planning to carryout research on sociological aspects of TB.

Administration Division

1. The Administration division handles the administrative, budgeting and financial issues pertaining to functioning of the Institute.
2. The administrative division facilitates for the comfortable stay of the participants who come for Training/Workshops/Seminars by taking care of their accommodation by proper up-keeping of Hostels and Guest Houses.
3. It also takes care of the Transport requirements for the Operations research and Field visits of Trainees.

It is also responsible for security, up- keeping and proper ambience of 23 acres of the sprawling NTI campus.

15.43 HSCC (INDIA) LIMITED, NOIDA

HSCC has been incorporated under the Companies Act, 1956 in March, 1983 as Public Sector Enterprise under the Ministry of Health & Family Welfare with an Authorized Capital of Rs. 50 lakhs and paid up capital of Rs. 40 lakhs. Authorized Capital and paid up capital has been increased from time to time. The Authorized Capital of the Company as on 31.03.13 is Rs. 500 lakhs divided into 5, 00,000 equity shares of Rs. 100/- each. The paid up Capital of the Company as on 31.03.13 is Rs. 240 lakhs. It includes the Bonus Shares of Rs. 120 lakhs and Rs. 80 lakhs issued, during the financial year 2003-04 and 2008-09 respectively, to existing Shareholders out of its Reserve & Surplus. Since inception the total business of the Company has been managed without any borrowing either from the Government or from other sources. HSCC has earned the distinction of maintaining its *'Mini Ratna'* status from September 1999 onwards.

HSCC is a multi-disciplinary renowned consultancy organization in healthcare infrastructure such as Hospital, Medical Colleges, Laboratories and procurement of medical equipments and pharmaceuticals.

Its service spectrum covers feasibility studies, design engineering, detailed tender documentation, construction supervision, comprehensive project management, procurement support services in all areas of civil, electrical, mechanical, information technology and auxiliary medical services. Its important clients include:

- Ministry of Health & Family Welfare and its Hospitals/Institutes
- Ministry of External Affairs and other Ministries
- State Governments and their Hospitals/Institutes
- PSU/Other Institutes such as ICMR, CSIR, ICAR, DOBT, PIMS, PGI Chandigarh, Govt. of Punjab, Govt. of Haryana and other Business Associates.

HSCC being knowledge management consultancy company in health infrastructure sector employs competitive and highly skilled cadre of Architects, Engineers, Economists, Chartered Accountants, Cost Accountants, MBAs and a pool of Consultants in the areas of Medicines and Corporate Planning etc. HSCC enjoys a good working employees relationship at all levels.

In order to develop into a world class Consultancy Organisation, thrust is on diversifying and expanding the operations and also the client base of the Company. Further, the Company has also been exploring business opportunities abroad through Ministry of External Affairs.

The Company is an ISO 9001 accredited company. The Company has from, time to time, taken various steps to upgrade quality assurance system and degree of clients satisfaction. The Company is "ISO 9001:2008" certified Company and has internal quality control as required for its various projects and assignments.

HSCC has been signing MOU with the Ministry of Health & Family Welfare since 1996-97. The Company has been rated excellent by DPE from the year 2007-08 to 2011-12 and expected to be rated 'Excellent' for the year 2012-13 based on its audited results.

The Company follows good Corporate Governance practices. Corporate Governance Practices in the Company focus on transparency, integrity, professionalism, accountability and proper disclosure. Knowledge Management System, e-tendering, e-procurement, Internal cum Concurrent Audit.

During the year the company had taken initiatives towards research and development for sustained and continuous innovation and incurred Rs. 5.80 lakh as under:-

- The Company prepared Reports for Bio-Safety Cabinet for use by Medical Doctors/Scientist/ Technician while handling unknown viruses and Environment Management.
- The Company developed system to monitor progress of Projects for timely Completion

During the year under review the company had made efforts towards **sustainable development and** incurred Rs. 5.73 lakh as under:-

- The Company prepared reports for development of Green Building concept for Hospital Projects and Q Management of OPD Patients in Hospitals.
- The Company provided training of the employees on aspects of sustainable developments.
- The Company has installed Solar Energy Equipment/Devices at corporate office building Noida.

During the year under review the company had made efforts towards **Corporate Social Responsibility** as under:-

- The Company has contributed during the financial year Rs. 4 lakhs towards Contribution to Prime Minister Relief fund;
- The Company has also organised Blood Donation camp and incurred Rs. 1.52 lakh towards this activity.

The Company was awarded the work of rendering Consultancy Services for Design & Engineering, Project Management and Procurement of Medical Equipments, Drugs & Pharmaceuticals etc. for various prestigious & challenging projects in India and abroad. A list of the major on-going projects where HSCC is rendering Consultancy Services is as under:

Summary of Major On-Going Consultancy Projects as on date

A. Architectural Planning, Design Engineering & Project Management Services

- Construction of North Eastern Institute for Ayurveda & Homeopathy for NEIGRIHMS, Shillong;
- Construction of General hospital at Naharlagun (A.P);
- Construction of PG Gents & Ladies Hostel, UG Ladies Hostel, Nursing Hostel and Internee Hostel at Regional Institute of Medical Sciences (RIMS), Imphal (Package-I);
- RIMS, Imphal (Package-II) - Construction of OPD block;
- Construction of Bio-Safety Level-3 Laboratory at RMRC, Dibrugarh;
- Construction of Super Specialty Block, OPD & Academic Block at Kolkata Medical College, Kolkata under PMSSY;
- Construction of Super Specialty Block, OPD & Academic Block at Kolkata Medical College, Kolkata under PMSSY;
- Construction of Super Specialty Block at Dr. R. P. Govt. Medical College, Kangra at Tanda (H.P) under PMSSY;
- Construction of Guru Tegh Bahadur Diagnostic Centre at Govt. Medical College, Amritsar under PMSSY;

- Construction of AIIMS Housing Balance and phase-II work at Bhubaneswar (Odisha) under PMSSY;
- Construction of PC Teaching Block for AIIMS within AIIMS Campus, Ansari Nagar, New Delhi;
- Construction of Dinning Block for AIIMS within AIIMS Campus, Ansari Nagar, New Delhi;
- Construction of Hostel block 1, 2, & 3 for AIIMS within AIIMS Campus, Ansari Nagar, New Delhi;
- Redevelopment (Phase-I) of Safdarjung Hospital, New Delhi;
- Super-speciality Block at Dr. Ram Manohar Lohia Hospital, New Delhi;
- Construction of All India Institute of Ayurveda (Under Department of Ayush, Ministry of Health & Family Welfare) at Sarita Vihar, New Delhi;
- Comprehensive Re-development Plan for Lady Hardinge Medical College, New Delhi;
- National Institute of Unani Medicine (NIUM), Bengaluru Construction of Regimental Therapy Block, Auditorium& Pharmacy building under phase-III works;
- Development of New Campus for IICB, Salt Lake, Kolkata;
- Nursing college & National level Physiotherapy Workshop at GMC, Patiala;
- Substation Work GMC, Patiala;
- Advanced Cancer Diagnostic,Treatment & Research Centre, Bhatinda;
- National Institute of of Animal Bio-technology, Hyderabad;
- Kalpana Chawla Govt. Medical College, Karnal, Haryana;
- Govt. Medical College at Palakkad, Kerala;
- Mother & Child-Metro Block within the campus of Bengaluru Medical College for Bengaluru Metro Rail Corporation;
- Construction of 750 Beded Hospital (Phase-I-400 beded) for IIT Kharagpur;
- Vaccine processing facilities for Institute of Veterinary Biological Products, Pune;
- IMTEC, Chandigarh.
- Punjab Health Systems (PHC's & CHC's);
- National Centre for Disease Control (NCDC), New Delhi;
- Pediatric Hospital, Srinagar;
- Mother & Child Hospital, Govt. of J&K;
- J & K-PCC and
- NRHM-Chhattisgarh, Uttar Pradesh, Kerala & Himachal Pradesh.

Abroad

- 200 Beded Emergency and Trauma Centre for Bir Hospital, Kathmandu, Nepal.
- District General Hospital at Dickoya, Sri Lanka.

B. Procurement Management Services

- Medical Equipment for NEIGRIHMS, Shillong.
- Drugs and Pharmaceuticals for Central Government Health Schemes.
- Procurement of Equipment for AIIA Sarita Vihar.
- Medical Equipments for Bir Hospital, Kathmandu, MEA.
- Supply of Medical Equipment for Sri Lanka.
- Medical Equipments for Yangon & Sittway Myanmar.

Financial Highlights

During the year 2012-13, the Company has completed 30 years and continued to maintain an all round progress in its activities and operations.

The Company's financial achievements during the year 2012-13 are as under:-

- Highest ever Total income of Rs. 5835 lakhs as compared to Rs. 4458 lakhs in the previous year resulting 30.90% growth,
- Highest ever Consultancy Fee of Rs. 3380 lakhs as compared to Rs. 2929 lakhs for previous year resulting 15.40% growth,
- Highest ever company's profit before tax was at Rs. 3600 lakhs as compared to Rs. 2352 lakhs in the previous year resulting 53.10% growth,
- Highest ever Net Profit of Rs. 2257 lakhs as compared to Rs. 1471 lakhs in the previous year resulting 53.50% growth,

- Highest ever Reserves & Surplus at Rs. 10347 lakhs as compared to Rs. 8708 lakhs in the previous year resulting 18.82 % growth,
- Highest ever Net Worth touched at Rs. 10587 lakhs as compared to Rs. 8948 lakhs in the previous year resulting 18.32 % growth,
- Highest ever Dividend of Rs. 468.03 lakhs compared to Rs. 300.02 lakhs in the previous year resulting in increase from 125% to 195% of paid-up capital.

This is the 28th consecutive year in which the company has recommended dividend and with this the cumulative dividend till 2012-13 will stand at Rs. 3058.19 lakhs.

15.44 PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) has been launched with the objectives of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services and to also augment facilities for quality medical education in the country. PMSSY has two components-setting up of AIIMS like institutions and upgradation of State Government Medical Colleges.

In first phase, six AIIMS are being set up, one each at Bhopal, Bhubaneswar, Jodhpur, Patna, Raipur and Rishikesh. Two more AIIMS, one each in Uttar Pradesh and West Bengal have been approved. Simultaneously, 19 existing Government Medical College Institutions have been undertaken for upgradation for creation of super speciality facilities in the first and second phases of PMSSY. In addition, it has also been decided to take up upgradation of 39 (thirty nine) more medical college institutions in the third phase of PMSSY.

Approved project cost for the entire PMSSY Projects is as given under:-

(Rs. in crore)

	Capital Cost	Recurring Cost	Total
1st Phase	6210	3097.62	9307.62
2nd Phase	2396	1031.5	3427.50
3rd Phase	5071	0	5071.00
Total	**13677**	**4129.12**	**17806.12**

Setting up of six AIIMS (PMSSY Phase-I)

50 MBBS students, selected on the basis of All India Entrance Examination, 2012 were admitted in each AIIMS (totalling 300 students) to the 1st MBBS course for Academic Session 2012-13. During academic session of year 2013-14, about 100 students in the second batch of MBBS and 60 students in the first batch of B.Sc. Nursing have been admitted in each AIIMS (totalling 600 MBBS and 360 B.Sc. Nursing). OPD Services have also commenced at all six new AIIMS. IPD Services for teaching purpose have commenced at five AIIMS, viz. AIIMS Bhubaneswar, AIIMS Patna, AIIMS Raipur, AIIMS, Jodhpur and AIIMS Rishikesh.

AIIMS Act has been amended by enactment of AIIMS (Amendment) Act, 2012 which has come into force with effect from 16th July, 2013. The amendment has brought new AIIMS under the ambit of AIIMS Act, 1956 and also provides for establishment of more than one AIIMS at various locations. In order to meet day to day functional requirement, the Directors of six new AIIMS have been delegated certain administrative and financial powers till Institute body is constituted and its first meeting is held. In addition, Ad-hoc Committees for selection of personnel to various cadres and for finance were constituted. The Central Government has approved creation 4089 posts in faculty and non-faculty grades for each new AIIMS. The approval has been conveyed to respective Institutes for further necessary action.

The Ministry has appointed M/s. HLL Life Care Ltd. as Procurement Support Agent (PSA) for procurement of equipments for six new AIIMS. PSA has initiated process of procurement. Separately, the Institutes have been advised to procure equipment to meet their minimum operation requirement for the current academic session and starting hospital this year.

Setting up of two AIIMS (PMSSY Phase-II)

The Central Government has approved establishment of one AIIMS each in the States of Uttar Pradesh and West Bengal. The Government of Uttar Pradesh has transferred the land to the Central Government for establishment of AIIMS at Rae Bareli. The Ministry has appointed M/s. HSCC (I) Ltd. as Project Management Consultant for the Project. Work for construction of housing complex for the AIIMS, Rae Bareli has started and is

in full swing. Tender for Hospital and Teaching Blocks is being finalized.

For the proposed AIIMS at Raiganj, West Bengal, the land is yet to be allotted by the State Government.

Upgradation of Government Medical Colleges (Phase-I, II & III)

The upgradation programme broadly envisages improving health infrastructure through construction of Super Speciality Blocks/Trauma Centres etc. and procurement of medical equipments for existing as well as new facilities. The upgradation of Medical Colleges has been undertaken in phases as under:-

Phase-I

Out of 13 medical colleges taken up for upgradation in the first phase of PMSSY, civil work at eight medical college institutions (viz. Trivandrum Medical College; Salem Medical College; Bengaluru Medical College; SGPGIMS, Lucknow; NIMS, Hyderabad; Jammu Medical College; Rajendra Institute of Medical Sciences (RIMS), Ranchi; and IMS, BHU, Varanasi has been completed.

In respect of Kolkata Medical College, construction of OPD Block, Academic Block has been taken up and 1st stage of construction has been completed and for the Super Speciality Block which is to be taken up in the second stage of construction, tender process has been initiated. 98% of work has been completed at Srinagar Medical College. In regard to Sree Venkateswara Institute of Medical Sciences (SVIMS), Tirupati; Grants Medical College, Mumbai and B.J. Medical College, Ahmedabad where upgradation involves procurement of medical equipments only, the procurement process is likely to be completed by July, 2014.

Phase-II

Out of 6 Medical College institutions taken up for upgradation in the second phase, civil work involves five institutions and the progress/status is as under:-

1. R.P. Government Medical College, Tanda - Civil work completed and the new SSB has been inaugurated on 1.3.2014;
2. Jawaharlal Nehru Medical College of AMU, Aligarh (86%);
3. Government Medical College, Amritsar (45%);
4. Pt. B.D. Sharma Postgraduate Institute of Medical Sciences, Rohtak (39%) and
5. In respect of Madurai Medical College, due to change in location for the new Super Speciality Block, plan had to be modified. The civil work has started in February, 2014.

At Government Medical College, Nagpur upgradation programme involves only procurement of equipments and entire procurement work is being undertaken by the Institute/State Government. An amount of Rs. 77.81 crore has been released to the Institute and expenditure of Rs. 36.14 crore has so far been made.

Phase-III

The Central Government has approved upgradation of additional 39 medical colleges under third phase of PMSSY-Upgradation on 07.11.2013. Gap Analysis Committee(s) have been constituted to conduct gap analysis/assess requirement of these medical colleges. In addition, Standard Tender Document, Standard Contract Agreement and IPHS guidelines for multi-speciality hospitals have been prepared by the Committees constituted for the purpose and these are under finalization. HLL, HSCC and CPWD have been appointed as Project Management & Supervision Consultants for civil work at the 39 upgradation projects. 9 medical colleges were identified for upgradation on priority basis.

Foundation stone of Government Medical College, Patiala has been laid by Hon'ble Health & Family Welfare Minister on 23rd February, 2014.

An expenditure of Rs. 21.05 crore and Rs. 2580.06 crore has been made for the entire PMSSY projects during X Plan and XI Plan respectively. An allocation of Rs. 12,000 crore has been made for XII Plan for the entire PMSSY projects. Year wise allocation and expenditure during XII Plan is as given below:-

(Rs. in crore)

Year	BE	RE	Expenditure
2012-13	1544.21	1010.00	973.50
2013-14	1975.00	1,377.00	1,282.11

15.45 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS), MUMBAI

International Institute for Population Sciences, Mumbai, was established in 1956 as the Demographic Training and Research Centre. The Institute is a "Deemed University" functioning under the administrative control of the Ministry of Health and Family Welfare, to impart training, conduct research and provide consultancy services in the field of Population Studies. The Institute has six Departments viz. Department of Mathematical Demography and Statistics, Department of Fertility Studies, Department of Public Health and Mortality Studies, Department of Migration and Urban Studies, Department of Population Policies and Programmes, and Department of Development Studies. In addition, Department of Extra Mural Studies is functioning since August 1993 on yearly project basis. Apart from the Director & Senior Professor, the faculty consists of 39 members, who are engaged in both teaching and research.

Teaching Programmes

During the year 2012-13, the Institute offered the following regular courses: (a) Diploma in Health Promotion Education (DHPE), (b) Master of Arts/ Science in Population Studies (M.A./M.Sc.), (c) Master of Population Studies (MPS), (d) Master of Philosophy in Population Studies (M.Phil.) and (e) Doctor of Philosophy in Population Studies (Ph.D.). Apart from these programmes, the Institute also offers Master of Population Studies (MPS) and Diploma in Population Studies (DPS) through distance learning.

During 2012-2013, 19 students qualified for award of Diploma in Health Promotion Education, 21 students qualified for award of degree in Master of Arts/Science in Population Studies, 46 students qualified for award of degree in Master of Population Studies, 35 students qualified for the award of degree in Master of Philosophy in Population Studies, 14 students had qualified for the award of Doctor of Philosophy in Population Studies, 27 students qualified for award of degree in Master of Population Studies (Distance Learning) and 1 students had qualified for the award of Diploma in Population Studies (Distance Learning).

Research Programme

Institute conducts research programme using its own resources and also through external funding. The externally funded projects are usually initiated at the request of the concerned agencies. The completed and ongoing projects at the Institute are given below.

A. Research Projects funded by the Institute

Completed Projects

- Functional Classification of Indian Towns;
- Digitization of Census Volumes 1872-1941.

Continuing Projects

- Understanding the pathway of poverty and fertility reduction in India;
- International Migration from Gujarat;
- Socio-economic and health conditions of Nepali migrants In Mumbai and
- Health Infrastructure and MCH Care in the Rural Areas of India.

New Projects

- Magnitude, Causes and Consequences of Kala-azar in India: A Study of Eastern Bihar;
- Use of verbal autopsy for estimating the causes of death in Amravati district of Maharashtra;
- A comparative study of two different methods of data collection used in a large-scale survey in India;
- Estimation of Vital Rates for Mumbai Presidency in the Colonial Period and
- Population Scenario in India: Long Term Prospective;

B. Research Projects funded by External Agencies

Completed Projects

- Training of District Level Officers (TDLO);
- Intergenerational Transfers, Population Aging and Social Protection in India and
- TMLM Project.

Continuing Projects

- Longitudinal Aging Study in India (LASI)-Pilot;
- Study of Global Ageing and Adult Health (SAGE)-India;
- Family Health and Wealth Study (FHWS);
- District Level Household and Facility Survey-4;
- Health of the Urban Poor (HUP);
- Comprehensive Nutrition Survey in Maharashtra;
- Vital Rates Survey in Nagaland (VRS Nagaland) and
- Enhancing Capacity to apply research evidence in Policy Making.

New Project

- Conditional Cash Transfer (CCT) Schemes and Welfare of Girl Children: Beneficiary Assessment of Select Schemes.
- Coprehensive Nutrition Survey in Gujarat.

Short-term Training/Instructional Courses

The Institute conducts short-term training courses on request. The following two short-term training programmes were conducted during the academic year 2012-13.

- "Demography, Gender and Reproductive Health" was organized during 8th July to 4th August, 2012.
- Population and Development Course for participants from Bhutan commenced on 1st October, 2012 and ended on 12th October, 2012.

Conferences/Seminars organised by IIPS

World Population Day

Observance of "World Population Day" on 11th July every year is one of the important activities of the Institute.

National Seminar

A. **National Seminar-** National Seminar on Population Health and Environment was organized by IIPS in collaboration with Indian Institute of Forest Management, Bhopal during 21-23 March, 2013. Focus of the seminar was to recognize the interconnectedness between people and their environment. Around 150 papers were presented in three plenary sessions, 19 oral and two poster sessions. First plenary session was on Health and Development in India, second dealt with Natural Resources and Environment and third was on Health and Development in Madhya Pradesh.

B. **Seminar on Migration-** A National Seminar on **"Migration and Development: Opportunities and Challenges"** was jointly organized by R.J. College, Mumbai and IIPS on 4-5th January, 2013. More than sixty papers were presented that focused on various issues related to migration, development, gender, environment and health. A poster competition was also organized for the college students.

Other Activities held at the Institute

Publication Unit- IIPS has a well-established publication unit. Periodically IIPS publishes Newsletters, Research Briefs and Working papers.

- **IIPS Newsletter:** The Institute brings out Newsletters, which publish information about various ongoing activities of the Institute. Two issues of IIPS Newsletters covering four numbers were printed during the academic year, 2012-13.
- **IIPS Research Brief Series:** The 'Research Brief Series' is a new initiative of the Institute started in 2007, to provide an opportunity to the faculty, Ph.D. students and visiting fellows to quickly disseminate the important findings of their research studies before they are published as a research report or in a scientific journal. So far 14 research briefs were published under this series.
- **IIPS Working Paper Series:** The 'Working Paper Series' is a new initiative started during 2009-10. Its main objective is to disseminate new research ideas, theoretical development and methodological insights initiated by IIPS to the national and international community as quickly as possible. The papers published under this series are peer-reviewed by two external experts working in the areas of Population, Health and Development. So far, 8 working papers were published.

Demography India Journal

The professional Journal of Indian Association for the Study of Population (IASP) is presently managed at IIPS. This long standing journal publishes peer reviewed articles and book reviews, focusing on demographic and health issues and more specifically on Indian Demography.

Information, Communication and Technology (ICT) Unit

The ICT Unit of the institute which was till recently known as the Computer and Data Centre is well equipped with the latest Pentium IV and higher generation computers and statistical software required for data analysis. The Unit has one main class room/lab room with 42 computers with three LCD projectors, another small class room/lab with capacity of 16 computers and LCD. Computer classes for MPS, MA/MSc, M.Phil and short term courses are held in these labs. The software packages installed are IBM SPSS Version 20, STATA Version 10, GIS Version 10, ML Win, Atlas Ti, Spectrum, Mortpak and Endnote. All the computers are configured for internet access and connected by Local Area Network. The ICT Unit has network attached storage (Nasstor) server which stores data from Census, National Family Health Survey, District Level Household Survey etc. and also providing the internal email facility to the institute. Wireless internet facilities have been established and made available to the students in the hostels and library. There are a total 260 desktop computers and eight servers in the Institute.

The data set of Census of 1991 and 2001, National Family Health Survey I, II and III, District Level Household Survey I, II and III, Demographic Health Survey (DHS) and National Sample Survey (NSS) data are available to researchers. Data sets from GATS, Youth, LASI and SAGE projects are also provided to researchers who request these data sets. An e-book in the CD-ROM media containing the full papers of DPS/ MPS/M.Phil students seminar has been prepared, and six e-books on the topic related to the reproductive health, child and maternal mortality are also prepared. ICT unit is maintaining IIPS website. ICT unit is in the process of making website bilingual (English-Hindi). Steps have been initiated to start e-Governance in the institute to cover the functioning of the various Departments of the institute including Accounts and Administration.

Library

The Institute maintains an excellent library with most recent books on population and related topics. There are 81680 books, 14946 bound volumes of periodicals and 16601 reprints and 800 CD ROMS in the library. The library receives about 325 Indian as well as foreign journals, out of which 175 are received by the way of subscription and another 150 are received by gift & exchange. The bibliographic information of more than 25000 journal articles & book chapters have been indexed and made available in library catalogue through library operation software. The full text online databases offered in the library are JSTOR, INDIASTAT.COM, SCIENCEDIRECT (Soc. Sc. Collection) SCOPUS. The library also provide full text online access to core journals identified for the discipline of population studies from the leading publishers such as Sage, Taylor & Francis, Oxford, Wiley, Cambridge, Springer etc. The library has books on different disciplines such as Demography, Statistics, Public Health, Family Planning, Anthropology, Mathematics, Economics, Sociology, Psychology, Health Education, Political Science, Geography, Computer Programming etc. The library has a special collection of Census of India published during 1872-2011 and online accessible on the campus. The library also holding demographic related literature published by the United Nations, World Health Organization, World Bank, International Labor Organization, etc. The library is housed in a separate building on the first and second floors consisting of a reading hall with a seating capacity of 70 at a time. The library provides abstract and current awareness services, documentation, reference, Inter Library Loan and photocopying facilities. The library is fully automated in System for Library and Information Management (SLIM-21) which offers Online Public Access Catalogue (OPAC) in user friendly manner. The library has good collection of demography related books printed (in Devnagari script) Hindi language and indexed in Devnagiri script for retrieval. The IIPS library is a Member Library of INFLIBNET Centre (Information and Library Networking of UGC).

15.46 FAMILY WELFARE TRAINING & RESEARCH CENTRE (FWTRC), MUMBAI

Family Welfare Training & Research Centre (F.W.T. & R.C.), Mumbai is a Central Training Institute responsible for the in-service training in the key health areas for different categories of health personnel all over the country. Training related to Primary Health Care, Family Welfare, R.C.H., HIV/AIDS and other integrated National Health Programmes are imparted to various categories of health professionals of state and district levels, i.e. DHOs, DEMOs, Key-trainers etc. from Health & Family Welfare Training Centres. Centre is also conducting a one year academic Post-graduate Diploma in Health Education (Renamed as Diploma in Health Promotion Education) for the candidates deputed from all over the country and also for candidates sponsored by WHO/UNICEF/UNDP/ DANIDA etc. The first course of D.H.P.E. was started in the year 1987-88. Presently, 27th batch of Diploma in Health Promotion Education Course is in progress, with 19 trainees from Maharashtra, Andhra Pradesh,, Madhya Pradesh and Odisha.

With the launch of Government of India's National Rural Health Mission and the present health care services, FWTRC Mumbai is also conducting a Post-Graduate Diploma in Community Health Care, for the para-medicals working in family welfare in Health Departments, NGOs and Private Sectors to improve their efficiency to cope up with the work under the NRHM for better delivery of health care services. This course is very much in line with the present mandate of national government to train medical manpower with rural background and serving in rural areas. The first course of this was started from October 2007. The duration of the course is 15 months. With total of 8 trainees, the fourth batch of PGDCHC has been completed in October 2013 and the fifth batch will commence shortly. Apart from regular training sessions, observational visits were also organized for the trainees during the academic year to various organizations such as K.E.M. Hospital, Water Treatment Plant, Sewage Department, Haffkine Institute and Research Centre etc. The trainees had also completed their three months field training and internship in their respective States/ Districts, the report of which was handed over by the trainees to FWT&RC.

The construction of the new Institutional premises of FWTRC, Mumbai at New Panvel, Navi Mumbai is progressing well. At present, approximately 60% of RCC structural work for Ground + 2 floors of the Institutional premises has been completed.

15.47 NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE (NIHFW), NEW DELHI

The National Institute of Health and Family Welfare (NIHFW), an autonomous organization of the Ministry of Health and Family Welfare, Government of India, acts as an 'apex technical institute' as well as a 'think tank' for promotion of Health and Family Welfare Programmes in the country. The Post-Graduate education and training, research and evaluation, consultancy and advisory services, specialized projects and specialized services in the field of health and family welfare have been the major focus of the Institute. In this endeavour, a wide range of issues have been addressed by the Institute through its departments like Communication, Community Health Administration, Education and Training, Epidemiology, Medical Care and Hospital Administration, Management Sciences, Planning and Evaluation, Population Genetics and Human Development, Reproductive Bio-Medicine, Statistics and Demography and Social Sciences.

Post-Graduate Education

Three regular courses under post-graduate education viz. (i) a three-year post-graduate degree (M.D.) in Community Health Administration; (ii) a two-year post-graduate 'Diploma in Health Administration'; and (iii) a one-year post-graduate 'Diploma in Public Health Management' have been conducted by the Institute. Also, three distance learning diploma courses of one-year duration each in 'Health and Family Welfare Management', 'Hospital Management' and 'Health Promotion' have been conducted regularly by the Institute every year.

New Initiatives in Post-Graduate Education

The Institute, with the support of European Union funded Institutional and Technical Suport (ITS) Project, is also developing five new courses viz. (i) Professional Development Course in Management, Public Health and Health Sector Reforms for Senior Medical Officers

on e-learning mode; (ii) Programme Management and Support Unit for Programme Mangers on e-learning mode; (iii) Post-graduate Diploma in Health Communication through distance learning for graduates as well as for those working in health sector; (iv) Post-Graduate Diploma in Applied Epidemiology for Medical Officers, Surveillance Officers and Epidemiologists; and (v) Post-Graduate Diploma in Public Health Nutrition for graduates working in Health sector.

In-service Training Programme

A large number of in-service training courses ranging from one to ten weeks duration for middle and senior level health personnel who are working at different levels in various parts of the country have been organized by the Institute. The notable in-service training course of the Institute is the Professional Development Course in Management, Public Health and Health Sector Reforms for Senior Medical Officers which is run by the Institute in collaboration with 15 collaborating training institutes situated in various parts of the country. Around 60 courses have been planned by the Institute for 2013-14 of which more than 20 have already been completed.

Research and Evaluation

The Institute is also known for its research endeavours and devotes a considerable time to research issues with special focus on operational research, applied research and evaluation of various health and family welfare programmes in the country. In all, the Institute has been engaged in 18 studies of which four have already been completed and the remaining are in various stages of execution. The completed studies during the year include: (i) Evaluation of immunization training of Medical Officers, Cold Chain handlers and Technicians; (ii) To study the knowledge and practices of school going Adolescents related to the use of smokeless forms of tobacco in selected states of India- a case study of state of Tamil Nadu; (iii) To study the knowledge and practices of school going. Adolescents related to the use of smokeless forms of tobacco in selected states of India- a case study of Assam; and (iv) Nursing Management for Reproductive and Child Health (RCH) Services in the North Eastern States of India.

Specialised Projects and Other Activities

RCH-II/NRHM

As a Nodal Institute for training under RCH-II/NRHM, the NIHFW has been continuing its responsibilities of organizing national level training courses and coordination of the RCH-II/NRHM training activities in various parts of the country with the help of 18 Collaborating Training Institutions (CTIs). Recently, three more institutions i.e., RIHFW, Baramulla, Jammu and Kashmir; RIHFW, Haldwani, Uttarakhand; and Regional Institute of Paramedical and Nursing Science, Aizawl, Mizoram, have joined as Collaborating Training Institutions.

Annual Sentinel Surveillance

The NIHFW continued with the responsibility of coordinating and monitoring of the Annual Sentinel Surveillance activities assigned by the National AIDS Control Organization (NACO). One of the key activities of the Project is to organise orientation trainings for the officers from all the States AIDS Control Societies and Regional Institutes (epidemiologists/micro-biologists and faculty from medical colleges/research organizations) to orient them to the operational guidelines for surveillance.

Annual Health Survey

Realising the need for generating comprehensive district level data on health and nutrition status of all the members of the family-fertility, mortality, maternal and child health, the Planning Commission has recommended Annual Health Survey (AHS) of all the districts. Currently, the survey is being carried out by the Institute in 284 districts in 9 States (Assam, Bihar, Chhattisgarh, Jharkhand, MP, Odisha, Rajasthan, UP and Uttarakhand).

District Level Household Survey (DLHS)-4

Ministry of Health and Family Welfare, Government of India, has included the Clinical, Anthropometric and Biochemical (CAB) component for data collection in the District Level Household Survey (DLHS)-4 during 2011-2013. International Institute for Population Sciences (IIPS), Mumbai, is the nodal agency to conduct the DLHS-4 and the responsibility of operationalizing the CAB component has been entrusted with National

Institute of Health and Family Welfare (NIHFW). In order to operationlize the CAB component for DLHS-4, the programme has been planned identical to AHS. The survey has been planned in 336 districts in the remaining 26 States and Union Territories (UTs) excluding those covered under AHS.

National Cold Chain and Vaccine Management Resource Centre (NCCVMRC)

NCCVMRC has been proposed to set up at NIHFW with the objective of building capacity of 500 district level cold chain technicians involved in Universal Immunization Programme to undertake the repair and maintenance of about 70,000 cold chain equipments in about 25,000 cold chain points in the country. In addition, about 50 cold chain officers and vaccine and logistics managers will be trained in vaccine logistics management at this Centre.

Health Policy Project (HPP)

The Policy Unit has been set up in the institute with the technical and financial support from USAID through Health Policy Project (HPP), Futures Group International, to undertake evidence based policy research and analysis, advocacy and multi-sectoral coordination on issues related to population, health and nutrition. Initially, the major focus of the Unit has been on population and family planning.

Mother and Child Tracking System (MCTS)

The MCTS centre has been established in the institute on October 1, 2012 with an objective to build the capacity for improving data quality on Mother and Child Tracking System (MCTS). The centre is working under the guidance of the Director, NIHFW, and the Ministry of Health and Family Welfare, Government of India.

National Health Portal

The Ministry of Health and Family Welfare, Government of India, has proposed to establish a Centre for Health Informatics at NIHFW under the overall administrative control of the Director, NIHFW. The work is in progress.

International Collaboration

NIHFW has been able to sustain the momentum in the process of collaborations with various international agencies such as WHO, UNICEF, USAID, Partners in Population and Development (PPD), INCLEN, Futures Group and European Union, IHBP, etc.

Use of Hindi in Official Work

The institute attaches due recognition to the use of Hindi in official work as part of official language implementation policy in the Institute. For example, to mark the significance of Hindi, the Institute proudly publishes a Hindi publication called *'Dhaarna'* with the articles contributed by the faculty and staff members of the Institute and others on issues like public health, population and family welfare.

Consultancy and Advisory Services

The Director and faculty members of the Institute have the privilege of serving as experts in various selection committees set-up by the national and international organizations and training courses and workshops organized by different institutions in the country. Also, they have honour to serve as examiners for Ph.D. and M.D. courses of different universities.

Specialized Services

Over the years, NIHFW has consistently retained its reputation as one of the centres of excellence in the area of reproductive health. As a regular activity, NIHFW publishes its quarterly journal - 'Health and Population: Perspectives and Issues'. The journal is indexed/ abstracted by nine national and international abstracting agencies. The National Documentation Centre (NDC) of the Institute fulfills the needs of the programme personnel and others who are concerned with health, population and family welfare.

Events

Events such as the World Population Day, Hindi Fortnight, Independence Day, Communal Harmony Week, World AIDS Day, Republic Day and Vigilance Awareness Week are observed every year.

15.48 RURAL HEALTH TRAINING CENTRE, NAJAFGARH, NEW DELHI

The centre was recognized as Rural Health Training Centre, Najafgarh in 1960, under the administrative control of Directorate General of Health Services

(DGHS), Govt. of India. In 1961 a decision was taken at the level of Directorate General of Health Services, Govt. of India to declare PHC, Najafgarh as a centre for imparting community health training for Medical Interns of Lady Harding Medical College under Rural Orientation of Medical Education (ROME) Scheme. To strengthen the Rural Health services, an ANM School was started in 1985 and vocationalised in 1991.

Training

- Training to Medical Interns under ROME Scheme. Around 350 unpaid Medical Interns undergone rural posting from this Centre.
- Training to ANM 10+2 (Voc.) Students with intake capacity of 40 students per academic session.
- Community Health Nursing Training to B.Sc/ M.Sc/GNM students of various Nursing Institutions like College of Nursing, Safdarjung Hospital, RML Hospital, Lady Hardinge Medical College, Holy Family Hospital, Batra Hospital, Apollo Hospital and various other Govt./State Govt./Pvt. Institutions. Nearly 1000 trainees were trained during the period.
- Promotional Training to Nursing Personnel.
- Health Education to the PGDHE Students.
- One Day Observation Visit.

15.49 GANDHIGRAM INSTITUTE OF RURAL HEALTH AND FAMILY WELFARE TRUST (GIRHFWT)

Established in 1964 with financial support from Ford Foundation, Government of India and Government of Tamil Nadu. The Health and Family Welfare Training Centre at GIRHFWT is one of 49 HFWTCs in the country. It trains Health and allied manpower working in PHC, Corporations/Municipalities and Tamil Nadu Integrated Nutrition Projects. During the year 2012-13, 21 persons were trained in Post Graduate Diploma on Health Promotion and Education course (PGDHPE).

Gandhigram Institute is also engaged in upgrading the capabilities of ANMs, staff nurses and students of nursing colleges through the Regional Health Teachers Training Institute (RHTTI). The RHTTI has under taken following activities during 2012-13 and 2013-14.

- **Diploma in Nursing Education and Administration (DNEA):** 9 number trained during 2012-13 and 2 enrolled for 13th batch of DNEA course during 2013-14. INC has instructed to upgrade the DNEA course into Post B.Sc. (N) Course, hence this being the last batch, candidate turnout is very less.
- Health Visitor Course (Promotional Training for ANM/MPHW (Female) (6 months)-15 trained during 2012-13 and 29 trained during 2013-14.
- Short-term training in Community Health Nursing: In short term training in community health nursing, total number of 628 were trained during 2012-13 and 939 during 2013-14.

For this activity during 2013-14 Rs. 250.00 lakhs were available under BE.

15.50 HLL LIFECARE LIMITED (HLL)

HLL Lifecare Ltd. (formerly Hindustan Latex Ltd.), [HLL] was incorporated on 1st March 1966 under the Companies Act, 1956. HLL was set up in the Rubber rich state of Kerala in 1969 with the objective of providing quality Male Condoms for Government of India's National Family Welfare Programme.

HLL is a *Miniratna* (Schedule 'B' category CPSE) under the administrative control of the Ministry of Health and Family Welfare with 100% shareholding by the Government. The authorized share capital of the Company is Rs. 300.00 crores and paid up share capital is Rs. 193.53 crore. The Company's Registered and Corporate office is at Thiruvananthapuram in Kerala.

HLL mainly focuses on developing and providing healthcare related products and services and has created a significant impact in the public health arena.

The purpose of business at HLL is "providing quality products and services at affordable costs". "Affordability" is single driving force at HLL and the vital element of HLL's Growth Strategy.

Manufacturing Units

HLL commenced its commercial operations on April 5, 1969 in the State of Kerala. Today, HLL has seven

state-of-the-art manufacturing facilities as mentioned below:

i. Peroorkada in Thiruvananthapuram (1969)- for Male Condoms;

ii. Kanagala near Belgaum (1985)- for Contraceptives and Pharmaceutical products;

iii. Akkulam in Thiruvananthapuram (1994)- for Hospital Products;

iv. Kakkanad in the Cochin Special Economic Zone (2004)- for Female Condoms and Male Condoms for export;

v. Manesar in Gurgaon (2007)- for Rapid *In-vitro* Diagnostic Test Kits;

vi. Indore (2010)- for production of a range of Pharma Products including Tablets, Capsules and Oral Rehydration Solution and

vii. Gajewal, Medak in Andhra Pradesh (2012) for Male Condoms.

The manufacturing unit at Peroorkada, in Thiruvananthapuram district of Kerala was set up in 1969 in technical collaboration with M/s Okamoto Industries Inc., Japan. The plant has undergone continuous modernisation over the years and has an annual production capacity of 1600 million pieces of condoms. The facility is equipped with modern machines and equipment for production, inspection and quality testing, conforming to GMP and meets international standards.

Akkulam Factory in Thiruvananthapuram district of Kerala is the state- of -the art facility for manufacture of Blood Bags and other medical devices namely Intra Uterine Devices (IUDs), Surgical Sutures, Hydrocephalus Shunts, Tissue Expanders and Tubal rings.

The annual production capacity of blood bags at the factory stood at 11.5 million pieces, copper IUDs-5.5 million pieces, surgical sutures-125000 dozens and tubal rings-2.5 million pairs. The products are exported to more than 20 countries. AFT has won awards for pollution control, productivity and innovation.

The Kanagala plant in Belgaum in the State of Karnataka commenced operations with the production of condoms in 1985 using Japanese technology. This unit underwent diversification in 1992 with the tabletting facility for birth control pills-Mala-D/N and the formulation and tabletting of Saheli (Centchroman) the indigenous, non-steroidal once-a-week pill. The tabletting of Emergency Contraceptive pills started in 2003. Commercial manufacturing of women healthcare products commenced in 2006. KFB has also added a world-class hormonal/steroidal formulation plant-UNIPILL Block in 2012.

HLL's female condom manufacturing facility at Cochin Special Economic Zone, Kakkanad in Kerala has been set up in technical collaboration with M/s. Female Health Company (FHC), US. It is the second generation of female condoms made from Synthetic Nitrile latex, the product generically being termed FC2. The installed capacity of the plant is 7 million pieces of FC2 per year. In addition, KFC has a fully automatic testing and packing facility for male condoms with an annual capacity of 150 million. This facility mainly caters to the export market.

In addition to the product certification, KFC is also certified by M/s TUV, with ISO 18001:2007 and ISO 14001:2004 certifications for safety, health and environment compliance.

HLL has its *in-vitro* immuno diagnostics kit manufacturing facility at Manesar in Gurgaon. It has an installed capacity to manufacture 26 million rapid pregnancy test kits per year. The unit commenced operations in November 2007. The unit manufactures rapid test kits for detection of metabolic hormones such as human Chorionic Gonadotropin (hCG) in urine and prognosis of diseases such as Dengue, Malaria (different strains), Kala-azar (leishmaniasis), TB, Chikungunya and other infectious diseases. The facility has Quality Management Systems like ISO 9001:2008, ISO 13485 and CE mark according to IVD 98/79/EC directive for pregnancy test cards for professional use brands like Makesure, P-Test and Nishchay.

Indore Facility, Indore (PFI): HLL's Indore facility commenced operation in April 2010 in the Industrial area in the commercial capital of Madhya Pradesh. The

facility manufactures a range of pharma products which include formulations such as tablets, capsules and Oral Rehyderation Salt. PFI also supplements the existing production facility of KFB in the area of women's healthcare products.

Gajewal facility, Medak, Andhra Pradesh (GFM): HLL's GFM commenced operations in Gajewal, Medak in Andhra Pradesh in 2012. The facility is equipped with modern production and testing machines with a capacity to produce 120 million Condoms annually.

Business Activities

HLL is engaged in manufacturing and supply of contraceptives and healthcare products like Condoms, Intra-uterine devices (IUD), Blood Bags, Surgical Sutures, Oral Contraceptive Pill's, Pharmaceuticals, Ayurvedic, Personal hygienic products and Diagnostic kits etc. through its seven production units - two at Thiruvananthapuram, and one each at Kochi, Belgaum, Indore, Hyderabad and Manesar. The range of services includes Infrastructure Development, Procurement Consultancy and Facility Management.

Financial Performance

The strategic and daring step taken by the Company in restructuring its business operations under six business groups has yielded laudable results with the company attaining highest ever revenue and profit. A summary of financial performance of the Company during the year ended 31st March, 2013 is given below.

Description	Amount (in lakh)
Revenue from operations (gross)	83,566.42
Less: Excise duty	(272.31)
Revenue from operations (net)	83,294.11
Other income	706.34
Total revenue	84,000.45
Expenses	
(a) Cost of materials consumed	19,036.76
(b) Purchases of stock-in-trade	18,365.52
(c) Changes in inventories of finished goods, work-in-progress and stock-in-trade	(2,769.18)
(d) Employee benefits expense	12,475.76
(e) Finance costs	1,402.68
(f) Depreciation and amortisation expense	2,084.96
(g) Other expenses	21,200.86
(h) Contract Expenses	8,422.22
Total expenses	**80,219.58**
Profit/(Loss) before Exceptional and extra ordinary items and tax	3,780.87
Exceptional items	---
Profit/(Loss) before tax	3,780.87
Tax expense:	773.40
Profit/(Loss) for the period from continuing operations	3,007.47
Profit/(Loss) from discontinuing operations	---
Profit/(Loss) for the period	3,007.47

New Facilities/Expansion

Capacity Augmentation of Surgical Suture manufacturing facility- During the year under review, HLL has augmented the production capacity of Surgical Suture manufacturing facility at Akkulam Factory, Thiruvananthapuram [AFT] to 6.25L dozen per annum from the existing level of 1.25L dozen, involving estimated capital outlay of Rs. 6.00 crore.

Augmentation of Sanitary Napkin manufacturing facility- HLL contemplates to augment capacity for production of Sanitary Napkins at Kanagala, Belgaum by adding one more Sanitary napkin machine at an estimated cost of Rs. 6.50 crore, including construction of a warehouse near the existing plant.

LNG Storage and Re-gasification facility- The Company is setting up a LNG Storage and

Re-gasification facility at it Condom manufacturing at Peroorkada in Thiruvananthapuram as usage of LNG as an alternative for furnace oil has various advantages. The project is estimated to cost Rs. 4.00 crore and the company has signed an MOU with M/s. Petronet LNG Ltd. to implement the project.

New Condom manufacturing plant at Kochi- The Company plans to acquired a Condom manufacturing facility at Irapuram, Kochi having annual installed capacity 300 M.Pcs involving estimated investment of Rs. 28.30 crore.

Physical Performance

A review of HLL's Physical Performance during year 2012-13 is given below:

HLL has achieved 100% capacity utilization at its Condom production units. Efforts are being made to achieve better capacity utilization for other products.

Manufacturing

Sl. No.	Product *	Unit	Installed capacity	Quantity manufactured	Capacity utilization (%)
1	Condoms	M.Pcs	1599.00	1629.23	101.89
2	Cu 'T'	M.Pcs	5.50	3.75	68.19
3	Blood Bag	M.Pcs	11.50	7.63	66.33
4	Steroidal OCPs	Million Cycles	98.66	46.23	46.85
5	Non-Steroidal OCPs	Million Cycles	30.00	28.52	95.07
6.	Pregnancy Test Cards	M.Pcs	26.00	19.14	73.63

* HLL's major products

Memorandum of Understanding

Department of Public Enterprises had rated the performance of the company as Excellent' for the year 2011-12.

Research and Development

The company's Research & Development Centre is implementing Research & Development projects in collaboration with Indian Institute of Technology, Kanpur, Indian Council of Medical Research, (HQ) New Delhi, Central Drugs Research Institute (CDRI), Sri Chitra Tirunal Institute of Medical Science and Technology (SCTIMST), Trivandrum, Regional Cancer Centre, Trivandrum, National Institute of Reproductive Research in Health, Mumbai, Population Council, Washington and International Vaccines Institute, Seoul.

The company proposes to set up an incubation centre at the Corporate Research & Development Centre for pilot scale production of products for clinical trials, stability testing and test marketing at an estimated cost of Rs. 158.20 lakh.

The amount spent on R & D activities during 2012-13 is given below:

Capital expenditure Rs. 1475.65 lakh

Recurring expenditure Rs. 22.66 lakh

Human Resources

The company gives high priority for development of human resources employed by it. With this objective, the company has formulated various policies for continuous development of employees collectively and

individually by providing appropriate training, motivation and employee welfare activities. During the year under review, the company had organized various training programmes involving 1205 man days for executives and 2086 man days for workmen.

During the year under review, industrial relations in the company continued to be very cordial and peaceful.

The company continues to follow the Presidential directives in respect of reservation to SC/ST/OBC Communities and efforts are taken to fulfil the directives in recruitment and promotion. Serious and focused effort was also taken for special recruitment drives.

The representation of SC/ST/OBC/Physically Challenged categories in the total employee strength as on 01.04.2013 is given below:

Descritpion	Number of employees
Representation of	
SC	301
ST	76
OBC	438
Physically challenged	41
Other categories	1019
Total strength	**1875**

Awards and Recognitions

The company obtained the following awards and recognitions during the year 2012-13.

- **"Performance Excellence Award 2012"** instituted by Indian Institute of Industrial Engineering (IIIE), in the Gold Category.
- Prestigious Indira Gandhi National Award from Government of India for the outstanding performance made by the Company in Official Language implementation consecutively for the 7th time.
- Awards from Town Official Language Implementation Committee (TOLIC) for implementation of OL Policy.
- The Hindi magazine "Samanvaya" bagged the first prize for best magazine instituted by TOLIC, Thiruvananthapuram.

15.51 HINDUSTAN LATEX FAMILY PLANNING PROMOTION TRUST (HLFPPT)

HLFPPT, a not-for-profit professional Health Service Organisation set up by the company continued to carry out projects under the following strategic areas.

- Social Marketing and Franchising;
- Prevention, care and support for HIV and Technical Assistance to NRHM;
- Knowledge Management and
- Engaging with PSUs and Private Corporates on Corporate Social Responsibility Projects.

HLFPPT has been rendering support in implementation of Reproductive and Child Health, HIV and AIDS Prevention, Care and Support Programmes in partnership with Ministry of Health & Family Welfare, Government of India, several State Governments and International Development agencies. HLFPPT has Pan India operations with offices in 21 States and core area is Reproductive Health.

The achievements during the year are summarized below:

Social Marketing and Franchising:

- In 2012-13, National Aids Control Organization [NACO] awarded the targeted Condom Social Marketing Programme to HLFPPT for implementation in six States namely Andhra Pradesh, Bihar, Delhi, Madhya Pradesh, Uttar Pradesh & Uttarakhand. The sales achieved in these states are - 62.3 million pieces of Condoms in UP & Uttarakhand, 9.4 million pieces of Condoms in Bihar, 12 million pieces of Condoms in MP, 4.5 million pieces of Condoms in Delhi, and 3.3. million pieces of Condoms in AP.
- HLFPPT is implementing Improved Family Planning and Reproductive Health Services project in Odisha and Bihar with support from DFID, to prevent unintended pregnancies and improve contraceptive prevalence especially among young, low parity, poor and socially excluded women.

- To facilitate reduction of Maternal Mortality Rate [MMR] HLFPPT is implementing the project Accelerating Access to Maternal Health Products and Services in 19 high focus districts of Rajasthan under the Brand name of Merrygold Health Network.
- With the endeavour to expand marketing of Contraceptives, HLFPPT initiated innovative project on Social Marketing of Cycle Beads with support from Institute of Reproductive Health. Cycle beads have been socially marketed and 5776 women are currently using this in 40 urban slums and 2 blocks of Kanpur district of Uttar Pradesh.
- HLFPPT worked as a consortium partner with FHI 360 and implemented a large scale Urban Health Initiative (UHI) focusing on family planning in 11 cities of Uttar Pradesh. Key role of HLFPPT was Social marketing of Oral contraceptive pills and Condoms. In 2012-13, the Trust sold 9.7 million pieces of Condoms and 4.2 lakh cycles of Oral Contraceptive Pills [OCPs].
- HLFPPT implemented Oral Rehydration Salt [ORS] and Zinc social marketing project in Lalitpur in 661 villages, with support from UNICEF. Lalitpur project was scaled up as project 'Amrit' in 22 districts in 6 States reaching more than 24,000 villages. ORS and Zinc were made available in more than 16,000 villages. More than 9,000 healthcare workers have been trained on diarrhoea management through ORS and Zinc and around 5 lakh households were reached through ORS and Zinc demonstrations.
- The Merrygold Health Network (MGHN) model is a social franchising model established across 35 districts of Uttar Pradesh to provide high quality, affordable Maternal and Child Health services. In 2012-13, under MGHN, 64 Merrygold Hospitals and 178 Merry silver clinics were operational in 30 districts of UP, with 9082 community level volunteers or Merry Tarang partners at remote village locations to provide information on maternal and new born care issues to women, refer women and accompany them to hospitals for Antenatal Care, Institutional deliveries, and family planning needs. In 2012-13, total services provided through this network include 15379 deliveries, 57217 Antenatal Care, 2759 Day Care procedure, 2110 IUD insertion, 429 sterilization cases. The Couple Year of Protection for 2012-13 is 21386.

HIV Programming and Technical Support in Sexual and Reproductive Health

- Technical Support Group (TSG) for Condom Promotion essentially functions with an intent to ensure continuous increase in the demand for socially marketed condoms and strengthen logistics, availability, accessibility, reduce wastage of free Condoms by working very closely with NACO. In 2012-13, totally 8,85,538 outlets were created across 15 States.
- As a commitment towards reducing HIV related morbidity and mortality in adults and children and mitigating the impact of HIV, HLFPPT implemented Promoting Access to Care and Treatment, through 34 Community Care Centers [CCCs] in 5 States and 1 Union Territory, with support of Global Fund through Population Foundation of India. 18,259 People Living with HIVs have registered in and accessed services from CCCs throughout the year 2012-13. 70 regular trainings and 91 refresher trainings were imparted for Medical Officer and Nurses and CCC staff.
- Link Worker Scheme project is being implemented with support from NACO, UPSACS, in 9 districts of Uttar Pradesh, to address complex needs for rural HIV prevention, care and support requirements. 360 Link Workers from village level workforce and 9175 volunteers have been trained on issues of HIV/AIDS, Gender, Sexuality, Sexual Tract Infections. 900 information centers, 1064 red ribbon clubs and 982 condom depots were established. 8866 HRG population, 40861 vulnerable population and 14272 bridge population, and 575 People Living with HIV (PLHIVs) were reached and linked to respective facility.
- Swagati Project (Intervention at TI level) was operational in coastal districts of Andhra Pradesh among the High Risk Groups. This community-

led initiative covered 8 districts and supported 18 Community Based Organizations, supported 22784 community members, facilitated 978 Community Based Groups, 842 community leaders were developed, 137 trainings were organized covering 4100 community members in 6 months on health, savings, social entitlement & crisis management, trained 136 paralegal volunteers, opened 1572 savings accounts for community members and facilitated 1430 formal IDs for the community members.

- In 2012-13, Female Condom scale-up programme was implemented in 18 districts of 9 States - Gujarat, Karnataka, UP, MP, Chhattisgarh, Punjab, Haryana, Delhi, and Assam. The programme aimed at empowering Female Sex Workers (FSWs) by addressing their vulnerabilities and building negotiation skills.
- HLFPPT continued to provide Technical Assistance to State Aids Control Society [SACS] in Andhra Pradesh, Madhya Pradesh & Chhattisgarh through Technical Support Units (TSU). The TSUs contributed significantly in strengthening HIV prevention through development and implementation of evidence based prevention strategies in the respective States.
- HLFPPT implemented Sankalp with support from the Employees' State Insurance Corporation (ESIC) in the States of Karnataka and Uttar Pradesh (UP). Sankalp with deep commitment to effect changes in the five important health issues, viz. RCH, HIV, malnutrition, lifestyle diseases and vector-borne diseases among industrial workforce and their family members.
- With support of Delhi State AIDS Control Society (DSACS) in 2012-13, HLFPPT capacitated 666 ASHAs in Delhi on basics of HIV AIDS and its preventive aspects. As part of HIV prevention and care mainstreaming effort, HLFPPT also build the capacities of 40 grass-root level NGOs working with People Living with HIVs & Orphans and Vulnerable Children, District Collectorate office staff and 125 school teachers in Delhi with DSACS support.
- HLFPPT continued promotion of voluntary blood donation in Kerala, with support of Kerala State Blood Transfusion Council, Kerala State Aids Control Society (KSACS) & Networking with NACO supported blood banks, donor motivator organizations and district forums, organize promotional events and voluntary blood donation camps etc. HLFPPT supported KSACS in initiating 400 Red Ribbon Clubs in educational institutions in Kerala and organized orientation programme & capacity building for student peer educators & Programme Officers in all 14 districts of Kerala.

Knowledge Management

- HLPPT has established knowledge management unit with the objective of documenting learnings in social marketing, various projects in HIV/AIDS and RCH; conducting research related to reproductive health and undertaking capacity building under NACP-IV and NRHM.
- To build capacity of health service providers on IUCD and Pregnancy Testing Cards, HLFPPT signed MOUs with State NRHMs of 10 high priority States viz. Assam, Bihar, Jammu & Kashmir, Haryana, Rajasthan, Chhattisgarh, Uttarakhand, Uttar Pradesh, Odisha, Jharkhand. 1865 health service providers were trained in 74 districts, 180 health service providers were provided hand holding at facility level on IUCD insertion, and as per programme mandate 5% IUCD clients were followed-up at household level.
- HLFPPT's innovative programmes during 2012-13 included development and roll-out of two e-learning modules on Family Planning and Infection Prevention & Waste Management. This was offered through a gateway and is accessible to programme managers and nursing professionals, across India.

HLL Biotech Ltd.

HLL Biotech Ltd. (HBL), the 100% subsidiary company incorporated in March 2012, is implementing the Integrated Vaccines Complex (IVC) project at Chengalpattu near Chennai. HBL started functioning from corporate office set up at TICEL Bio-Park,

Taramani, Chennai on 7th June 2012. The total manpower strength of HBL as on 31st March 2013 was 51.

HBL is in discussion with different Vaccine manufacturers and know-how providers for acquiring know-how/technology for Measles vaccine, Hepatitis B vaccine, Pentavalent vaccine and Haemophilus influenzae type b vaccine and Japanese Encephalitis (JE) vaccines in the first phase. The process technology for Rabies vaccine is developed in-house by HBL R&D team and the pre-clinical trials of the developed vaccine is progressing as per schedule.

The means of financing envisaged for Rs. 594 crore IVC project is 1:1 debt-equity. Out of Rs. 285 crore equity investment planned by Government of India, a sum of Rs. 178 crore has already been infused in two tranches.

15.52 REGIONAL OFFICE OF THE HEALTH AND FAMILY WELFARE (ROHFW)

Regional Offices of Health and Family Welfare (ROH&FW) were established by merging Regional Coordinating Offices (RCO) and Regional Health Offices (RHO) in 1978 to supervise, monitor and co-ordinate matters relating to centrally sponsored Health & Family Welfare Programmes. Currently, there are 19 Regional Offices of Health & Family Welfare functioning under the Directorate General of Health Services, located in the various State Capitals and headed by a Senior Regional Director. The essential units of the ROH&FW are: (i) Malaria operation Field Research Scheme (MOFRS), (ii) Entomological Section, (iii) Malaria Section, (iv) Health Information Filed Unit (HIFU) and (v) Regional Evaluation Team (RET).

Roles and Responsibilities:

- Liaison of centre-state activities for implementation National Health Programmes.
- Cross-checking of the quality of the malaria work, maintenance of free malaria clinic in the office premises and review/analysis of the technical reports related to NVBDCP.
- Checking of the records in respect of Family Welfare beneficiaries and other registers maintained during the tour and provide feedback related to Family Welfare programme activities.
- Organizing training for laboratory technicians, medical and para-medical staff as well other categories of staff on orientation in various National Health Programme.
- Specified responsibilities are undertaken by Regional Evaluation Team (RET), Health Information Field Unit (HIFU) and Malaria Operational Field Research Scheme (MOFRS).

Performance of Technical Activities:

The Activities under taken by ROH & FW for the year 2013-14 are as below:-

- 84 Review meetings were held with State Programme Offices to review implementation of National Health Programmes.
- Implementation of National Health Programmes was reviewed by filed visits to district & sub-district level health facilities.
- 384 Meeting were participated at National and State levels.
- 119 Training Programmes were organized in which 1263 participants were imparted training in malaria microscopy, ICD-10 and other activities.
- 5 drug resistance studies, 33 entomological survey and 27 evaluation studies were undertaken through MOFRS, RETS and CBHI teams.
- 337184 peripheral smears were cross examined for malaria. Of them 3148 slides were found with discrepancies. Feedback was given to concerning health care facility and corrective actions were taken.

15.53 NEW DELHI TUBERCULOSIS CENTRE, NEW DELHI

NDTB Centre is a referral Centre for TB patients from all parts of the country who could avail diagnostic and treatment facilities. The Centre was designated as State TB Training and Demonstration Centre for the state of Delhi in the year 2005. Since then the Centre has been imparting training and retraining facilities to the medical and paramedical staff of the 25 Chest Clinics under RNTCP.

The Centre has a quality assured, well-functioning Laboratory which has been designated as Intermediate Reference Laboratory (IRL) by Central TB Division, Ministry of Health and Family Welfare, Government of India. The culture of mycobacterium and Drug Susceptibility Tests (DST) is performed in routine here. In addition, culture and DST is also carried out for samples of MDR suspects referred from 15 out of 25 Chest Clinics of Delhi. The IRL along with National Reference Laboratory at National Institute of TB and Respiratory Diseases have been truly the backbone for bringing the entire State under DOTS PLUS MDR Treatment since 2009.

The Bio-safety Level III Lab at New Delhi TB Centre is functioning with the introduction of newer diagnostic tests like Liquid culture MGIT 60 and Line Probe Assay (which gives the results within one week). The laboratory is providing free service to TB patients coming through Revised National TB Control Programme.

At present, the institute has following activities:

- Referral OPD services for TB and Allied diseases patients,
- Special Clinics for TB and Diabetes, TB and HIV, Chronic Obstructive Airways Diseases and Tobacco cessation clinic,
- State TB Training and Demonstration Centre related activities,
- Intermediate Reference Laboratory activities and
- Research in the field of TB and Respiratory Diseases.

Newer Initiatives taken during the year:

- A step forward by creating and launching its own website www.ndtbc.com. The site has information about various facilities and activities undertaken by the Centre.
- National level Programmatic Management of Drug Resistant TB trainings for medical and paramedical staff of northern states of India were started during the year.
- Faculty members participated in National level RNTCP appraisals of districts of different states preparing for DOTS Plus activities.
- Two Research papers prepared by faculty of the Centre were published in the International journals during the year in addition to publications in national journals.
- Three operational Research proposals prepared by faculty of the Centre were submitted to National Operational Research Committee under RNTCP for approval.
- The Institute has won the crown of being designated as a National Institute under RNTCP along with National Institute of TB and Respiratory Diseases, New Delhi, National Institute for Research in Tuberculosis, Chennai, NTI Bengaluru and Jalma Institute, Agra. The institute has been given the responsibility of acting as a nodal agency for involvement of other health sectors in RNTCP.
- "TB Supervisor Course" (Previously TB Health Visitor Course) has been re-designed and has got accredited by RNTCP India. The course material has been finalized and the course will commence from next academic year.

During the year 2012-13, 12663 patients visited and revisited the centre for diagnosis and treatment of tuberculosis and other respiratory diseases. In all, about 29,000 laboratory examinations were done including drug sensitivity, culture and drug susceptibility testing. As far as teaching and training activities are concerned, in all 1091 medical and para medical personnel have been trained including students from Maulana Azad Medical College and PG students from VP Chest Institute. Centre has been actively participating in National Conferences. During the year, 3 research papers were presented at NATCON 2012 and 1 paper was presented in the international conference at Kaula Lampur. Newer research projects were undertaken during the year by the faculty members in collaboration with the other institutes to contribute in the research in tuberculosis.

An insight on New Delhi TB Center's activities during 2013-2014:

Outpatient Attendance:

Parameters	Year 2012-13	Year 2013-2014	
		Achievement up to October, 2013	Target for 2013-14
New out patient registered	6815	4140	7400
Revisits of patients	5848	3056	6000
Total out patients attendance	12663	7196	13400

Patients attendance for utilizing various diagnostic/treatment facilities available at New Delhi TB Centre:

Parameters	Year 2012-13	Year 2013-2014	
		Achievement up to October, 2013	Target for 2013-14
Attending for Laboratory tests	28786	5824	11000
Attending for Mantoux test	5173	2684	5000
Taking treatment under DOT Centre of NDTB Centre	100	118	-
Radiological Examinations	582	390	680
Attending special clinics (Diabetes, HIV, COAD)	136	401	-

Trainings/IRL Visits/Publications:

Parameters	2012-13	Achievements up to October 2013
Personnel trained	1091	660
IRL Visits for EQA	26	-
Supervision & monitoring of chest clinics	36	3
Research and publications	7	4

Research Projects being undertaken

- Rapid screening of Ofloxacin resistance among MDR (TB) suspects by molecular and solid culture method - submitted to National OR Committee.
- Assessment of barrier for utilization of RNTCP services in an urban slum of Delhi - a community based study -submitted to National OR Committee.
- Capture Recapture study to assess the prevalence of TB disease in urban area of Delhi -submitted to State OR Committee.
- To study association of TB and Tobacco usage among DOTS patients in Delhi- submitted to State OR Committee.
- Genetic polymorphism of rare mutation in Rifampicin resistance of *M. tuberculosis infected patients*- Project being done by M.Sc. students posted in Laboratory.
- Usefulness of Florescent based Rapid Liquid culture method for diagnosis of tuberculosis in children - Project being done by M.Sc. students posted in Laboratory.
- Usefulness of colorimetric MTT assay for diagnosis of Multi Drug Resistant Tuberculosis in Low resource conditions-Project being done by M.Sc. students posted in laboratory.

- MD/MS Thesis in different subjects being conducted in collaboration- for PG students of Maulana Azad Medical College and Lady Harding Medical College.

15.54 CENTRAL HEALTH EDUCATION BUREAU (CHEB)

Central Health Education Bureau was established in 1956 under the Directorate General of Health Services to promote Health Education in the country. It plans and implements programmes for promotion of health education in the country through training of Health professionals in the field of Health Education and Promotion, production of prototype health education material (both electronic and printed material) for promotion of health education, conducting health behavioural research, dissemination of Health Education to the general population etc.

The Major activities of CHEB in the financial year 2013-14 were:-

1. Running Postgraduate Diploma course in Health Education, affiliated to University of Delhi and recognised by Medical Council of India since 1971.
2. A total of 43 Orientation Training Programmes have been conducted for International and National level students. The trainees comprised of medical students (undergraduate & postgraduate) and nursing students. A total of 1593 trainees have been provided orientation training on Health Education and Health Promotion during the year.
3. Development of IEC Action Plans for Preventive component of "National Programme of Prevention and Management of Burn Injuries" and of "Capacity Building for Establishment of Trauma Care Facilities in Govt. Hospitals on National Highways" in the identified states during 12th Plan (2012-17).
4. Actively contributed and participated in India International Trade Fair 2013 in Health pavilion of Ministry of Health & Family Welfare. The various health education activities like healthy lifestyle exhibition, drawing competition, and health educational games were organised for visitors coming to IITF 2013.
5. Innovations in Health Education awareness by Planning and Developing Health Tambola on topics such as Organ Donation, Health Equity, NCDs, Women Issues, Mental stress etc.
6. Celebrated World Health Day 2013 at Nirman Bhavan, New Delhi and screened 1260 officials for Blood Pressure to create awareness about the importance of getting regular blood pressure check-up. An exhibition on Healthy Life style was also displayed.
7. Celebrated World No Tobacco Day 2013 at National Bal Bhawan, New Delhi and organised exhibitions on Health Hazards of Tobacco, slogan writing competition and oath taking ceremony for the students enrolled during summer vacations.
8. Planning and conducting Health Awareness Programme on "Indian Organ Donation day" with NOTTO in March 2014.
9. Pretesting of Pledge form of draft Transplantation of human Organs and Tissue Rules- 2013.
10. Contribution in development of Health Education curriculum for class 3rd to 10th students along with NCD cell, Dte.GHS and NIHFW.
11. Display of 08 exhibitions on Healthy life style at different places in Delhi.
12. Launching new website of CHEB.
13. Draft of new edition of Booklet on "Healthy Lifestyle" finalised.

Chapter 16

FACILITIES FOR SCHEDULED CASTES AND SCHEDULED TRIBES

16.1 INTRODUCTION

The Scheduled Castes and Scheduled Tribes Cell in the Ministry continued to look after the service-interests of these categories of employees during 2013-14. The Cell assisted the Liaison Officer in the Ministry to ensure that representation from Scheduled Castes/Scheduled Tribes, OBCs and Physically Handicapped Persons in the establishment/services under this Ministry received proper consideration.

The Cell circulated various instructions/orders received from the Department of Personnel and Training on the subject to the peripheral units of the Ministry for guidance and necessary compliance. It also collected various types of statistical data on the representation of Scheduled Castes/Scheduled Tribes/OBCs/Physically Handicapped Persons from the Subordinate Offices/Autonomous/ Statutory Bodies of Department of Health & Family Welfare as required by the Department of Personnel and Training, National Commission for Scheduled Castes and Scheduled Tribes etc. The Cell also rendered advice on reservation procedures and maintenance of reservation particularly post based rosters.

During 2013-14 inspection of rosters was carried out in respect of four offices namely:-

GMSD	Guwahati
CGHS	Guwahati
CDL	Guwahati
CGHS	Nagpur

The salient aspects of the scheme of reservation were emphasised to the participating units/offices. Suggestions were made to streamline the maintenance and operation of rosters in these Institutes/Organizations. The defects and procedural lapses noticed were brought to the attention of the concerned authorities.

The representation of Scheduled Castes, Scheduled Tribes and Other Backward Classes in (i) the Central Health Services Cadre (administered by Department of Health & Family Welfare) and (ii) the Department of Health & FW, its Attached and Subordinate Offices as on 1.1.2013 is as follows:-

Name of Cadre	Total Employees	SC	ST	OBC
(i) Central Health Services : (All Group A Posts)	3283	526	186	230
(ii) Department of Health & Family Welfare-its Attached Offices.	1253	212	72	188

Note: This statement relates to persons and not to posts. Posts vacant, etc. have not, therefore, been taken into account.

16.2 PRIMARY HEALTH CARE INFRASTRUCTURE

Given the concentration of Tribal inhabitation in far-flung areas, forest lands, hills and remote villages the population norms have been relaxed at different levels of health facilities for better infrastructure development as under:

Centre	Population Norms	
	Plain Areas	Hilly/Tribal/ difficult Areas
Sub-Centre	5,000	3,000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Under the Minimum Needs Programme

27912 Sub Centres, 4001 Primary Health Centres and 948 Community Health Centres are in position in tribal areas as on 31.03.2012.

16.3 NATIONAL HEALTH MISSION (NHM)

In order to provide effective health care to the rural population throughout the country with special focus on 18 States with poor health indicators and weak health infrastructure, the Honourable Prime Minister has launched the National Rural Health Mission (NRHM) in April, 2005.The Mission adopts a synergistic approach by relating health to determinants of good health. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels addressing issues relating to manpower planning as well as infrastructure strengthening to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. The Union Cabinet vide its decision taken dated 1st May, 2013 has approved the launch of National Urban Health Mission (NUHM) as a Sub-Mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-Mission.

The Mission also aims at bridging the gap in Rural Health Care services through a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources. The ASHA would reinforce community action for universal immunization, safe delivery, newborn care, and prevention of water-borne and other communicable diseases, nutrition and sanitation. ASHA is provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norm could be relaxed for one ASHA per habitation depending on the workload.

The NRHM also provides an overarching umbrella to the existing programmes of Health & Family Welfare including RCH-II, Vector Borne Disease Control Programme, Blindness, Iodine deficiency, Leprosy and Integrated Disease Surveillance Programme. It addresses the issue of health in the context of sector-wide approach with focus on sanitation and hygiene, nutrition and safe drinking water.

The Primary Health Care Services in rural areas are provided through a network of 1,48,366 Sub Centres, 24049 Primary Health Centres, 4833 Community Health Centres across the country as on 31.03.2012. The services being provided through the above centres are available to all sections of population including SC/ST.

16.4 NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP)

Under National Vector Borne Disease Control Programme, the services for prevention and control of Malaria, Kala-Azar, Filaria, Japanese Encephalitis, Dengue/Dengue Hemorrhagic Fever (DHF) and Chikungunya are provided to all sections of the community without any discrimination. Since vector borne diseases are more prevalent in low social economic group focused attention is given to areas dominated by the tribal population in North Eastern states and some parts of Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Odisha & Karnataka. Additional inputs under externally assisted projects from Global Fund to N.E states and from World Bank to other States are provided, especially for control of malaria. World Bank is providing support for Kala-azar elimination in the states of Bihar, Jharkhand and West Bengal. In addition, the N.E. states are being provided 100% central assistance for implementation of the programme from domestic budget.

16.5 NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

Under the National Leprosy Eradication Programme, free leprosy diagnosis and treatment services are provided uniformly to all sections of the society irrespective of caste and religion including Scheduled Castes and Scheduled Tribes population. Intensified IEC (Information, Education and Communication) activities are carried out through the rural media to cover population residing in remote, inaccessible and tribal areas as one of the target groups where awareness generation activities are more focused.

Dressing material, supportive medicines and Micro-Cellular Rubber (MCR) footwear are provided for prevention of disability among persons with insensitive hands and feet. Re-Constructive Surgery (RCS) services are being provided for correction of disability in leprosy affected persons. An amount of Rs. 8000/- is also provided as incentive to each leprosy affected persons for undergoing re-constructive surgery in identified Govt./NGO institutions to compensate loss of wages during their stay in hospital. Medical facilities are provided to leprosy affected persons throughout the country residing in self-settled colonies. Funds are also allocated to NGOs under Survey Education Treatment (SET) scheme, most of which are working in tribal areas for providing services like IEC, prevention of disability and follow up of cases for treatment completion.

Disaggregated data on SC and ST population is also collected under the programme through monthly reports from States/UT's. During the year 2012-13, newly detected cases among the population of SC and ST were 18.49% and 17.01% respectively, whereas during the current year 2013-14 (Up to August, 2013) newly detected cases among the population of SC and ST are 19.13% and 16.69% respectively at National level.

16.6 REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

Under Revised National Tuberculosis Control Programme (RNTCP), the benefits of the programme are available to all sections of the society on a uniform basis irrespective of caste, gender, religion etc. The sputum microscopy and treatment services including supply of Anti TB Drugs are provided free of cost to all for full course of treatment. However, in large proportion of tribal and hard to reach areas, the norms for establishing Microscopy Centres has been relaxed from 1 per 1,00,000 population to 50,000 and the TB Units for every 1,00,000 population (as against 75,000 to 1,25,000). To improve access to tribal and other marginalized groups, there is also provision for:

- Additional TB Units and Designated Microscopy Centres (DMC) in tribal/difficult areas
- Compensation for transportation of patient & attendant in tribal areas
- Higher rate of salary to contractual staff posted in tribal areas
- Enhanced vehicle maintenance and travel allowance in tribal areas
- Provision of TBHVs for urban areas

16.6.1 Facilities for Tribal & Marginalized Groups

Revised National Tuberculosis Control Programme (RNTCP) provides quality diagnosis and treatment facilities including Anti TB Drugs to all TB patients irrespective of caste, creed and socio-economic status. However, to improve the access to services for tribal and other marginalized groups, norms for Designated Microscopy Centers (DMCs) and TB Units are relaxed by 50%. Some of the additional provisions are also made for effective service delivery with the following objectives:

- Encourage tribal population to report early in the course of illness for diagnosis;
- Enhance treatment outcomes amongst tribal population and
- Promote closer supervision of tribal areas by RNTCP staff.

16.6.2 Additional Provisions for Tribal areas

- Travel costs as bus fares for patients and one attendant is provided for follow-up and treatment. To cover these costs the patients are given an aggregate amount of Rs. 250/- on completion of treatment.
- Sputum collection and transport Rs. 100/- to Rs. 200/- per month per volunteer based on number of visits to DMC to hand over collected sputum.An amount of Rs. 100/- per month if there is a minimum of one visit to the health center per week with collected samples. Rs. 200/- per month for more than one visit per week to the center.
- Higher rate of salary to contractual STS, STLS & LT posted at TUs with tribal area DMC, at the rate of an additional Rs. 1000/- over and above the regular salary as a tribal area allowance.
- Increased rate of maintenance of two wheeler up to 20% in tribal areas.

16.7 NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS (NPCB)

The National Programme for Control of Blindness was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020. The Scheme is being implemented uniformly in all districts of the country. There is no separate provision for SC/ST population as benefits of the scheme are meant for all as per need. However, following initiatives have been implemented under the programme during the 12th Five Year Plan, keeping in view NE States including Sikkim, which are tribal predominant.

- Construction of dedicated Eye Units in North-Eastern States including Sikkim and other hilly states.
- Appointment of Ophthalmic manpower (Ophthalmic Surgeons, Ophthalmic Assistants and Eye Donation Counsellors on contractual basis) to meet shortage of ophthalmic manpower.
- Setting up of Multipurpose District Mobile Ophthalmic Units for diagnosis and medical management of eye diseases for coverage of difficult areas.
- Besides Cataract, treatment and management of other Eye diseases like Diabetic Retinopathy, Glaucoma, Laser Techniques, Corneal Transplantation, Vitreoretinal Surgery, Retina of Prematurity (ROP) and Squint under Childhood Blindness etc.

16.8 BUDGET ALLOCATION

Allocations are made for implementation of health programmes across all segments of the society. However, Programme Officers have been directed to ensure allocation of funds to an extent of 8.2% and 15.2% towards Tribal Sub-Plan (TSP) and Scheduled Caste Sub-Plan (SCSP) respectively. Under NRHM, State Governments have been advised to earmark certain percentage of allocation to districts with SC/ST population above 35% and propose the same in the Programme Implementation Plan (PIP) of 2013-14.

The allocation under Scheduled Caste Sub-Plan (SCSP) and Tribal Sub-Plan (TSP) for the year 2013-14 in respect of major health schemes /programmes is given in the table below:

Sl. No.	Name of the Scheme	SCSP	TSP
National Health Mission (NHM)-Centrally Sponsored Schemes			
1.	RCH Flexible Pool	1080.32	582.82
2.	Mission Flexible Pool	1164.57	628.26
3.	Routine Immunization	161.63	87.20
4.	Pulse Polio Immunization	162.64	87.24
5.	Iodine Deficiency Disorder Control Programme	10.10	5.45
6.	Strengthening of District Hospital for providing advanced secondary care	0.20	0.11
7.	Providing free generic medicines in all public Health institutions in the country	0.20	0.11
8.	National Urban Health Mission-Flexible Pool	0.20	0.11
9.	National Vector Borne Diseases Control Programme	115.57	62.35
10.	Revised National TB Control Programme	143.48	77.40

11. National Leprosy Eradication Programme	10.30	5.56
12. Integrated Disease Surveillance Programme	12.73	6.87
13. National Programme for Control of Blindness	46.47	25.07
14. National Mental Health Programme	40.41	21.80
15. National Programme for Health Care for Elderly	10.10	5.45
16. National Programme for Prevention and Control of Deafness	9.09	4.90
17. National Tabacco Control Programme	4.04	2.18
18. National Oral Health Programme	2.02	1.09
19. National Programme for Prevention and Control of Cancer, Diabetes, CVD & Stroke (NPCDCS)	60.61	32.70
20. Other new Initiatives under Non-Communicable diseases	1.01	0.54
21. Infrastructure Maintenance	995.70	537.13
Health (Non-NHM)-Centrally Sponsored Programme		
22. National Mental Health Programme	30.31	16.35
23. Assistance to State for Capacity Building (Trauma Care)	13.44	7.25
24. National Programme for Prevention and Control of Cancer, Diabetes, CVD and Stroke	73.75	39.78
25. National Programme for Health Care for Elderly	20.20	10.90
26. Human Resource for Health	232.68	125.53
27. Strengthening of State Drug Regulatory System	20.20	10.90
28. Strengthening of State Food Regulatory System	11.11	5.99
Total	**4433.08**	**2391.53**

Chapter 17

USE OF HINDI IN OFFICIAL WORK

17.1 PROGRESSIVE USE OF HINDI

The Ministry of Health and Family Welfare is committed to promoting to use of Hindi in Official work during 2013-14 as the annual programme issued by the Department of Official Language, Ministry of Home Affairs and Official Languages policy of the Union. The matter pertaining to the use of Hindi in the Ministry is supervised by a Joint Secretary in-charge of Official Language. There is an official language Division of the Ministry headed by a Director, reports to the Joint Secretary.

A number of measures have been taken for encouraging use of Hindi in the official work. They are summarized below:

17.2 IMPLEMENTATION OF 3(3) OF THE OFFICIAL LANGUAGE ACT

In pursuance of the official language policy of the Government of India, all documents covered under section 3 (3) of the Official Language Act, 1963 are being issued both in English and Hindi. Action plan based on the checkpoints identified in the Ministry has been prepared to ensure compliance of the official language policy. Annual programme and other orders/instructions issued by the Department of Official language were forwarded to all the sections of the Ministry and its subordinate/attached offices/autonomous organizations for information and directives were issued for their compliance.

17.3 OFFICIAL LANGUGE IMPLEMENTATION COMMITTEE (OLIC)

There is an official language Implementation Committee (OLIC) under the chairmanship of a Joint Secretary in-charge of the Official Language and its meetings are held regularly in each quarter. This committee checks out strategies implement the Constitutional provisions of Official Language Policy of the Union in the Ministry and its subordinate/attached offices/autonomous organizations and to achieve the targets prescribed in the Annual Programme issued by the Department of Official Language, Ministry of Home Affairs. The committee periodically reviews the progress made in the use of Official Language (Hindi) and suggests and recommends measures to be taken for the effective implementation of the official language policy. The subordinate/attached offices/autonomous organizations of the Ministry were also instructed for convening their OLIC meetings regularly.

17.4 HINDI FORTNIGHT

In order to encourage the use of Hindi in official work amongst officers/employees of the Department, the Hindi fortnight was organized in the Department during 14-30 September, 2013. Various competitions such as Hindi essay writing, Hindi Typing, Hindi noting/drafting, Hindi general knowledge, Hindi dictation and self-composed poetry recitation were organized. As many as 44 winners of these competitions were awarded with cash prizes and certificates.

17.5 HINDI WORKSHOPS

During the year three Hindi workshops were organized in the Department to encourage the officials to accomplish their minimum possible official work in Hindi. In these workshops various provisions relating to official language policy were explained and the participants were given training as how to install Unicode in their computers and how to type out letters in Hindi using the English key board. This session proved to very much thrilling and useful for all participants. In all 70 officers/officials participated in these workshops.

17.6 OFFICIAL LANGUAGE CONFERENCE

The Department has taken a new initiative from the current year to organize annually two Official Language

Conferences in all offices under its administrative control with a view to create conductive atmosphere for usage of the official language policy of the Union of India. The scheme was inaugurated on 26th December, 2012 at the National Institute of Mental Health and Neuro Sciences, Bangaluru. Hereafter, two days conference held on 22-23 February, 2013 in Pasture Institute of India (Tamil Nadu). More than 125 participants including representatives from various offices under the Department took part in the conference. On the opening day there were three sessions namely, 'the problems in usage of Official Language and their solutions, translation related technique and Standardization of Hindi and its spellings'. On the second day, two sessions were dedicated to the technological advancements where intensive training of 'offline' and 'online' Hindi typing was given to the participants on computers through Unicode using the English Key Board and they were made to practice the same. Whole session of conference performed by Shri Rajesh Shrivastva, Assistant Director (OL), Ministry of Health & Family Welfare, while Major orator of various sessions were: Shri Ram Niwas Shukla, Deputy Director (OL), Shri Manoj Abusaria, Deputy Director (OL) and Shri Rajesh Shrivastva, Assistant Director (OL). Programme held under Chairmanship of Shri B. Sekhar, Director, PII, Coonoor, (Tamil Nadu) was very successful.

17.7 INSPECTIONS REGARDING PROGRESSIVE USE OF HINDI

In order to oversee the achievement of targets laid down in the Annual Programme issued by the Department of Official Language, offices were inspected by the officers of the Ministry which included 9 offices of Chennai, Chandigarh, Kerala and New Delhi.

Chapter 18

ACTIVITIES IN NORTH EAST REGION

18.1 INTRODUCTION

A separate North East Division in the Department and a Regional Resource Centre at Guwahati has been set up to provide capacity building support to the NE States. Flexibilities have been provided under the RCH and NRHM Flexi pools to take care of the specific developmental requirements of the NE Region while ensuring that the national priorities are also kept in view. A scheme under the nomenclature 'Forward Linkages for NRHM in NE' has been specifically launched to take care of the secondary and tertiary care, infrastructure requirements of the NE States.

Problems in the Health Sector in the North Eastern States

- Shortage of trained medical manpower.
- Providing access to sparsely populated, remote, far flung areas.
- Improvement of Governance in the Health sector.
- Need for improved quality of health services rendered.
- Making effective and full utilization of existing facilities.
- Effective and timely utilization of financial resources available.
- Morbidity and Mortality due to Malaria.
- High level of tobacco consumption and the associated high risk to cancer.
- High incidence of HIV/AIDS in Nagaland, Manipur and the increasing incidence in Mizoram and Meghalaya.

18.2 NATIONAL RURAL HEALTH MISSION (NRHM) IN NORTH EAST

The National Rural Health Mission (2005-12) was launched to provide effective healthcare to rural population throughout the country with special focus on 18 States, which have weak public health indicators and weak infrastructure. These 18 States include all the 8 North Eastern States namely Arunachal Pradesh, Assam, Manipur, Mizoram, Meghalaya, Nagaland, Sikkim and Tripura. NRHM has been approved for continuation during the 12th Plan period also.

The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people. Reduction of child and maternal mortalities, population stabilization and reduction of disease burden on account of communicable disease like TB, Vector Borne Diseases, Leprosy etc. are some of turn key goals of the Mission.

Achievements under NRHM (2013-14):

- Beginning from 2005-06 total number of ASHAs selected in the NE States up till 2013-14 comes to 54439.
- 767 PHCs functioning on 24x7 basis in the NE States.
- 199 CHCs functioning on 24x7 basis in the NE States.
- 125 centres operational as First Referral Units (FRU), including DHs, SDHs, CHCs & other levels.
- AYUSH facilities is available in 1007 Centres, including DHs, CHCs, PHCs and other health facilities above SCs but below block level.
- 1.35 lakh Institutional Deliveries done.
- 31.14 lakh beneficiaries of JSY recorded.
- 1.68 lakh children fully immunized.

Forward Linkages to NRHM in the NE

With a view to complement the initiatives under the NRHM Programme, the scheme for Forward Linkages

to NRHM in NE has been introduced during the 11th Five year Plan with an outlay of Rs. 900 crore, to be financed from likely savings from other health schemes. This aims at improving the Tertiary and Secondary level health infrastructure of the region in a comprehensive manner. An outlay of Rs.748.00 crore has made for the scheme in the 12th Plan.

An amount of 110.00 crore has been allocated for the year 2013-14 under the Forward Linkages Scheme.

18.3 NORTH EASTERN INDIRA GANDHI REGIONAL INSTITUTE OF HEALTH & MEDICAL SCIENCES (NEIGRIHMS), SHILLONG

NEIGRIHMS is a super specialty teaching institute under the Ministry of Health & Family Welfare established in 1987 under the Meghalaya Regulation of societies Act 1983.

The objective of the institutes to provide advanced and specialized medical facilities of the highest level in the selected specialties and to serve as a regional referral service centre for comprehensive health care. The Institute is also conducting both the Post Graduate and Under Graduate courses in medical sciences. The B.Sc. Nursing programmed started by the Institute is the first technical graduate programme in the state of Meghalaya.

At present, the Institute has 467 beds. The number of beds will be increased to 500 with opening of new department. The institute at present is offering super specialty services in Cardiology, Neurology, CTVS, Urology and Gynaecology, ENT, Orthopaedics and Ophthalmology. These departments are very well supported by the department of Radiology, Anaesthesiology, Pathology, Microbiology, Forensic Medicine and Biochemistry.

MD/MS Programme in NEIGRIHMS

The Ministry of Health & Family Welfare has approved starting of MD/MS course in four disciplines i.e. Anaesthesiology, Obstetrics & Gynaecology, Pathology and Microbiology with two seats in each respective department. The MD/MS courses in these department has started in the current academic year with the recruitment of faculty PG course will be initiated in mort department.

A sum of Rs. 106.25 crore has been released to NEIGRIHMS during the year 2013-14.

The major projects of NEIGRIHMS are as under:

i) Expansion of Nursing College and Hostel at a total cost of Rs.61.89 crore was approved by the Standing Finance Committee (SFC) in its meeting held on 30-10-2013 under the chairmanship of Secretary (H&FW) and also approved by Hon'ble HFM. Administrative approval of the Competent Authority (HFM) has been conveyed to NEIGRIHMS on 16-01-2014. The institute has already initiated the process.

ii) Two EFC proposals that is Establishment of Under Graduate Medical College with Hostel and Setting up of Regional Cancer Centre at an estimated cost of Rs. 377.16 crore is under pipeline.

18.4 REGIONAL INSTITUTE OF MEDICAL SCIENCES (RIMS), IMPHAL

RIMS Institute along with the attached RIMS Hospital was transferred from the Society which managed the Medical College to the Ministry of Home in August, 1976. It was transferred from Ministry of Home to North Eastern Council (NEC) by a decision of the Government of India. When the Ministry of DoNER was formed and NEC was allotted to it, RIMS came under the Ministry of DoNER. RIMS again transferred from the Ministry of DoNER to the Ministry of Health & Family Welfare on 1st April, 2007 on the basis of Sidhu Committee recommendation and on the basis of MoU between NEC, DoNER and Ministry of Health & Family Welfare.

RIMS is an institute of regional importance catering to the needs of the North Eastern Region in the field of medical education by providing undergraduate and post graduate courses. RIMS is a 1074 bedded teaching hospital equipped with modern state of the art equipment and teaching facilities having an intake capacity of 100 undergraduate and 150 Post Graduate. It also runs the Ph.D. course in various subjects and M.Phil. in Clinical Psychology as well.

The courses being run alongwith intake capacity in the institute are as follow:

A	MBBS	100 seats per annum	15% AIQ
B	MD/MS/DCP	147 seats per annum	50% AIQ
C	M.Ch.	03 seats per annum	50% AIQ
D	M.Phil.	07 seats per annum	
E	B.Sc. Nursing	50 seats per annum	
F	BDS	50 seats per annum	15% AIQ

RIMS has projected an outlay of Rs. 2527.37 crore during the 12th plan period. This amount will be used for procurement of medical equipments, expansion and development of infrastructure of the Institute and for enhancement of annual intake of the students in various courses. The project components under this phase are as (a) Hospital Repair/Renovation (b) Academic Complex & Library (c) Bio Medical Waste Disposal (d) Water Supply, Drainage & Sewerage (e) Compound Wall/ Fencing (f) Guest House (g) Hostel Accommodation (h) New OPD (i) Nursing College (j) Dental College etc.

A sum of Rs. 227.40 crore has been released to RIMS during the year 2013-14.

The major projects of RIMS are as under:

i) The project for up-gradation of RIMS to bring it at par with AIIMS, New Delhi (Phase-II) at an estimated cost of Rs. 129.00 crore is under implementation, which is also monitored by the PM Office on monthly basis.

ii) Increasing the number of undergraduate seats from 100 to 150 for which EFC proposal at a cost of Rs. 202.00 crore has already been approved.

18.5 LOKOPRIYA GOPINATH BORDOLOI REGIONAL INSTITUTE OF MENTAL HEALTH, TEZPUR, ASSAM

The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH) is a tertiary care standalone speciality care institute in the field of mental health and allied sciences under the Ministry of Health and Family Welfare, Government of India. The LGBRIMH was established in the year 1876 in the Sonitpur district of Assam. It caters to the needs of the country with special emphasis to the North Eastern Region. The institute is modelled after NIMHANS and it is expected to become a comprehensive neuro psychiatric unit during the forthcoming years.

The LGBRIMH has been set up as an autonomous institute by the Govt. of India with key areas of expertise in the Treatment, Teaching, and Research activities in the field of mental health and allied sciences. The institute has an attached hospital with inpatient care facilities for 336 patients of different diagnostic groups for both male and female patients. The inpatient facilities are offered free of cost to all the patients and the patients are also provided free food, medicines, diagnostic facilities, linen and other aids of daily living during their stay in the hospital. The institute offers regular post-graduate and post-masters courses under the Gauhati University in Psychiatry, M. Sc. in Psychiatric Nursing, M. Phil in Psychiatric Social Work and M. Phil in Clinical Psychology courses, and also Post-Basic Diploma course in Psychiatric Nursing. Other than these the institute also offers short term training for the students of various institutions across the country. The institute is also engaged in various research activities in the field of mental health as stipulated by the requirements of the training courses.

During the year, the institute has contributed significantly in its assigned role of patient care, manpower development, collaborative ventures and research in the field of mental health. The institute has also initiated certain innovative welfare programmes for the community in large. The following summary and presented statistics are reflective of the activities undertaken by the institute during the last year.

Patient care statistics of the Institute:

OPD Treatment:

- From April 2013 to October 2013, a total of 55180 patients visited the OPD which included 29652 male patients and 25528 female patients.

Patient Admission:

- From April 2013 to October 2013, a total of 911 patients were admitted for in patient care and treatment of which 705 were male patients and 206 female patients.

Patient Discharge:

- From April 2013 to October 2013, a total of 902 patients were discharged which included 686 male patients and 216 female patients.

Student Intake during the last year:

- A total number of 35 students were enrolled under different courses (i.e. M. Phil in Psychiatric Social Work-5, M. Phil in Clinical Psychology-4, M.D. (Psychiatry)-2, D.N.B. (Psychiatry)-2, M. Sc. Nursing (Psychiatric Nursing)-12 and DPN-10 for the various courses run by the institute during the session 2013-14.
- Statistics of Students passed out during the last academic session is as follows MD-3, M. Sc. in Psych nursing-10; M .Phil in Clinical Psychology-3; M. Phil in Psychiatric Social Work-3; Diploma in Psy. Nursing-3.

Financial indicators during the year:

- The Budget for the year Rs. 64.00 crore
- The Revised estimate is Rs. 118.00 crore
- The overall expenditure during the session was Rs. 48.55 crore (Up to Nov. 2013)

18.6 REGIONAL INSTITUTE OF PARAMEDICAL AND NURSING SCIENCES, (RIPANS), AIZAWAL (MIZORAM)

Regional Institute of Paramedical and Nursing Science (RIPANS), Aizawl was set up by the Ministry of Home Affairs, Government of India in 1992-93 to provide Nursing, Pharmacy and Paramedical education to the people of North East including Sikkim and to maintain the pace of nursing education and nursing services with other developments, medical and technological services.

The Regional Paramedical and Nursing Sciences Training Institute (RP&NTI) which was later renamed as Regional Institute of Paramedical and Nursing Sciences (RIPANS) on 05.08.2005 thus started functioning in 1996 with 182 students. The institute has been transferred to Ministry of Health and Family Welfare w.e.f. 01.04.2007.

At present the institute is conducting five Degree Courses as given below:

Sl. No.	Name of Course	Duration
1	B.Sc. (Nursing)	4 years
2	B.Sc. MLT	4 years
3	B. Pharm	4 years
4	Bachelor of Sciences in Radio Imagining Technology (B.Sc.R.I.T)	4 years
5	Bachelor of Scineces in Optometry & Ophthalmic Techniques (B.Sc. OOT)	4 years

The courses are affiliated to Mizoram University and are recognized by Indian Nursing Council (INC), Pharmacy Council of India (PCI) and All India Council for Technical Education (AICTE).

A sum of Rs. 41.09 crore has been released to RIPANS during the year 2013-14.

The major projects of RIPANS are as under:

i) The Project for creation of additional facilities of Hostel accommodation, academic block, library, examination hall etc. at an estimated cost of Rs. 76.03 crore has been approved. The work on the project has since started.

ii) It has been decided to upgrade RIPANS as 9th Regional Institute of Allied Health Services (RIAHS). The Institute has engaged M/s HLL as their Project Management Consultant. The Consultant has prepared the concept plan. The concept plan was discussed and deliberated in the Ministry and it has been decided that the project be taken up for its appraisal.

18.7 NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS IN NORTH EAST STATES

National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100% centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020.

The programme is being implemented in a decentralized manner through respective State/District Health Societies. Benefits of the scheme are meant for all needy population including tribal population. NE States including Sikkim being tribal predominant and having peculiar geographical conditions and inadequate eye-care infrastructure, is a priority area under NPCB. With the aim to improve eye-care services in these states, following new initiatives have been introduced under NPCB:

1. Assistance for construction of dedicated Eye Wards & Eye OTs in District Hospitals.
2. Appointment of Ophthalmic manpower (Ophthalmic Surgeons, Ophthalmic Assistants and Eye Donation Counsellors) in States on contractual basis.
3. In addition to Cataract, provision of grant-in-aid to NGOs for management of other Eye diseases other than Cataract like Diabetic Retinopathy, Glaucoma Management, Laser Techniques, Corneal Transplantation, Vitreoretinal Surgery, Treatment of childhood blindness etc.
4. Development of Mobile Ophthalmic Units in NE States, Hilly States & difficult Terrains for diagnosis and medical management of eye diseases.
5. Involvement of Private Practitioners in Sub District, Block and Village level.

As a result, the performance of cataract surgery in NE Region has improved from 79,390 surgeries in 2011-12 to 1,18,050 surgeries in 2013-14, State-wise breakups for which are as under:

S. No.	State	2011-12		2012-13		2013-14	
		Target	Ach.	Target	Ach.	Target	Ach.
1	Arunachal Pd.	3400	1059	2000	1098	3500	1651
2	Assam	114000	63555	85000	62463	85000	53764
3	Manipur	5300	1448	5300	4405	12500	3174
4	Meghalaya	5000	2512	2000	2014	3000	1026
5	Mizoram	4000	1867	4000	2088	4000	1423
6	Nagaland	2850	1008	1750	905	1750	494
7	Sikkim	1700	510	800	428	800	303
8	Tripura	8500	7431	7000	6743	7500	6372
	TOTAL	**144750**	**79390**	**107850**	**80144**	**118050**	**68207***

**=Report for the months of February and March, 2014 are awaited from most of the States.*

18.8 NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME IN NORTH EASTERN STATES

Malaria situation in North Eastern States

The North-Eastern region is prone to malaria transmission mainly due to:

- ➢ topography and climatic conditions that largely facilitate perennial malaria transmission,
- ➢ prevalence of highly efficient malaria vectors,
- ➢ Pre-dominance of Pf as well as prevalence of chloroquine resistantpf malaria.

The North-Eastern states namely Arunachal Pradesh, Assam, Meghalaya, Mizoram, Manipur, Nagaland, Sikkim and Tripura together contribute about 4% of the country's population 7.8% of malaria cases, 12.0% of Pf cases and 21.8 % of malaria deaths reported in the country of the year 2012. The epidemiological and malaria-metric indicators are given.

Malaria Situation in the NE States during 1996-2012				
Year	Cases (in million)		Deaths	API
	Total	Pf		
1996	0.28	0.14	142	8.01
1997	0.23	0.12	93	6.51
1998	0.19	0.09	100	5.12
1999	0.24	0.13	221	6.40
2000	0.17	0.08	93	4.49
2001	0.21	0.11	211	5.29
2002	0.18	0.09	162	4.57
2003	0.16	0.08	169	3.93
2004	0.14	0.08	183	3.36
2005	0.15	0.09	251	3.64
2006	0.24	0.15	901	5.67
2007	0.19	0.12	581	4.58
2008	0.19	0.13	349	4.38
2009	0.23	0.18	488	5.19
2010	0.17	0.13	290	3.80
2011	0.11	0.09	162	2.49
2012	0.08	0.06	113	1.80

The state-wise situation of malaria in year 2012 is given below:

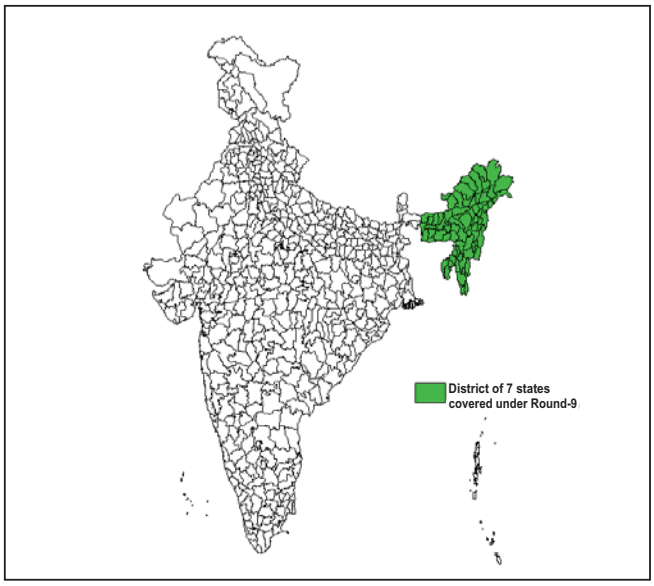
State-wise situation of Malaria in NE states-2012

S. N.	States/ UTs	Pop. (in 000)	B.S.E.	Positive Cases	P.f. Cases	Pf%	ABER (%)	API (per 1000)	SPR (%)	SfR (%)	Deaths (No.)
1	Arunachal Pradesh	1369	150707	8368	2789	33.91	9.38	4.86	5.18	1.76	5
2	Assam	32459	3973341	29999	20579	66.63	12.97	0.97	0.75	0.50	13
3	Manipur	2723	115257	255	83	32.55	4.23	0.09	0.22	0.07	0
4	Meghalaya	3067	354574	20834	19805	95.13	11.34	6.73	5.94	5.65	52
5	Mizoram	1179	168421	9883	9437	95.05	16.24	9.59	5.90	5.61	25
6	Nagaland	1981	214943	2891	821	28.40	10.58	1.46	1.35	0.38	1
7	Sikkim	203	6574	77	14	18.18	3.48	0.41	1.17	0.21	0
8	Tripura	3694	268189	11565	10915	94.71	7.07	3.09	4.37	4.14	7
	Total	**46674**	**5252006**	**83872**	**64443**	**76.83**	**11.25**	**1.80**	**1.60**	**1.23**	**113**

The table shows that Meghalaya and Mizoram are having API more than 5.

Assistance to States: Government of India provides 100% central assistance for programme implementation to the North Eastern States Including Sikkim. The Govt. of India also provides commodities like drugs, LLINs, insecticides/larvicides as per approved norms to all NE States as per their technical requirements. The assistance provided since 2010-11 is at (***Appendix-N.E.-I***)

The additional support under Global Fund for AIDS, Tuberculosis and Malaria (GFATM) is provided to all NE States except Sikkim for implementation of intensified Malaria Control Project (IMCP), with the objectives:



i. to increase access to rapid diagnosis and treatment in remote and inaccessible areas through community participation,

ii. malaria transmission risk reduction by use of (LLINs) and

iii. to enhance awareness about malaria control and promote community, NGO and private sector participation.

For strengthening early case detection and complete treatment more than 54520 ASHAs have been sanctioned are engaged in 53713 these areas. Out of them, 43667 have been trained and involved in high malaria endemic areas along with Fever Treatment Depots (FTDs) and Malaria clinics. This is in addition to the treatment facilities available at the health facilities and hospitals. Anti-malaria drugs and funds for training are provided by Govt. of India under the programme.

As per the National Drug Policy, Chloroquine is used for treatment of all P.vivax cases. And Artemesinin Combination Therapy (ACT) with Sulfadoxine Pyrimethamine (AS+SP) combination is being implemented for the treatment all Pf cases in the country. However, in North-Eastern states early signs of resistance to currently used SP-ACT, has been noticed and so, as per the advice of Technical Advisory Committee, effective combination of Artemether-Lumefantrine (ACT-AL) has been recommended for the treatment of Pf cases in the North Eastern States.

Indoor Residual Spraying (IRS): Under integrated vector control initiative, IRS is implemented selectively only in high risk pockets as per district-wise Micro Action Plans from domestic budget. The Directorate has issued Guidelines on IRS to the States for technical guidance. Guidelines on uniform evaluation of insecticides have also been developed in collaboration with National Institute of Malaria Research (NIMR), Delhi. Over the years, there is a reduction in IRS covered population in view of paradigm shift to alternative vector control measures such as extensive use of Insecticide Treated Nets (ITNs) and Long Lasing Insecticide Treated Nets (LLINs).

The strategies of the project are:

i. Early diagnosis and prompt treatment with special reference to the drug resistant pockets,

ii. integrated vector control, including promotion of LLINs, intensive IEC and capacity building and efficient public-private partnership among, CBO, NGO, and other voluntary sectors and

iii. Training the health workers and community volunteers.

Japanese Encephalitis is mainly endemic in Assam, Manipur and Nagaland as these States are regularly reporting JE/AES cases. The details of AES/JE cases from 2011 are as follows:

Sl. No	Affected States	2011				2012				2013 (P)			
		AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths	AES Cases	Deaths	JE Cases	Deaths
1	Assam	1319	250	489	113	1343	229	463	100	1388	272	495	134
2	Manipur	11	0	9	0	2	0	0	0	1	0	0	0
3	Nagaland	44	6	29	5	21	2	0	0	20	0	4	0

For control of J.E., Government of India has strengthened 9 sentinel sites in Assam and one each Manipur and Nagaland for diagnosis of J.E. cases. Regarding JE vaccination, 16 districts in Assam, 1 district in Arunachal Pradesh, 5 districts in Manipur and 3 districts in Nagaland have been covered under J.E. vaccination programme since 2006.

Dengue: NE States till few years back did not have problem of Dengue. Manipur has reported for the 1st time in 2007. The state-wise details of dengue cases from 2010 are as follows:

Sr. No.	Affected States	2010		2011		2012		2013 (P)	
		Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
1	Assam	237	2	0	0	1058	5	4526	2
2	Arunachal Pradesh	0	0	0	0	346	0	0	0
3	Manipur	7	0	220	0	6	0	9	0
4	Meghalaya	1	0	0	0	27	2	43	0
5	Mizoram	0	0	0	0	6	0	7	0
6	Nagaland	0	0	3	0	0	0	0	0
7	Sikkim	0	0	2	0	2	0	38	0

Chikungunya: Assam, Arunachal Pradesh, Manipur, Mizoram, Nagaland, and Tripura are not endemic for Chikungunya. However in Meghalaya for the first time, the state has reported 16 clinically suspected Chikungunya cases from West Garo Hills district during 2010. During 2011, the state has reported 168 clinically suspected and 32 confirmed cases from West Garo Hills district. No death has been reported due to Chikungunya. Since 2012, no clinically suspected case has been reported from the state of Meghalaya.

Lymphatic Filariasis is endemic in 7 districts of Assam, whereas other states in NE region are reported as non-filaria endemic. The strategy of Elimination of Lymphatic Filariasis with annual single dose Mass administration of DEC is being implemented since 2004. The coverage of population from 2010 is as under:

Year	Coverage (%)
2010	84.37
2011	87.92
2012	85.53
2013	86.87

Appendix - N.E.-I

Statement Showing Central Assistance provided to North Eastern States under NVBDCP

(Rs in lakhs)

State	2010-11			2011-12			2012-13		
	Cash	Kind	Total	Cash	Kind	Total	Cash	Kind	Total
Arunachal Pradesh	614.00	266.69	880.69	706.53	820.29	1526.82	357.48	477.95	835.43
Assam	1264.60	3645.43	4910.03	1059.87	2714.52	3774.39	68.31	1633.45	1701.76
Manipur	340.00	262.04	602.04	338.31	72.45	410.76	148.15	80.20	228.35
Meghalaya	278.50	810.54	1089.04	371.13	258.99	640.12	263.13	507.08	770.21
Mizoram	369.20	404.91	774.11	362.97	339.34	702.31	422.83	314.79	737.62
Nagaland	490.70	797.21	1287.91	578.48	419.25	997.73	486.43	443.72	930.15
Tripura	318.80	1111.74	1430.54	253.61	148.21	401.82	0.00	905.64	905.64
Sikkim	10.91	126.80	137.71	12.00	10.60	22.60	31.12	2.18	33.30
Total	**3686.71**	**7425.36**	**11112.07**	**3682.90**	**4783.65**	**8476.55**	**1777.45**	**4365.01**	**6142.46**

Allocation and Releases made to N.E. States during 2013-14

(Rs in lakhs)

State	Allocation			Releases		
	Cash	Kind	Total	Cash	Kind	Total
Arunachal Pradesh	1278.60	598.05	1876.65	1016.31	0.0	1016.31
Assam	3516.64	1651.55	5168.19	3315.29	498.16	3813.45
Manipur	662.70	344.71	1007.41	211.63	0.00	211.63
Meghalaya	261.80	385.16	1146.96	445.54	0.00	445.54
Mizoram	885.60	512.89	1398.49	614.19	0.00	614.19
Nagaland	830.20	848.05	1678.25	439.06	0.26	439.32
Tripura	1110.60	669.28	1779.88	722.76	12.58	735.34
Sikkim	50.00	0.00	50.00	27.36	0.00	27.36
Total	**8596.14**	**5009.69**	**14105.83**	**6792.14**	**511**	**7303.14**

18.9 NATIONAL LEPROSY ERADICATION PROGRAMME

All the States of North East Region have achieved elimination of leprosy. As on March 2014, there were 1239 leprosy cases on record in these states giving a PR of 0.26/10,000 population. During the year, 1345 new leprosy cases were detected with Annual New Case Detection Rate of 2.8/1,00,000 population. North East Region contributes to 3.76% of country's population and only 1.05% of country's new cases detected during the year. Out of total 87 districts in the region, only 4 districts in Assam are High Endemic with >10/100,000 population new cases detected annually. Leprosy services have already been integrated with General Health Care system in all NE states and leprosy diagnosis and treatment (MDT) services are available in all the PHCs and Government hospitals/dispensaries. All the Medical Officers and GHC staff are being adequately trained in leprosy. The district nucleus teams are being actively involved in programme monitoring and supervision.

18.10 NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME

The National Iodine Deficiency Disorders Control Programme (NIDDCP) is being implemented in all the North Eastern States. IDD prevalence surveys have been conducted in all the states. State level IDD Control Cell and IDD Monitoring Laboratory have been set up, in all the NE States. Resurveys done in the State of Arunachal Pradesh, Manipur, Sikkim and Mizoram have indicated a decline in the prevalence of IDD as a result of iodated salt consumption.

18.11 DEVELOPMENT OF NURSING SERVICES & UP-GRADATION/ STRENGTHENING OF NURSING SERVICES

Opening of ANM/GNM Schools: CCEA has approved this Ministry's proposal for opening of 132 ANM Schools and 137 GNM Schools for XI plan period. For the North Eastern region, this Ministry has approved 16 ANM schools and 21 GNM schools. A sum of Rs.3.349 crore has been approved for release during 2013-14 under the new scheme of opening of ANM/ GNM Schools to the State of Mizoram for opening two ANM schools.

18.12 NATIONAL PROGRAMME FOR CONTROL OF FLUORSIS

National Programme for Prevention and Control of Fluorosis (NPPCF) is being implemented in Assam in 3 districts namely, Naugaon, Karbi-Anglong and Kamrup.

The sanctioned contractual staff i.e. District Consultant, Laboratory Technician and Field Investigator (latter for six months) have been engaged and Laboratories established along with lon meters in the 3 districts. The Districts Nodal Officer, District Consultant (Fluorosis) and Laboratory Technician of all districts have been trained at National Institute of Nutrition, Hyderabad on the implementation of NPPCF. So far, surveys regarding Fluorosis have been undertaken in Naugaon and Kamrup.

The funds released under the programme for Naugaon is Rs. 34.97 lakh (2009-10 & 2013-14).

18.13 NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY

In the North-Eastern Region, the National Programme for the Health Care of Elderly (NPHCE) is in operation in Assam and Sikkim. In Assam, the Programme has been implemented in five districts, viz. Dibrugarh, Jorhat, Lakhimpur, Sibsagar and Kamrup. In Sikkim, it is implemented in two districts viz. East Sikkim and South Sikkim.

Funds amounting to Rs. 668.27 lakh to Assam and Rs. 203.03 lakh to Sikkim have been released under NPHCE so far. In Assam, the Guwahati Medical College (GMC) is one of the eight Regional Geriatric Centres (RGC) selected under NPCHE in the country during 11th Five Year Plan which functions as referral units with 30 bedded Geriatric Department and OPD facilities. So far, an amount of Rs. 373.65 lakh has been released to the RGC in Assam under the programme.

In Assam, daily Geriatric OPD and 10 bedded Geriatric Ward has started in all the five Districts. Bi-weekly geriatric clinics have also been started in various Community Health Centres under the five Districts. At the Regional Geriatric Centre, 30 bedded Geriatric Ward and daily geriatric OPD have been established.

In Sikkim, daily Geriatric OPD and 10 bedded Geriatric Ward has started in the two Districts. Bi-weekly geriatric clinics at Community Health Centres and Weekly geriatric clinics at Primary Health Centres have also been started in the two districts.

Proposals for implementing the NPHCE during 2013-14 in the States of Arunachal Pradesh, Manipur, Mizoram and Nagaland have been received from the respective State governments which are under consideration.

18.14 NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CARDIO VASCULAR DISEASES AND STROKE (NPCDCS)

In the 11th Five Year Plan, National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was taken up in 100 districts spread over 21 States including the two States of Assam and Sikkim in the North East. In the 12th Five Year Plan, NPCDCS is being implemented in the 35 States/UTs from 2013-14, including all the states of North East.

18.15 ACTIVITIES OF NATIONAL CENTRES FOR DISEASE CONTROL UNDERTAKEN UNDER DIFFERENT SCHEMES/PROGRAMMES IN THE NORTH-EASTERN STATES

Integrated Disease Surveillance Project (IDSP)

Integrated Disease Surveillance Programme (IDSP) was launched in 2004 with the objective to strengthen surveillance system for epidemic prone diseases for early detection and control of disease outbreaks. As on date, all States and Union Territories including North Eastern States are implementing IDSP. The component wise details of status/achievements in North East states are as under:

1. **IT Networking:** In N.E states, IDSP is establishing linkages with all states/districts HQ & all Govt. medical colleges on a satellite Broadband hybrid network.

2. **Manpower Status:** Since July 2010, manpower recruitment has been decentralized and state wise break up of technical manpower is as:

Sl No	States	Epidemiologists in position/ sanctioned	Microbiologists in position/ sanctioned	Entomologist in position/ sanctioned
1.	Arunachal Pradesh	16/17	2/2	1/1
2.	Assam	23/28	5/7	0/1
3.	Manipur	2/10	0/2	1/1
4.	Meghalaya	0/8	2/2	1/1
5.	Mizoram	1/10	3/3	1/1
6.	Nagaland	12/12	3/3	0/1
7.	Sikkim	1/5	2/2	1/1
8.	Tripura	0/5	1/2	0/1
	Total	**55 / 95**	**18/23**	**5/8**

3. **Training Status:** Training of Trainers (ToT) of State and District Rapid Response Teams (RRT) has been completed for eight North Eastern States.

4. **Data Management Status:** IDSP presently receives weekly disease surveillance reports from about 96% of the districts of NE region (84 out of 87 districts). Data analysis and action are being taken by respective districts.

Sl. No.	States	Districts reporting / Total districts	Portal reporting / Total districts
1	Arunachal Pradesh	16/16	15/16
2	Assam	27/27	26/27
3	Manipur	8/9	8/9
4	Meghalaya	5/7	5/7
5	Mizoram	9/9	6/9
6	Nagaland	11/11	10/11
7	Sikkim	4/4	4/4
8	Tripura	4/4	4/4
	Total	**84/87**	**78/87**

5. **Strengthening of Laboratories:** General Hospital Naharlagun at Arunachal Pradesh, K. K. Civil Hospital, Golaghat at Assam, District Hospital Churachandpur at Manipur, district priority lab at Tura at Meghalaya, two district priority labs at Lunglei and Aizawalat Mizoram, two district priority labs at Dimapur and Kohima, Nagaland, district priority labs at Gangtok, Sikkim, and district priority lab at Kailashahar, Tripura are supported by microbiologist and funds for consumables (4 lakhs/annum) for investigation of epidemic prone diseases on routine basis and during outbreaks.

   Further, a State referral lab network is being established in Assam, Tripura and Manipur by utilizing existing functional labs at Medical Colleges and various other major centers in the States and linking them with the adjoining districts for providing diagnostic services for Epidemic Prone Disease. Annual grant of Rs. 2 lakhs for maintenance of performance standards is provided to each lab during outbreaks. In addition, the tests conducted for outbreaks are reimbursed with a ceiling of Rs. 3 lakhs annually.

6. **Finance:** The Grants-in-aid released and expenditure incurred in last 6 years i.e. starting from the inception of the project till now is as (as on 31.03.2014).

Sl. No.	States	Amount released (in lakhs)	Amount expenditure (in lakhs)
1	Arunachal Pradesh	751.05	776.20
2	Assam	777.80	826.07
3	Manipur	229.05	200.61
4	Meghalaya	271.30	265.87
5	Mizoram	536	555.36
6	Nagaland	630	185.53
7	Sikkim	176.57	136.03
8	Tripura	139.71	128.16
	Total	**3511.48**	**3588.51**

7. **Outbreaks detected:** The major component of the project is to detect and respond to outbreaks in the early rising phase. In North East states a total of 91 outbreaks have been detected through IDSP during 2013. The state wise break up is as under:

Sl. No.	States	No. of Outbreaks in 2013 (up to 29th September)
1.	Arunachal Pradesh	7
2.	Assam	70
3.	Manipur	4
4	Meghalaya	1
5.	Mizoram	1
6.	Nagaland	1
7.	Sikkim	3
8.	Tripura	4
	Total	**91**

18.16 REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME (RNTCP)

The entire population of the North Eastern states including Sikkim has been covered under the Revised National TB Control Programme (RNTCP).

- Over the years, a strong network of RNTCP diagnostic and treatment services has been established in NE States through the general health system. 168 sub-district TB Units and 638 RNTCP Designated Microscopy centres have been established till second quarter of 2013. As the NE region has large proportion of tribal, hilly and hard to reach areas, the norms for establishing Microscopy centres has been relaxed from 1 per 100,000 population to 50,000 and the TB Units for every 250,000 (as against 500,000).
- The states have shown considerable improvement in programme performance and in 2012, the annualized total case notification rate was 162.9 on average in the region, treatment success rate has been consistently maintained over 87%.
- RNTCP has initiated 56254 patients on treatment in 2012 in the North East Region.
- The programme has collaborated with private and public sector health institutions in the area. More than 573 NGOs and PPs have been involved in the entire region and 43 medical colleges have been engaged proactively, including establishment of Zonal Task Force in the region. Innovative methods have been successfully implemented with the tea gardens in Assam. Collaboration with the health services under the Defense Forces has also been achieved in some of the states.
- HIV-TB coordination activities have been implemented in all the North Eastern states. Cross referral activities are being reported by all the states.
- Quality sputum microscopy is an important component of RNTCP. All the states in North East have implemented the External Quality Assurance (EQA) protocol. All the North-Eastern States have initiated Programme Management for Drug Resistant TB (PMDT) services.

As a special case, transportation of drugs by air from GMSDs to the North Eastern States has been provisioned for under the programme. Infrastructural requirement as per needs of the programme with enhancement for North Eastern States on account of hilly region and difficult terrain are accorded on priority.

In addition to the routing performance monitoring, enhanced focus on monitoring of North-Eastern States

are done using focused periodic revision. CTD regularly monitors the activity through analysis of quarterly performance reports from the districts and feedback is given for necessary corrective action, if required.

Performance

Performance of the programme in the region based on the Annual reports of 2012 is as below:

State	Population (in lakh) covered by RNTCP1	Total patients registered for treatment	No of Smear positive patients diagnosed2	Annual total case notification rate	Annual new smear positive case notification rate	Treatment Success rate of new smear positive patients
Arunachal Pradesh	14.1	2357	1231	167.0	56.8	87%
Assam	316.0	35788	21901	113.3	49.0	83%
Manipur	27.7	2744	1183	99.2	31.1	84%
Meghalaya	30.4	5114	2619	168.2	52.4	83%
Mizoram	11.1	2337	777	210.6	51.0	99%
Nagaland	19.9	3525	1755	177.1	60.4	91%
Sikkim	6.1	1832	782	298.5	80.5	84%
Tripura	37.0	2557	1798	69.1	37.6	87%
Grand Total	**462.3**	**56254**	**32046**			
Average				**162.9**	**52.4**	**87%**

Overall performance of the programme in Arunachal Pradesh, Assam, Nagaland, Meghalaya and Sikkim is good. In other States (Manipur, Mizoram and Tripura) also the programme performance is gradually improving.

State-wise statement of NE States for the financial year 2012-13 and 2013-14 is as follows:

(Rs. in lakh)

State	2012-13				2013-14
	Allocation	Release	Expenditure	Closing balance as on 31.03.2013	Cash Release upto 24.07.2013
Arunachal Pradesh	396.52	387.4	362.33	17.1	314.28
Assam	1088.95	871.95	876.5	-53.32	894.71
Manipur	330.91	218.44	251.31	4.01	255.87
Meghalaya	243.62	138.24	207.24	-62.11	200.16
Mizoram	278.63	277.56	291.65	9.54	228.93
Nagaland	305.3	291.74	286.12	38.79	233.18
Sikkim	162.01	95.73	117.82	-8.03	--
Tripura	194.07	118.94	111.24	3.71	156.03
Total	**3000.01**	**2400**	**2504.21**	**-50.31**	**2283.16**

Chapter 19

GENDER ISSUES

19.1 INTRODUCTION

Major component of Health & Family Welfare Programme is related to Health problems of women and children, as they are more vulnerable to ill health and diseases. Since women folk constitute about half of population, it is essential to know the health status of women so that the causes of ill health are identified, discussed and misconceptions removed. Ill health of women is mainly due to poor nutrition due to gender discrimination, low age at marriage, risk factors during pregnancy, unsafe, unplanned and multiple deliveries, limited access to family planning methods and unsafe abortion services.

In order to overcome these problems, the women need to be educated, motivate/persuaded to accept the Family Welfare Programme to increase demand for services. Accordingly, the Government seeks to provide services in a life cycle approach. Under the RCH Programme the need for improving women health in general and bringing down maternal mortality rate has been strongly stressed in the National Population Policy 2000. This policy recommends a holistic strategy for bringing about total intersectoral coordination at the grassroot levels and involving the NGOs, Civil Societies, Panchayati Raj Institutions and Women's Group in bringing down Maternal Mortality Rate and Infant Mortality Rate.

Several new initiatives have been taken to make the maternal health programme broad based and client friendly to reduce maternal mortality. The major interventions include provisioning of additional ANMs and Public Health/Staff Nurses in certain sub-centres, PHCs/CHCs, Laboratory Technicians, Referral Transport, 24-Hours Delivery Services at PHCs/CHCs, Safe Motherhood Consultants, Safe Abortion Services, Essential Obstetric Care, Emergency Obstetric Care, Skilled Manpower on contractual and hiring basis, Training of Dais, Training of MBBS doctors in Anesthetic Skills for Emergency Obstetric Care at FRUs, operationalisation of FRUs through supply of drugs in the form of emergency obstetric drug kits, Blood Storage Centers (BSC) at FRUs and Prevention and management of RTI/STI. Details of these interventions are given in the Maternal Health Chapter of this Report. However some points on these Programmes are given below:

19.2 JANANI SURAKSHA YOJANA (JSY)

Janani Suraksha Yojana (JSY) was launched in April 2005, to enable women especially from the vulnerable sections of the society to access institutional delivery and thereby effect reductions in maternal and neonatal mortality. The scheme provides conditional cash assistance to pregnant women for giving birth in a government health facility by providing access to skilled birth attendance and emergency obstetric care.

The scheme is under implementation in all States and Union Territories (UTs), with a special focus on Low Performing States (LPS). Around 9 lakh Accredited Social Health Activists (ASHAs) are working as an effective link between the government and poor pregnant women who get financial incentive to promote institutional delivery.

The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Odisha and Jammu and Kashmir. While these states have been named Low Performing States (LPS), the remaining states have been named High Performing states (HPS).

The number of beneficiaries under the scheme has increased manifold i.e. from 7.38 lakhs in 2005-06 to 1.05 crores in 2013-14. Similarly, expenditure has

increased from Rs. 38.29 crores in 2005-06 to Rs. 1748 crores in 2013-14.

Eligibility for Cash Assistance for Pregnant Women

The eligibility for cash assistance under the JSY is shown below:

Low Performing States (LPS)	All pregnant women delivering in government health centres or accredited private institutions
High Performing States (HPS)	All BPL/Scheduled Caste (SC)/ Scheduled Tribe (ST) women delivering in a government health centre or accredited private institutions.

Cash Assistance for Institutional (in Rs.)

The cash entitlement for different categories of mothers is as follows:

Category	Rural area		Total	Urban area		Total
	Mother's package	ASHA's package*		Mother's package	ASHA's package**	
Low Performing States (LPS)	1400	600	2000	1000	400	1400
High Performing States (HPS)	700	600	1300	600	400	1000

**ASHA incentive of Rs. 600/- in rural area includes Rs. 300/- for ANC component and Rs. 300/- for accompanying pregnant woman for institutional delivery.*

***ASHA incentive of Rs. 400/- in urban area includes Rs. 200/- for ANC component and Rs. 200/- for accompanying pregnant woman for institutional delivery.*

Subsidizing cost of Caesarean Section

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

Assistance for Home Delivery

All BPL pregnant women regardless of age and number of children preferring to delivery at home are entitled to financial assistance of Rs. 500/-per delivery in all the States/UTs.

19.3 JANANI SHISHU SURAKSHA KARYAKARAM (JSSK)

Free Service Guarantees at Public Health Facilities: Janani Shishu Suraksha Karyakaram (JSSK):

- Capitalizing on the surge in institutional deliveries brought about by JSY to provide service guarantees at health facilities, Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) in 1st June, 2011 to eliminate out of pocket expenditure for pregnant women and sick new-borns on drugs, diet, diagnostics, user charges, referral transport, etc. The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including Caesarean section. Under this scheme, pregnant women are entitled to free drugs and consumables, free diagnostics, free blood wherever required, and free diet up to 3 days for normal delivery and 7 days for C-section. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. This has now been expanded to cover the complications during ANC, PNC and also sick infants.
- To implement this scheme, more than Rs. 2107 crores have been allocated during the year 2012-13 and more than Rs. 2000 crores have been sanctioned up till now in 2013-14 under RCH and Mission Flexipool.

19.4 MOTHER AND CHILD TRACKING SYSTEM

To catch every pregnant women and every neonates and infants for quality ANC, INC, PNC, FP, Immunization services, the pregnant women and

neonates are being tracked by name. **Web Enabled Mother and Child Tracking System (MCTS)** is being implemented to register and track every pregnant woman, neonate, infant and child by name for quality ANC, INC, PNC, FP, Immunization services. As on March, 2014 more than 6.20 crores women and 5.17 crores children have been registered under MCTS.

A new initiative of prevention of PPH through Community Based Advanced distribution of Misoprostol by ASHAs/ ANMs has been launched in the districts with high home delivery rates.

19.5 RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

This is a new initiative launched in February 2013 which includes provision for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability. An estimated 27 crore children in the age group of zero to eighteen (0-18) years are expected to be covered across the country in a phased manner. Child Health Screening and Early Intervention Services will cover 30 common health conditions for early detection and free treatment and management.

Dedicated mobile health teams placed in every block, screen children from birth till 6 years at Anganwadi centres at least twice a year and screen children enrolled in Government and Government aided schools atleast once a year. Newborn are screened for birth defects in health facilities where deliveries take place and during the home visit by ASHA.

- Health screening of children is carried out by block level mobile health teams consisting of AYUSH doctors and paramedics duly trained in the use of necessary tools for screening.
    - o In 2013-14, 11,839 Mobile Health teams have been approved of which till January, 2014, 5,491 teams in 22 States/UTs have been recruited.
- Early Intervention Centres are being operationalized at District Hospitals for management of cases referred from block upwards. Linkages with secondary and tertiary level health services are provided in case higher level of management is required, including surgical interventions, free of cost.
    - o 445 master trainers across States/UTs have been trained. 225 District Early Intervention Centres (DEICs) are being established.
    - o By January, 2014, the number of children screened has exceeded 5.82 crore, (69.80 lakhs children from birth to 6 years and 5.13 crores children enrolled in Government and Government aided school). 1.30 lakh have received free treatment including surgeries for congenital heart disease, cleft lip and correction of club foot etc.
- Through early identification and linkages to care, support and treatment, screening will help in providing a comprehensive package of services to reduce the household expenditure of the poor and marginalized, reduce the disease burden and build health awareness. The scheme will diminish the burden on the health system besides encouraging caregivers/parents to seek health care early for their children. This is likely to translate into economic benefits both for the country and for individual families in the long run.

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

Adverse Child Sex-Ratio in India

The Child Sex Ratio (CSR) for the age group of 0-6 years as per the 2011 census (provisional) has dipped further to 919 girls as against 927 per thousand boys recorded in 2001 Census. This negative trend reaffirms the fact that the girl child is more at risk than ever before. Except for the States/UTs viz. Puducherry (967), Tamil Nadu (943), Karnataka (948), Delhi (871), Goa (942), Kerala (964), Mizoram (970), Gujarat (890), Arunachal Pradesh (972), Andaman & Nicobar Islands (968), Himachal Pradesh (909), Haryana (834), Chandigarh (880) and Punjab (846), the CSR has shown

a declining trend in 18 States and 3 UTs. The steepest fall of 79 points is in J&K and the largest increase of 48 points is in Punjab. **(Appendix-I)**

Jammu & Kashmir, Maharashtra and Haryana have had the worst 30 years decline in child sex ratios. Among the larger States, Chhattisgarh has the highest Child Sex Ratio (CSR) of 969 followed by Kerala with 964. Haryana (834) is at the bottom followed by Punjab (846). This census saw a declining trend even in North Eastern States expect Mizoram and Arunachal Pradesh. Half of the districts in the country showed decline in the CSR greater than national average. The number of districts with Child Sex Ratio of 950 and above has been reduced from 259 to 182.

Reasons for adverse Sex Ratio

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

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

Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

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

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

Punishment under the Act

- Imprisonment up to 3 years and fine up to Rs. 10,000
- For any subsequent offences, he/she may be imprisoned up to 5 years and fine up to Rs. 50,000/1,00,000
- The name of the Registered Medical Practitioner is reported by the Appropriate Authority to the State Medical Council concerned for taking necessary action including suspension of the registration if the charges are framed by the court and till the case is disposed of and on conviction, for removal of his name for a period of 5 years for the first offence and permanently for the subsequent offence.

Implementation of PC & PNDT Act in States/UTs

As per the Quality Progress Reports (QPRs) submitted by States/UTs 49998 bodies have been registered under the PC & PNDT Act. So far a total of 1682 machines have been sealed and seized for violations of the law. A total of 1945 ongoing court cases and 201 convictions have been secured under PC & PNDT Act and following the conviction the medical licenses of 97 doctors have been suspended/cancelled. **(Appendix-II)**

As a result of intensification of the drive against illegal sex determination, 288 cases has been filed in 2012-13, 279 in 2011-12 as compared to 157 in 2010-11.

PROGRESS CARD

	Cases	Convictions	Sealing	License cancellation/ suspensions
May 2011	869	55	409	-
Jan. 2012	1040	85	869	16
June 2012	1212	111	866	33
Jan. 2013	1327	111	989	33
July 2013	1521	116	1180	53
Sept. 2013	1833	143	1242	65

Recent steps taken by the Government of India

New Amendment to the 'Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Rules, 1996:

Government of India has recently notified several important amendments in Rules under the Act as mentioned below:

- Rule 11(2) has been amended to provide for confiscation of unregistered machines and punishment against unregistered clinics/facilities. Earlier the guilty could escape by paying penalty equal to five times of the registration fee.
- Rule 3B has been inserted with regard to the Regulation of portable ultrasound machines and Regulation of services to be offered by Mobile Genetic Clinic.
- Rule 3(3) (3) has been inserted restricting the registration of medical practitioners qualified under the Act to conduct ultrasonography in maximum of two ultrasound facilities within a district. Number of hours during which the Registered Medical Practitioner would be present in each clinic would be specified clearly.
- Rule 5(1) has been amended to enhance the Registration fee for bodies under Rule 5 of the PNDT Rules 1996 from the existing Rs. 3000/ to Rs. 25000/- for Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic or Imaging Centre, and from Rs. 4000/- to Rs. 35000/- for an institute, hospital, nursing home, or any place providing jointly the service of a Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic, Ultrasound Clinic or Imaging Centre.
- Rule 13 has been amended mandating every Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre, intimation every change of employee, place, address and equipment installed to the Appropriate Authority 30 days in advance of the expected date of such change and seek issuance of a new certificate with the changes duly incorporated.

The above two (3 & 5) recent amendents to PC & PNDT Rules have been challenged in various High Courts and the Supreme Court and the matter is sub-judice.

- Rules for six months training in Ultrasound for the MBBS Doctors have been notified vide GSR.14 E dated 10 January, 2014. The Rules include the training curriculum, criteria for accreditation of institutions and procedure for competency based evaluation test.
- Revised form F has been notified vide GSR 77 (E) dated 31st January 2014. The received format is more simplified as the invasive and non-invasive portions have been separated.
- Rules for Code of conduct for Appropriate Authorities has been notified vide GSR 119 (E) dated 24th February, 2014. Legal, monitoring, administrative and financial procedure have been explicitly laid down to facilitate Appropriate

Authorities in the course of effective implementation of the PC & PNDT Act.

Monitoring and review of the implementation scaled up

i. Central Supervisory Board (CSB) under the PNDT Act has been reconstituted. The 18th, 19th, 20th and 21st meetings of CSB have been held at an interval of six months on 14th January, 2012, 20th July 2012 16th January 2013 and 23rd July 2013. Important amendments to the PNDT Rules have been approved and notified.

ii. 14 states with the most skewed child sex ratio have been identified for concerted attention. A meeting of Health Secretaries of these States was convened on 20th April 2011. As the primary responsibility for implementing the Act rests with the states, they have been asked to take the following steps:

- Constitute State Supervisory Board, conduct its regular meetings and send quarterly progress report to the Central Supervisory Board as per the Act
- Notify District Collectors as District Appropriate Authority
- Constitute State Inspection and Monitoring Committees (SIMC)
- Identify districts with skewed Child Sex Ratio and focus on them
- Conduct regular surveys, update registrations and renewals to avoid multiple registrations
- Ensure analysis and scrutiny of Form -F (which provides detailed information on the pregnant woman and copy of which has to be sent to the District Appropriate Authority every month under the Act)
- Obtain regular information from ultrasound manufacturers regarding the sale of machines which is also mandatory as per the Act.
- Conduct workshops and training for judiciary and public prosecutors.
- Give training to appropriate authorities for building strong cases against offenders
- Strengthen inter-state coordination for regulating ultrasound clinics across borders.

iii. Directions given vide Order dated 04.03.2013 by the Hon'ble Supreme Court in the matter of WP (C) 349/2006 were communicated to the States/ UTs at the level of Health Minister to Chief Ministers and Chief Secretaries to ensure immediate compliance.

iv. Inspections by the National Inspection and Monitoring Committee (NIMC) have been scaled up. Inspections have been carried out in 34 districts of 16 states including Gujarat, Uttar Pradesh, Rajasthan, Maharashtra, Madhya Pradesh, Delhi, Bihar, Odisha, Haryana, Punjab, Andhra Pradesh, Chhattisgarh, Uttarakhand, Himachal Pradesh, Karnataka, Jammu & Kashmir and Jharkhand. A total of 114 clinics were inspected and 45 clinics were sealed from August 2011 Sept. 2013. 23 cases have already been filed in court.

v. The intensification of the drive against sex determination through effective implementation of the Act is being reviewed regularly in State meetings. Five regional review workshops for North, West, Central, North-East and Southern regions have been organized to evaluate and review the progress of implementation of PC & PNDT Act in the country.

vi. Hon'ble Prime Minister of India has urged Chief Ministers of all States to provide personal leadership to reserve the declining trend in child sex ratio and address the neglect of the girl child through focus on education and empowerment.

vii. Union Health Secretary has addressed all Chief Secretaries to take effective measures and regularly monitor implementation of the PNDT Act.

viii. Considering that almost all states have shown declining trend in child sex ratio, a Ministerial meeting was held under the Chairpersonship of Minister for Health & Family Welfare with Health Ministers of States on 28th September, 2011 at New Delhi to strengthen effective implementation of the PC & PNDT Act.

ix. Status of Implementation of PC & PNDT Act was included in the TORs of the Joint Review Mission (JRM), Common Review Mission (CRM) and Integrated Monitoring Visits for the current year so that teams can assess the situation on the ground.

Capacity building programme for all stake holders

- State level capacity building programme on enforcement of the Act has also been organized for district PNDT Officers in the States of Rajasthan, Gujarat, West Bengal, Haryana, Kerala, Maharashtra, Uttar Pradesh and Bihar.
- Capacity building programmes for Judicial Officers and public prosecutors have been conducted in Chandigarh, Maharashtra, Uttar Pradesh, West Bengal, Andhra Pradesh, Gujarat and Rajasthan.
- The National workshop for State Appropriate Authorities and State Nodal Officers of PNDT was organized 27th & 29th Feb. 2012 by Ministry of Health & Family Welfare in collaboration with UNFPA. The 2nd National workshop was held 28th & 29th November, 2013 in Pune.

Other initiatives taken by MoHFW

- Four expert committees have been constituted under the chairmanship of Joint Secretary on the recommendation of Central Supervisory Board to look into the amendments to the PC & PNDT Act, simplification of form-F, lay down code of conduct and to evolve regulatory mechanisms on sale & operations of USG machines.
- Medical Council of India has accepted the proposal to include a chapter on the issue of declining of Child Sex Ratio in the MBBS curriculum for the sensitizations of MBBS doctors.
- Medical Council of India has been directed to cancel registration of doctors convicted under the Act.
- PNDT has been included under NRHM and states have been asked to take advantage of funding available under NRHM for strengthening infrastructure and augmentation of human resources required for effective implementation of the Act. Rs. 2935.79 lakh and Rs.1731.56 lakh have been allocated under NRHM during 2012-13 and 2013-14 respectively.
- In addition to the Ministry's website, (www.mohfw.nic.in), an independent website, 'pndt.gov.in' for PNDT Division has been launched by the Minister for Health & FW. This website contains all the relevant information relating to the Act and the Rules.
- Minister for Health & Family Welfare launched the Toll Free Telephone (1800 110 500) to facilitate the public to lodge complaint anonymously, if so desired, against any violation of the provisions of the Act by any authority or individual and to seek PNDT related general information.

Appendix-I

Trend of child sex ratio in last three Censuses

S.No.	State/UT	1991	2001	Absolute Difference (1991-2001)	2001	2011	Absolute Difference (2001-2011)
1	Jammu & Kashmir	NA	941	NA	941	862	- 79
2	Dadra & Nagar Haveli	1013	979	- 34	979	926	- 53
3	Lakshadweep	941	959	18	959	911	- 48
4	Daman & Diu	958	926	- 32	926	904	- 22
5	Andhra Pradesh	975	961	- 14	961	939	- 22
6	Rajasthan	916	909	- 7	909	888	- 21
7	Nagaland	993	964	- 29	964	943	- 21
8	Manipur	974	957	- 17	957	936	- 21
9	Maharashtra	946	913	- 33	913	894	- 19
10	Uttaranchal	948	908	- 40	908	890	- 18
11	Jharkhand	979	965	- 14	965	948	- 17
12	Uttar Pradesh	927	916	- 11	916	902	- 14
13	Madhya Pradesh	941	932	- 9	932	918	- 14
14	Odisha	967	953	- 14	953	941	- 12
15	Tripura	967	966	- 1	966	957	- 9
16	Bihar	953	942	- 11	942	935	- 7
17	Sikkim	965	963	- 2	963	957	- 6
18	Chhattisgarh	974	975	1	975	969	- 6
19	West Bengal	967	960	- 7	960	956	- 4
20	Meghalaya	986	973	- 13	973	970	- 3
21	Assam	975	965	- 10	965	962	- 3
22	Puducherry	963	967	4	967	967	0
23	Tamil Nadu	948	942	- 6	942	943	1
24	Karnataka	960	946	- 14	946	948	2
25	Delhi	915	868	- 47	868	871	3
26	Goa	964	938	- 26	938	942	4
27	Kerala	958	960	2	960	964	4
28	Mizoram	969	964	- 5	964	970	6
29	Gujarat	928	883	- 45	883	890	7
30	Arunachal Pradesh	982	964	- 18	964	972	8
31	Andaman & Nicobar Islands	973	957	- 16	957	968	11
32	Himachal Pradesh	951	896	- 55	896	909	13
33	Haryana	879	819	- 60	819	834	15
34	Chandigarh	899	845	- 54	845	880	35
35	Punjab	875	798	- 77	798	846	48
	INDIA	**945**	**927**	**- 18**	**927**	**919**	**8**

Note: (-) shows negative sign

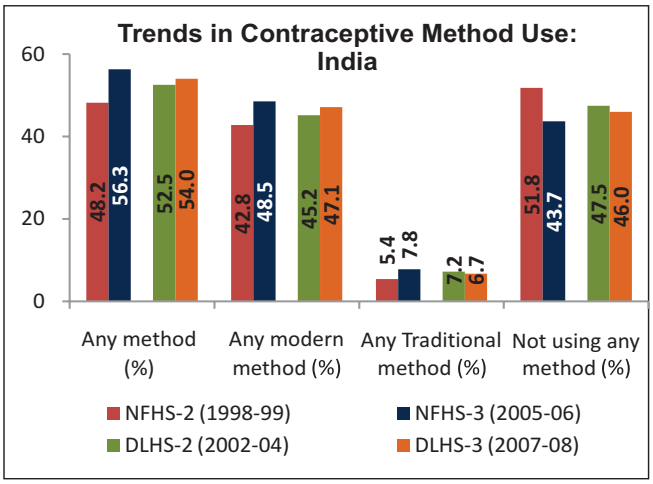
Appendix-II

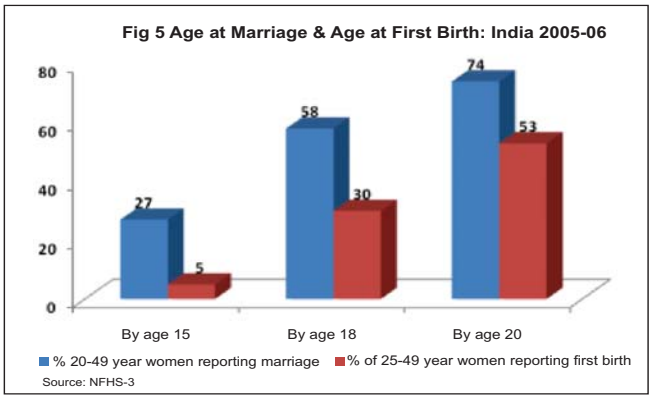
Status of registration, cases and convictions under PC & PNDT Act (up to March, 2014)

S.No.	States/ UTs	No. of bodies registered	No. of on-going Court/Cases	Machines Seized / Sealed	Convictions	No. of suspension/ cancellation of medical license
1	Andhra Pradesh	5003	52	132	0	0
2	Arunachal Pradesh	35	0	0	0	0
3	Assam	692	5	2	0	0
4	Bihar	1418	6	6	11	0
5	Chhattisgarh	656	7	0	0	0
6	Goa	155	18	1	0	0
7	Gujarat	4318	127	3	6	1
8	Haryana	1573	97	241	49	8
9	Himachal Pradesh	253	0	0	1	0
10	Jammu & Kashmir	300	6	72	1	0
11	Jharkhand	695	19	0	0	0
12	Karnataka	2878	45	0	0	0
13	Kerala	1548	0	0	0	0
14	Madhya Pradesh	1404	18	2	2	2
15	Maharashtra	9002	481	709	61	59
16	Manipur	77	0	0	0	0
17	Meghalaya	38	0	0	0	0
18	Mizoram	47	0	0	0	0
19	Nagaland	45	0	0	0	0
20	Odisha	685	24	6	3	0
21	Punjab	1400	127	0	28	4
22	Rajasthan	2199	578	384	37	21
23	Sikkim	24	0	0	0	0
24	Tamil Nadu	5494	77	72	0	0
25	Tripura	66	0	0	0	0
26	Uttarakhand	531	22	4	0	0
27	Uttar Pradesh	5248	154	34	1	0
28	West Bengal	2185	18	14	0	0
29	A & N. Island	10	0	0	0	0
30	Chandigarh	104	2	0	0	0
31	D. & N. Haveli	13	0	0	0	0
32	Daman & Diu	12	0	0	0	0
33	Delhi	1794	62	0	1	2
34	Lakshadweep	18	0	0	0	0
35	Puducherry	78	0	0	0	0
	TOTAL	**49998**	**1945**	**1682**	**201**	**97**

19.7 FAMILY PLANNING

The last survey figures available are from NFHS-3 (2005-06) and DLHS-3 (2007-08), which are being used for describing current family planning situation in India. Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9 (NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure). Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). The proximate determinants of fertility like, age at marriage and age at first childbirth (which are societal preferences) are also showing good improvement at the national level. The adjoining figure indicates the current position of social determinants of fertility in the country.





AHS survey has been conducted in 9 states (8 EAG States + Assam) which indicates that:

- All the states except Uttarakhandhas shown an increase in use of modern contraceptives.

Current Family Planning Efforts

Family Planning have undergone a paradigm shift and emerged as one of the interventions to reduce maternal and infant mortalities and morbidities. It is well-established that the states with high contraceptive prevalence rate have lower maternal and infant mortalities.

Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. Studies show that if the current unmet need for family planning could be fulfilled over the next 5 years, we can avert 35,000 maternal deaths, 1.2 million infant death, save more than Rs. 4450 crores and save Rs. 6500 crores, if safe abortion services are coupled with increased family planning services. This strategic direction is the guiding principle in implementation of family planning programme in future.

Contraceptive services under the National Family Welfare programme

The methods available currently in India may be broadly divided into two categories, spacing methods and permanent methods. There is another method (emergency contraceptive pill) to be used in cases of emergency.

Spacing Methods- These are the reversible methods of contraception to be used by couples who wish to have children in future. These include:

A. Oral contraceptive pills-

- These are hormonal pills which have to be taken by a woman, preferably at a fixed time, daily. The strip also contains additional placebo/iron pills to be consumed during the hormonal pill free days.

The method may be used by majority of women after screening by a trained provider.

- At present, there is a scheme for delivery of OCPs at the doorstep of beneficiaries by ASHA with a minimal charge. The brand "MALA-N" is available free of cost at all public healthcare facilities.

B. Condoms-

- These are the barrier methods of contraception which offer the dual protection of preventing unwanted pregnancies as well as transmission of RTI/STI including HIV. The brand "Nirodh" is available free of cost at government health facilities and supplied at doorstep by ASHAs for minimal cost .

C. Intrauterine contraceptive devices (IUCD) -

- Copper containing IUCDs are a highly effective method for long term birth spacing.
- Should not be used by women with uterine anomalies or women with active PID or those who are at increased risk of STI/RTI (women with multiple partners).
- The acceptor needs to return for follow up visit after 1, 3 and 6 months of IUCD insertion as the expulsion rate is highest in this duration.
- Two types of IUCD:
  - o Cu IUCD 380A (10 yrs)
  - o Cu IUCD 375 (5 yrs)
- New approach of method delivery- postpartum IUCD insertion within 48 hours of delivery by specially trained providers to tap the opportunities offered by institutional deliveries. Service providers and ASHAs accompanying clients are being provided with incentive of Rs. 150/-.

Permanent Methods- These methods may be adopted by any member of the couple and are generally considered irreversible.

A. Female Sterilisation-

- o ***Minilap*** - Minilaparotomy involves making a small incision in the abdomen. The fallopian tubes are brought to the incision to be cut or blocked. Can be performed by a trained MBBS doctor.
- o ***Laparoscopic*** - Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen. Can be done only by trained and certified Gynaecologist/Surgeon.

B. Male Sterilisation

- Through a puncture or small incision in the scrotum, the provider locates each of the 2 vas deference that carries sperm to the seminal vesicle and cuts and then ties the two cut ends. The procedure is performed by MBBS doctors trained in the procedure. However, the couple needs to use an alternative method of contraception for first three months after sterilization till no sperms are detected in semen.
- Two techniques being used in India are:
  - o Conventional
  - o Non- scalpel vasectomy - no incision, only puncture and hence no stiches.

Emergency Contraceptive Pill

- To be consumed in cases of emergency arising out of unplanned/unprotected intercourse.
- The pill should be consumed within 72 hours of the sexual act and should never be considered a replacement for a regular contraceptive.

Other Commodities - Pregnancy testing kits

- Helps to detect pregnancy as early as one week after the missed period, thus proving an early opportunity for medical termination of pregnancy, thus saving lives lost to unsafe abortions.
- These are available at the sub centre level and also carried by ASHA.

[1]In 233 pilot districts of 17 States, Condoms are not available at SHC and PHC level and supplied by ASHA at doorstep.

Service Delivery Points

- All the spacing methods, viz. IUCDs, OCPs and condoms are available at the public health facilities beginning from the sub-centre level. Additionally, OCPs condoms, and emergency contraceptive pills (since these are not skill based services) are available at the village level also through trained ASHAs.
- Permanent methods are generally available at primary health centre level or above. They are provided by MBBS doctors who have been trained to provide these services. Laparoscopic sterilization is being offered at CHCs and above level by a specialist Gynaecologist/Surgeon only.
- These services are provided to around 20 crores eligible couples; Details of services provided at different level of:

Family Planning Method Spacing Methods	Service Provider	Service Location
IUD 380 A/IUCD 375	Trained & certified ANMs, LHVs, SNs and doctors	Sub centre& higher levels
Oral Contraceptive Pills (OCPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels
Condoms	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level Sub centre & higher levels
Limiting Methods		
Minilap	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Laparoscopic Sterilization	Trained & certified Specialist Doctors (OBG & General Surgeons)	Usually CHC & higher levels
NSV: No Scalpel Vasectomy	Trained & certified MBBS doctors & Specialist Doctors	PHC & higher levels
Emergency Contraception		
Emergency Contraceptive Pills (ECPs)	Trained ASHAs, ANMs, LHVs, SNs and doctors	Village level, Sub centre & higher levels

Note: Contraceptives like OCPs, Condoms are also provided through Social Marketing Organizations

The Salient Features of the Family Planning Programme

A. On-going interventions:

- More emphasis on Spacing methods like IUCD.
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilaptubectomy services because of its logistical simplicity and requirement of only MBBS doctors and not post graduate Gynaecologists/Surgeons.
- A rational human resource development plan is in place for provision of IUCD, minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUD insertion.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at state and district levels.
- Accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.

- Increasing male participation and promoting Non-Scalpel Vasectomy.
- Compensation scheme for sterilization acceptors- under the scheme MoHFW provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting sterilisations.
- 'National Family Planning Indemnity Scheme' under which clients are indemnified in the eventualities of deaths, complications and failures following sterilization. The providers/accredited institutions are indemnified against litigations in those eventualities.
- Improving contraceptives supply management up to peripheral facilities.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities.
- Strong political will and advocacy at the highest level, especially in states with high fertility rates.

B. New interventions to improve access to contraception:

Home Delivery of Contraceptives (HDC): A new scheme has been launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. The scheme was launched in 233 pilot districts of 17 states on 11 July 2011 and is now expanded to the entire country from 17th Dec. 2012. ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Rs. 1 for a pack of 3 condoms, Rs. 1 for a cycle of OCPs and Rs. 2 for a pack of one tablet of ECP.

C. Ensuring Spacing at Birth (ESB): Under a new scheme launched by the Government of India, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child. The scheme is operational in 18 states (EAG, North Eastern and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:

- o Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage.
- o Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child
- o Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only.

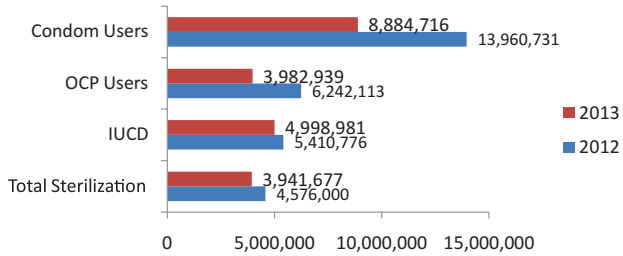
- MoHFW has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning Programme. Training of state level trainers has already been completed and process is underway to train service providers up to the sub-center level.
- A new method of IUCD insertion (post-partum IUCD insertion) has been introduced by the Government.
- Promoting Post-partum Family Planning services at district hospitals by providing for placement of dedicated Family Planning Counsellors and training of personnel.

D. Pregnancy Testing Kits

- Nishchay-Home based pregnancy test kits (PTKs) was launched under NRHM in 2008 across the country.
- The PTKs are being made available at subcenters and to the ASHAs.
- The PTKs facilitate the early detection and decision making for the outcomes of pregnancy.

Progress made under Family Planning Programme

Service Delivery 2012-13- The performance of family planning services during 2012 and 2013 (provisional figures) is provided below (source: HMIS):



- Number of IUCDs and sterilisations has remained static in spite of declining CBR and TFR. There is a need to sustain momentum to reach the replacement level fertility.

- Considering the current efforts to focus on spacing, it is expected that IUCD performance would increase in near future.

Promotion of IUCDs as a short & long term spacing method

In 2006, Government of India launched "Repositioning IUCD in National Family Welfare Programme" with an objective to improve the method mix in contraceptive services and has adopted diverse strategies including advocacy of IUCD at various levels; community mobilization for IUCD; capacity building of public health system staff starting from ANMs to provide quality IUCD services and intensive IEC activities to dispel myths about IUCD. Currently, increased emphasis is given to promotion of IUCD insertion as a key spacing method under Family Planning programme.

"Alternative Training Methodology in IUCD" using anatomical, simulator pelvic models incorporating adult learning principles and humanistic training technique was started in September 2007 to train service providers in provision of quality IUCD services. (Details of action taken and achievements in different Family Planning methods in chapter-9 on Family Planning)

19.8 REVISED NATIONAL TB CONTROL PROGRAMME (RNTCP)

Under the Revised National TB Control Programme, facilities are provided free of cost to the TB patients irrespective of sex. Thus the benefits of the Programme are uniformly available for all including women and girls. For providing DOTS to the TB patients, women self-help groups are encouraged to work as DOT providers. ASHAs, Anganwadi workers, Mahila Mandals etc. are particularly involved for this purpose.

Under the Revised National TB Control Programme, gender based data in respect of TB cases detected and put on treatment and their outcome is monitored. Information on male to female ratio in different types of cases and treatment outcome is given below. However, a constant feature of the RNTCP pulmonary TB case notifications is that more male patients are detected than female patients, with the ratio being 2.2:1. A number of community based epidemiological studies have consistently demonstrated that in all age groups, pulmonary TB is predominantly a male disease. The provision of country-wide available and accessible TB services as close to the patients as possible is important to ensure that the services under the programme are available.

Table1: Males to Females ratio in different type of TB cases registered in year 2012

Patients Registered 2012)	Male	Female	Male: Female Ratio
NSP	435396	194193	2.2:1
NSN	199820	117796	1.7:1
NEP	119756	114273	1.1:1
Others	1244	895	1.4:1
RELAPSE	79775	26688	3.0:1
Total	**835991**	**453845**	**1.8:1**

NSP: New Smear Positive, NSN: New Smear Negative, NEP: New Extra Pulmonary

Table:2 Treatment Outcome (New Smear Positive cases) in Male and Female, 2011*

	Male	%	Female	%	Total	%
Cured	371986	83.9%	172745	87.4%	544731	84.9%
Treatment Completed	13126	3.0%	5518	2.8%	18644	2.9%
Died	19828	4.5%	6313	3.2%	26141	4.1%
Failure	9116	2.1%	3173	1.6%	12289	1.9%
Defaulted	26317	5.9%	8762	4.4%	35079	5.5%
Transferred	3187	0.7%	1208	0.6%	4395	0.7%
Total	**443560**		**197719**		**641279**	

**The treatment outcomes are reported only after 12-15 months, hence outcomes the cohort of 2012 would only be reported completely henceforth.*

Quantum of funds provided to each private and voluantary organizations as grants-in-aid of Rs. 1 lakh and above but below Rs. 5 lakhs and the purpose for which these were utilized.

Sl no	Name of the recipient	Amount (in lakhs)	Purpose
1	APICON 2012, Coimbatore*	2.0	Annual Conference by Association of Physicians of India
2.	NATCON 2012, Patna	2.0	Annual Conference of Bihar TB Association
3.	Indian Society for Malaria and other Communicable Diseases	1.0	Annual Joint Conference

All Utilization Certificates have been received except from APICON 2012. One time assistance as grants-in-aid of Rs 10 lakhs and above but below Rs. 50 lakhs provided to private and voluntary organizations or societies for which the funds were utilized Nil.

19.9 DEVELOPMENT OF NURSING SERVICES

Nursing Personnel are the largest workforces in a Hospital. They play an important role in the health care delivery system. A sum of Rs. 200.00 crore has been allocated for the year 2013-14 for implementing the New Scheme of Upgradation/Strengthening of Nursing Services for establishing ANM and GNM schools across the country under the scheme of upgradation/ strengthening of nursing services. Nursing personnel are better equipped through this programme to provide quality patient care in the Hospitals and in other settings also. As per the available statistics 95% of the beneficiaries are women only and therefore, the programme will have significant impact on women empowerment.

19.10 NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

Although leprosy affects all irrespective of gender, males are affected more as compared to females. This can be attributed to greater mobility and increased opportunities for contact among the male population. Intensive IEC activities have been carried out through mass media and local media focusing more on the female population for creating greater awareness about the signs and symptoms of the disease among females especially from areas with low literacy rate. ASHAs are also being involved in referring suspect leprosy cases to health facility for diagnosis and for ensuring treatment completion. For facilitating involvement of ASHAs under the programme, an incentive is proposed to be given for referring suspect cases to health facility and follow up of diagnosed for treatment completion. This is expected to help in improving case finding in general and identifying female cases in particular.

Under the programme, state wise disaggregated data on gender is collected on monthly basis. During the year 2012 -13, out of 126,900 new leprosy cases detected, 46839 (36.9%) number of female cases were detected.

RFD

Result-Framework Document Report of Department of Health and Family Welfare for 2012-2013

Section 1: VISION, MISSION, OBJECTIVES AND FUNCTIONS

Vision: To achieve acceptable standards of Health Care for the people of the country by the end of the 12th Five Year Plan.

Mission:

1. To ensure availability of quality healthcare on equitable, accessible and affordable basis across regions and communities with special focus on under-served population and marginalized groups.
2. To establish comprehensive primary healthcare delivery system and well functioning linkages with secondary and tertiary care health delivery system.
3. To Reduce Infant Mortality rate to less than 27 per 1000 live births and Maternal Mortality Ratio to less than 100 per 100,000 live births by 2017.
4. To reduce the incidence of communicable diseases and putting in place a strategy to reduce the burden of non-communicable diseases.
5. To ensure a reduction in the growth rate of population with a view to achieving population stabilization.
6. To develop the training capacity for providing human resources for health (medical, paramedical and managerial) with adequate skill mix at all levels.
7. To regulate health service delivery and promote rational use of pharmaceuticals in the country.
8. To provide quality Leprosy treatment services to all section of the population and achieve the target of less than 1 case per 10,000 population (Elimination) in all districts of the country & also reducing the burden of disability due to Leprosy during 12th plan period.

Objectives:

1. Universal access to primary health care services for all sections of society with effective linkages to secondary and tertiary health care.
2. Improving Maternal and Child Health.
3. Focusing on population stabilization in the country.
4. Developing human resources for health to achieve health goals.
5. Reducing overall disease burden of the society.
6. Strengthening Secondary and Tertiary health care.

Functions:

1. Policy formulation on issues relating to health and family welfare sectors.
2. Management of hospitals and other health institutions under the control of Department of Health and Family Welfare.
3. Extending support to states for strengthening their health care and family welfare system.
4. Reducing the burden of Communicable and Non-Communicable diseases.
5. Focusing on development of human resources through appropriate medical and public health education.
6. Providing regulatory framework for matters in the Concurrent List of the Constitution viz. medical, nursing and paramedical education, pharmaceuticals, etc.
7. Formulation of guidelines on issues relating to implementation of National Leprosy
8. Elimination Programme & strengthening supervision and Monitoring support to States/UTs.

Section- 2: Achievement of Result-Framework Documents for Department of Health and Family Welfare 2012-13

S.N.	Objective	Weight	Action	SuccessIndicator	Unit	Weight	Target/Criteria Value					Performance		
							Excellent	Very Good	Good	Fair	Poor	Achievement	Raw	Weighted
							100%	90%	80%	70%	60%	Score	Score	Score
1.	Universal access to primary health care services for all sections of society with effective linkages to secondary and tertiary	36.5	Strengthening of Health Infrastructure	Operationalization of 24X7 Facility at PHC level	Number	4	500	450	400	350	300	371	74.2	2.97
				Operationalisation of CHCs into First Referral Units (FRU)	Number	3	200	180	160	140	120	237	100	3
				Equipping Districts with Mobile Medical Units	No. of Districts	2	50	45	40	35	30	41	82	1.64
				Operationalisation of Patient Transportation Services	Number	3	600	550	500	450	400	1066	100	3
				Construction of New Sub Centre Building	Number	2	950	900	850	800	750	1671	100	2
				Establishment of Special New Born Care Units in District Hospitals	Number	1	100	90	80	70	60	81	81	0.81
				Establishment of Stabilisation Units for new born in CHCs	Number	1	220	200	178	156	134	230	100	1
				Establishment of New Born Care Corners in PHCs	Number	1	3300	3000	2670	2340	2010	3340	100	1
			Strengthening of Community Involvement	Constitution of new Village Health, Sanitation & Nutrition Committees (VHSNC)	Number	1	30000	25000	20000	18000	15000	16306	64.35	0.64
				Holding Village Health & Nutrition Days	Lacks	2	60	55	48	42	36	80.7	100	2
			Augmentation of Availability of Human Resources	Deployment of new ANMs	Number	2	8000	7200	6400	5600	4800	6433	80.41	1.61
				Deployment of new Doctors/Specialists	Number	2	1100	1000	900	800	700	1295	100	2
				Deployment of new Staff Nurses	Number	2	3000	2500	2200	2000	1800	3233	100	2
				Deployment of new Paramedical staff	Number	2	2600	2500	2400	2300	2200	3085	100	2

			Capacity Building	ASHA Training (up to VI th & VIIth Module)	Number	2	130000	125000	110000	100000	60000	151922	100	2
				Personnel trained on IMNCI	Number	1.5	22200	20000	17800	15600	13400	23000	100	1.5
				Doctors trained on LSAS	Number	1	288	282	268	254	244	293	100	1
				Doctors trained on EMoC	Number	1	230	227	216	204	197	226	89.09	0.89
				ANMs/SNs/LHVs trained as SBA	Number	1	10400	10250	9730	9220	8880	10679	100	1
				Navjat Shishu Suraksha Karyakram (NSSK)	Number	2	16650	15000	13350	11700	10050	18000	100	2
2	Improving Maternal and Child Health	8	Promote Institutional Deliveries	Institutional Deliveries as a percentage of total deliveries	%	3	72	70	67	66	65	82.4	100	3
			Support through Janani Suraksha Yojana	JSY Beneficiaries (in lakhs)	Number	2	115	110	104	99	95.37	110	90	1.8
			Targetting Full Immunisation (Age group of 0-12 months)	Target Children immunized	%	3	82	80	76	72	69	85.7	100	3
3	Focusing on population stabilization in the country	6	Female Sterilisation	Female Sterilization acceptors (in lakhs)	Number	2	47	46	43.7	41.4	39.88	47	100	2
			Male Sterilisation	Male Sterilisation acceptors (in lakhs)	Number	2	2.1	2	1.9	1.8	1.73	1.8	70	1.4
			Intra Uterine Device (IUD) Insertion	IUD Insertion (in lakhs)	Number	2	62	60	57	56	55	55	60	1.2
4	Developing human resources for health to achieve health goals	9	Strengthening & upgradation of Govt. Medical College	Completion of Upgradation of identified Medical Colleges	Number	4	25	20	16	12	10	24	98	3.92
			Setting up one National Institution of Para-medical Sciences(NIPS) and 8 Regional Institutes of Paramedical Sci.(RIPS)	Commencement of Work for NIPS	Date	1	31/10/12	30/11/12	31/12/12	31/01/13	28/02/13	15/01/13	75.16	0.75
				Commencement of Work for RIPS	Number	1	6	5	3	2	1	2	70	0.7
			Establishment of Nursing Institutes at various levels	Approval for DPRs for new ANM Schools	Number	1	27	25	20	15	3	27	100	1

				Approval for DPRs for new GNM Schools	Number	1	28	25	20	15	10	42	100	1
			Revision of Medical education curriculum	Creating a Draft Curriculum	Date	1	11/11/12	31/12/12	31/01/13	28/02/13	31/03/13	15/01/13	85.16	0.85
5	Reducing overall disease burden of the society	15.5	Reduce incidence of Malaria cases	Annual Parasite Incidence (API)	Per 1000 population	2	1.2	1.3	1.52	1.67	1.8	0.85	100	2
			Reduce incidence of Filariasis	Coverage of eligible people under Mass Drug Administration (MDA)	%	0.5	90	85	80	75	70	90	100	0.5
				Endemic Districts (250) achieving Micro Filariarate of < 1 %	Number	0.5	55	50	45	40	35	186	100	0.5
			Reduce incidence of Kala-azar	BPHCs reporting less than 1 case of Kala-azar per 10000 population out of 514 such BPHCs	Number of BPHCs	1	475	450	400	380	285	383	71.5	0.72
			Reduce incidence of Leprosy	Annual prevalence rate of < 10 per lakh population in High burden Districts (209)	Number of Districts	1	70	60	50	45	40	41	62	0.62
				Reconstructive Surgeries conducted	Number	0.5	3000	2700	2400	2100	1800	2120	70.67	0.35
			Control of Tuberculosis	New Sputum Positive (NSP) Success rate	%	1	88.5	88	85	75	70	88	90	0.9
				New Sputum Positive (NSP) case detection rate	%	1	74.5	74	67	60	52	68.4	82	0.82
				Detection and putting on treatment MDR TB Cases	Number	0.5	10500	10000	9500	9000	8500	14059	100	0.5
			Reduction in Prevalence of Blindness	Cataract Surgeries performed (in lakhs)	Number	0.5	68	65	60	55	50	60	80	0.4
				No. of spectacles to school children screened with refractive error (in lakhs)	Number	0.51	4	3.5	3.2	3	2.8	6	100	0.51

				Collection of donated eyes for corneal transplantation	Number	0.5	62000	60000	55000	50000	45000	48000	66	0.33
			Strengthening facilities for diagnosis and treatment of cancer	Development of District Cancer Facilities	Number of districts	0.5	75	70	65	60	50	8	0	0
				Strengthening of Tertiary Cancer Centres	Number of centres	1	5	4	3	2	1	5	100	1
			Establishment of Tobacco Testing laboratories	Operationalization of Tobacco Testing labs for Nicotine and Tar	Number	0.51	6	4	3	2	1	0	0	0
			Ensure availability of minimum mental health care services	Starting of Academic Session in Centres of Excellence	Number	1	4	3	2	1		6	100	1
				Approval for starting up of PG courses in Mental Health Specialities	Number	0.5	25	20	15	10	5	14	78	0.39
			Opportunistic screening, diagnosis and management of Diabetes, Cardiovascular Diseases and Stroke	Set up NCD Clinics and Cardiac Care Units in District Hospitals	Number of districts	0.74	80	70	60	50	40	55	75	0.56
				Screening of NCDs at CHCs and below initiated in Districts	Number of districts	0.73	73	70	60	50	40	90	100	0.73
			Provide Health Care to the Elderly Population	Operationalization of Geriatric OPD and 10 beds ward at District Hospitals	Number of districts	0.51	80	70	60	55	50	39	0	0
				Establishment of Regional Geriatric Centres	Number	0.5	4	3	2	1		0	0	0
6	Strengthening Secondary and Tertiary health care	10	Setting up of AIIMS like Institutions (6 No.)	commencement of Academic Session in Medical Colleges	Number	2.75	5	4	3	2	1	6	100	2.75
			Upgradation of Govt. Medical Colleges (8 No.)	completion of construction work in Hospitals	%	2.75	85	80	75	70	60	72	74	2.04
				Upgradtion facilities at Govt. Medical Colleges made functional	Number	3	6	5	4	3	2	3	70	2.1
			Upgradation of Govt. Medical Colleges in II phase (3 No.)	Start of construction in Medical Colleges	Number	1.5	3	2	1			1	80	1.2

*	Efficient Functioning of the RFD System	3	Timely submission of Draft for Approval	On-time submission	Date	2	05/03/12	06/03/12	07/03/12	08/03/12	09/03/12	05/03/12	100	2
			Timely submission of Results	On- time submission	Date	1	01/05/12	03/05/12	04/05/12	05/05/12	06/05/12	01/05/12	100	1
*	Administrative Reforms	6	Implement mitigating strategies for reducing potential risk of corruption	% of implementation	%	2	100	95	90	85	80	100	100	2
			Implement ISO 9001 as per the approved action plan	Area of operations covered	%	2	100	95	90	85	80	0	80	0
			Timely preparation of departmental Innovation Action Plan (IAP)	On-time submission	Date	2	01/05/13	02/05/13	03/05/13	06/05/13	07/05/13	30/04/13	100	2
*	Improving Internal Efficiency / responsiveness / service delivery of Ministry / Department	4	Implementation of Sevottam	Independent Audit of Implementation of Citizen's Charter	%	2	100	90	80	70	60	93	93	1.86
				Independent Audit of implementation of public grievance redressal system	%	2	100	90	80	70	60	47.67	60	0
*	Ensuring compliance to the Financial Accountability Framework	2	Timely submission of ATNs on Audit paras of C&AG	Percentage of ATNs submitted within due date (4 months) from date of presentation of Report to Parliament by CAG during the year.	%	0.5	100	90	80	70	60	0	0	0
			Timely submission of ATRs to the PAC Sectt. on PAC Reports.	Percentage of ATRS submitted within due date (6 months) from date of presentation of Report to Parliament by PAC during the year.	%	0.5	100	90	80	70	60	100	100	0.5
			Early disposal of pending ATNs on Audit Paras of C&AG Reports presented to Parliament before 31.3.2012.	Percentage of outstanding ATNs disposed off during the year.	%	0.5	100	90	80	70	60	27	0	0
			Early disposal of pending ATRs on PAC Reports presented to Parliament before 31.3.2012	Percentage of outstanding ATRS disposed off during the year.	%	0.5	100	90	80	70	60	100	100	0.5

Section 3 TREND VALUE FOR SUCCESS INDICATORS RFD 2012-2013

Sl. No.	Objective	Weight	Action Points	Success Indicators	Actual value	Actual value	Actual value (Anticipated)	Projected value	Projected value	Projected value	Success Indicators
				Success Indicator	Unit	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
1	2	3	4	5	6	7	8	9	10	11	12
1	Universal access to primary healthcare services for all sections of society with effective linkages to secondary and tertiary health care	36.5	Strengthening of Health Infrastructure	Operationalisation of 24X7 Facility at PHC level	Number	1128	1100	800	450	450	450
				Operationalisation of CHCs into First Referral Units (FRU)	Number	114	660	450	180	180	180
				Equipping Districts with Mobile Medical Units	No.of districts	53	150	90	45	45	45
				Operationalisation of Patient Transportation Services	Number	NA	NA	500	550	550	550
				Construction of New Sub Centre Building	Number	NA	NA	900	900	900	900
				Establishment of Special New Born Care Units in District Hospitals	Number	95	65	72	90	90	90
				Establishment of Stabilisation Units for new born in CHCs	Number	265	280	315	200	200	200
				Establishment of New Born Care Corners in PHCs	Number	1200	1100	1080	3000	3000	3000
			Strengthening of Community Involvement	Constitution of new Village Health, Sanitation & Nutrition Committees (VHSNC)	Number	1622	-	-	25000	25000	25000
				Holding Village Health & Nutrition Days	Lakh	54.8	68	55	55	55	55
			Augmentation of Availability of Human Resources	Deployment of new ANMs	Number	8514	8000	7200	7200	7200	7200
				Deployment of new Doctors/ Specialists	Number	2196	3600	1000	1000	1000	1000
				Deployment of new Staff Nurses	Number	2430	9000	2500	2500	2500	2500
				Deployment of new Paramedical staff	Number	12010	5000	2000	2500	2500	2500
			Capacity Building	ASHA Training (up to VI th& VIIth Module	Number	243354	200000	100000	125000	125000	125000
				Personnel trained on IMNCI	Number	58105	50000	45000	20000	20000	20000
				Doctors trained on LSAS	Number	230	260	180	282	282	282
				Doctors trained on EMoC	Number	110	156	135	227	227	227
				ANMs/SNs/LHVs trained as SBA	Number	9500	10000	8100	10250	10250	10250
				Navjat Shishu Suraksha Karyakram (NSSK)	Number	NA	24000	12000	16650	15000	15000
2	Improving Maternal & Child Health	8.0	Promote Institutional Deliveries Support through Janani Suraksha Yojana	Institutional Deliveries	%	52	55	60	70	70	70
				JSY Beneficiaries (in lakhs)	Number	92.29	103	105	110	110	110

			Tageting Full Immunisation (Age group of 0-12 month)	Target Children immunised	%	61	71.4	70	80	80	80
3	Focusing on population stabilization in the country	6.0	Female Sterilisation	Female Sterilisation (in lakhs)	Number	47.4	46	50.00	46	46	46
			Male Sterilisation	Male Sterilisation (in lakhs)	Number	2.71	2.60	3.00	2.00	2.00	2
			Intra Uterine Device (IUD) Insertion	IUD Insertion (in lakhs)	Number	57.64	55.00	60.00	60.00	60.00	60
4	Developing human resources for health to achieve health goals	9.0	Strengthening & Upgradation of Govt. Medical Colleges	Completion of Upgradation of identified Medical Colleges	Number	Nil	40	30	20	20	20
			Setting up one National	Commencement of Work for NIPS	Date	Nil	Nil	31/12/11	30/11/12	-	-
			Institute of Paramedical Sciences (NIPS) and Regional Institutes of Paramedical Scis.	Commencement of Work for RIPS	No.	Nil	Nil	4	5	5	5
			Establishment of Nursing	Approval for DPRs for new ANM Schools	Number	Nil	54	12	25	25	25
			Institutes at various levels	Approval for DPRs for new GNM Schools	Number	Nil	54	31	25	25	25
			Revision of Medical Education Curriculum	Creation of Draft Curriculum	Date		-	-	31/12/12	-	-
5	Reducing overall disease burden of the society	15.5	To reduce incidence of Malaria cases	Annual Parasite Incidence (API)	per 1000 population	1.4	1.4	1.1	1.3	1.3	1.3
			Reduce incidence of Filariasis	Coverage of eligible people under Mass Drug Administration (MDA)	%	86.7	84.1	86.3	85	85	85
				Endemic districts(250) achieving Micro Filaria rate of < 1%	Number		-	-	50	50	50
			Reduce incidence of Kala-azar	BPHCs reporting less than 1 case of Kala-azar per 10000 population out of 514 BPHCs	No. of BPHCs	319	355	393	450	450	450
			Reduce incidence of Leprosy	Annual prevelence rate of < 10 per lakh population in high burdon districts (209)	No. of districts	10.93	-	-	60	60	60

				Reconstructive Surgeries performed	Number	2856	2570	3200	2700	2700	2700
			Control of Tuberculosis	New Sputum Positive (NSP) Success rate	%	87.0%	88.0%	88.0%	88.0%	88.0%	88.0%
				New Sputum Positive (NSP) case detection rate	%	71.0%	71.0%	74.0%	74.0%	74.0%	74.0%
				Detection and putting on treatment MDR TB cases.	Number		-	-	10000	10000	10000
			Reduction in Prevalence of Blindness	Cataract Surgeries performed (in lakhs)	Number	59.06	60	65	65	65	65
				No. of spectacles to school children screened with refractive error	lakh	5.06	3	3	3.5	3.5	3.5
				Collection of donated eyes for corneal transplantation	Number	46589	40000	60000	60000	60000	60000
			Strengthening facilities for diagnosis and treatment of cancer	Development of District Cancer Facilities	Number of Districts	Nil	30	70	70	70	70
				Strengthening of Tertiary Cancer Centres	Number of Centres	Nil	45	6	4	4	4
			Establishment of Tobacco Testing laboratories	Operationalization of Tobacco Testing labs for Nicotine & Tar	Number	Nil	Nil	4	4	4	4
			Ensure availability of minimum mental health care services	Starting of Academic session in Centres of Excellence	Number	7	3	1	3	3	3
				Approval for starting up of PG courses in Mental Health Specialities	Number	19	4	36	32	32	32
			Opportunistic screening, diagnosis and management of Diabetes, Cardiovascular Diseases and Stroke	Set up NCD Clinics and Cardiac Care Units in District Hospitals	Number of districts	Nil	30	70	70	70	70
				Screening of NCDs at CHCs and below initiated in Districts	Number of districts	Nil	30	70	70	70	70
			Provide Health Care to the Elderly Population	Operationalisation of Geriatric OPD and 10 Beds ward at District Hospitals	No. of Districts	Nil	Nil	70	70	70	70
				Establishment of Regional Geriatric Centres	No	Nil	Nil	8	3	3	3
6	Strengthening Seconday and Tertiary health care	10.0	Setting up of AIIMS like Institutions (6 Nos.)	commencement of Academic session in Medical Colleges	Number	Nil	-	-	4	4	4
				completion of construction work in Hospitals	%	Nil	15	50	80	80	89
			Upgradation of Govt. Medical colleges (8Nos)	Upgraded facilities at Govt. Medical Colleges made functional	Number	Nil	5	7	5	5	5
			Upgradation of Govt. Medical colleges in II Phase (3 Nos)	Start of construction in Medical Colleges	Number	Nil	Nil	5	2	2	2

Section 4: Description and Definition of Success Indicators and Proposed Measurement Methodology

Operationalisation of 24x7 facilities at PHC level

To ensure round the clock access to Public Health facilities, Primary Health Centres are expected to provide 24-hour service in basic Obstetric and Nursing facilities. Under NRHM, PHCs are being operationalized for providing 24x7 services in a phased manner by placing at least 1-2 Medical Officers and more than 3 Staff Nurses in these facilities. All 24x7 PHCs, providing delivery services, would also have newborn care corners and provide basic new born care services including resuscitation, prevention of infections, provision of warmth and early and exclusively breast feeding. State will take due precaution to fulfill all critical & most desirable criteria as per Govt. of India guidelines while upgrading these PHCs along with facilities for ENBC. All these PHCs have delivery facility, operation theatre & ambulance services.

First Referral Units (FRUs)

Upgradation of District Hospitals, Sub District Hospitals and Community Health Centres as First referral Units is being attempted to provide for Comprehensive Obstetric Care for Women and Acute Respiratory Infection (ARI) treatment for children. It requires holistic planning by linking Human Resources, Blood Storage Centers (BSCs) and other logistics. The definition of FRU includes the following three components.

- Essential Obstetric Care
- Provision of Blood Storage Unit
- New Born Care Services

During 2012-13, the focus is on functionality and ensuring that threshold levels of physical infrastructure and associated human resources are in place for functioning of the 24x7 services at optimum levels. Therefore, rather than having large numbers of 24x7 services functioning at sub-optional levels, focus is on functional consideration and targets for 2012-13 have set keeping in view the functionality focus.

FRU Guidelines could be refer to, if necessary.

1. Mobile Medical Units (MMU)

The main objective is to provide basic healthcare facilities in remote, far-flung hilly and tribal areas through the use of Mobile Medical Units. As a first step, it is envisaged to have one MMU in all the districts in the country. Mobile Medical Units have been constituted with 1 Medical Officers and vehicle. The Medical officer visits each and every village and hamlet to identified malnourished and seek children and provide medical services at their homes. If required the child is referred to nearest health center. He also examines pregnant and lactating mothers and other people and provide them medical care.

2. Patient Transport Services

It has been observed that most of the times due to delay in reaching health care facility like FRU, 24x7 PHCs, Secondary or Tertiary centers, mothers are deprived of emergency obstetric care result in ginmaternal death, still birth and neonatal deaths. The main objective is to prevent all these complications, it is important that mothers should be referred to the health care facility on time as due to lack of money they avoid going to centers at distant place and because of delay in reaching appropriate center for proper treatment they fall prey to death.

As per the statistical data available, about 10% of critically ill children are high risk requiring urgent care by specialist either at FRU or District Hospital or Tertiary level hospitals. Many such cases dies for want of referral transport and

special services, hence, it is essential to shift such cases as early as possible to avoid the Child morbidity and mortality. For speedy & effective transfer of ill children to referral higher center a provision of a special hired vehicle on 24x7 hrs. services is provided in each block at selected RH/SDH level and call center will be established at district place to inform the driver of vehicle so as the patient will be transferred to the necessary referral center.

3. Special New Born Child Care Units (SNCU)

These are specialised new born and sick child care units at district hospitals with specialised equipments, which include phototherapy unit, oxygen hoods, infusion pumps, radiant warmer, Laryngoscope and ET tubes, nasal cannulas Bag and mask and weighing scale.

These units have a minimum of 12 to 16 beds with a staff of 3 physicians, 10 nurses, and 4 support staff to provide round the clock services for a new born or child requiring special care such as managing newborn with neonatal sepsis and child with pneumonia, dehydration, etc., prevention of hypothermia, prevention of infection, early initiation and exclusive breast feeding, post-natal care, immunisation and referral services.

4. Stabilisation Units (SU)

Stabilisation Units are meant for providing facilities for newborn babies and children referred by the peripheral units (Primary Health centres) so that the babies can be stabilised through effective care. These are being set up in Community Health Centre (CHCs) / First Referral Units (FRUs). These units provide services, which include resuscitation, provision of warmth, early initiation of breast feeding, prevention of infection and cord care, supporting care including oxygen, Intra Venous (IV) fluids, provision for monitoring of vital signs including blood pressure and referral services. These units have specialised equipments, which include open care system (radiant warmer), laryngoscope, weighing scale and suction machine.

5. New Born Baby Corners

These are special corners within the labour room where support for effective management of a newborn is provided. The services include resuscitation, provision of warmth and prevention of infection, cord care and early initiation of breast-feeding. The equipments at newborn care corners include weighing scale, radiant warmer, suction machine and mucus sucker.

6. Life Saving Anaesthetic Skills (LSAS)

To increase trained manpower for provision of services during Emergency Obstetric situation, Medical Officers are trained in Life Saving Anaesthetic Skills (LSAS), so that more doctors are able to provide emergency obstetric care services at the designated FRU/CHCs.

7. Rogi Kalyan Samitis (RKS)

For effective community management of public health facilities/Institutions, Hospital Development Committees / Rogi Kalyan Samitis [RKS] are constituted at the PHC/CHC/District Hospital level. It comprises members from Panchayati Raj Institutions, civil society and representatives from public hospital. Untied grants are provided to RKS at various levels i.e. PHC/CHC/District level to carry out activities considered essential for improving services delivery. RKS is also authorized to retain the user fees at the institutional level for meeting the day-to-day needs of the institutions.

8. Village Health and Sanitation Committee (VHSC)

VHSC is expected to prepare village level health action plan. It comprises Panchayat president / member, representative from civil society, Anganwadi Worker (AWW) and Auxiliary Nurse Midwife (ANM). To encourage Panchayats to

constitute VHSCs, untied grants are given through NRHM. These grants are used to meet local health needs of the villages, including maintenance needs of the Sub centres.

9. Integrated District Action Plan

The objective of the District Action Plan is to identify the gaps and identify health requirements of the district through local level planning. The district plan would be an aggregation of block /village plans. These plans would cover health as well as other determinants of health like nutrition, drinking water, sanitation, etc.

10. Accredited Social Health Activist (ASHA)

The Accredited Social Health Activist (ASHA) is the essential link between the community and the health facility. A trained female community health worker ASHA is being provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norms are relaxed for one ASHA per habitation depending on the workload. ASHA's are involved in doorstep delivery of contraceptives which has been welcomed by the communities and are involved in delivery of sanitary napkins to females in reproductive age group along-with Home based New born care by being trained in the 6th and 7th module.

11. Contractual Appointments

To overcome shortage of manpower in management of health facilities, NRHM provides additional manpower in the form of contractual staff to health facilities at various levels. For Sub-centre, NRHM provides Auxiliary Nurse Mid-wives (ANMs), Staff Nurses at PHCs to ensure round the clock services. Similarly, contractual appointment of doctors /specialists, paramedical staff is being made to meet the requirement of states as per NRHM norms. States have given flexibility for recruitment of contractual manpower including specialists.

12. Integrated Management of Neonatal and Childhood Illness (IMNCI)

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, i.e. prematurity, and sepsis. In addition, IMNCI teaches about nutrition including breastfeeding promotion, complementary feeding and micronutrients.

13. Navjaat Shishu Suraksha Karyakram (NSSK)

Care at birth i.e. prevention of hypothermia, prevention of infection, early initiation of breast-feeding and basic newborn resuscitation are important for any neonatal programme. The objective of this new initiative is to have one person trained in basic newborn care and resuscitation at every delivery. The training package is based on the latest available scientific evidence. The training is for 2 days and is expected to reduce neonatal mortality significantly in the country.

14. Facility based Integrated Management of Neonatal and Childhood Illness (F-IMNCI)

F-IMNCI is the integration of the Facility based Care package with the IMNCI package, to empower the Health personnel with the skills to manage new born and childhood illness at the community level as well as the facility. Facility based care IMNCI focuses on providing appropriate inpatient management of the major causes of Neonatal and Childhood mortality such as asphyxia, sepsis, low birth weight in neonates and pneumonia, diarrhoea, malaria, meningitis, severe malnutrition in children. The interventions in the training manuals are based on the latest available scientific evidence and the manuals will be updated as new information is acquired. The training is for 11 days. The long-term programme needs for new born & child care will be met by the health personnel and workers possessing the optimum skills (F-IMNCI) for managing newborn and children both at the community level as well as the facility level.

a) Emergency Obstetric Care (EMOC)

Medical Officers are being trained in Obstetric Care and skills including Caesarean Section (EmOC Training), so as to make more doctors available to provide Emergency Obstetric Care Services at the designated FRU/CHCs.

b) Institutional Deliveries

Institutional Deliveries include the deliveries in the following categories of health facilities:

- Hospitals
- Dispensaries / Clinics
- UHC/UHP/UFWC
- CHC/ Rural Hospital
- PHC
- Sub Centre
- AYUSH Hospital/ Clinic

c) Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana is a safe motherhood intervention under the NRHM being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional deliveries. Under this scheme, cash incentives are provided to the beneficiary as well as village link worker/ASHA to come to the institution for delivery and also the cost of transportation. Besides this Janani Shishu Suraksha Karyakram (JSSK) has also been launched on 1st June 2011 to provide completely free and cashless services to pregnant women including normal deliveries and caesarean operations and sick new born (up to 30 days after birth) in Government health institutions in both rural & urban areas. Sick Neonatal Care Unit, New Born Baby Corners; Stabilization Units are being operationalized in the health facilities.

d) Vector Borne Diseases

i) Malaria

The following indicators are used for assessment of Malaria:

a) Surveillance-Annual Blood Examination Rate (ABER): Percentage of total no of slides examined annually out of total population under surveillance. This is calculated as:

$$\frac{\text{Number of Slide Examined in the Year}}{\text{Population under surveillance}} \times 100$$

b) Incidence of Malaria - Annual Parasite Incidence (API): Confirmed Malaria Cases annually per 1000 population under surveillance. This is calculated as :

$$\frac{\text{Number of confirmed malaria cases in the Year}}{\text{Population under surveillance}} \times 1000$$

ii) Kala azar

The indicator used for Kala-azar detection is annual new case detection of Kala-azar per 10,000 population.

$$\frac{\text{Number of Kala-azar cases in the Year}}{\text{Kala-azar Endemic Population}} \times 10000$$

iii) Filaria

The indicator for elimination of Lymphatic Filarisis is the 'coverage of eligible people under Mass Drug Administration' (MDA)

This is calculated as:

$$\frac{\text{Number of people administered with anti-filarial drugs during MDA}}{\text{Eligible population at the risk of filarial}} \times 100$$

e) Leprosy

Annual New Case Detection Rate (ANCDR)

$$\frac{\text{Number of new cases detected during the year}}{\text{Population as on 31st March}} \times 100000$$

f) Tuberculosis

The term "case detection" denotes that TB is diagnosed in a patient and is reported within the national surveillance system. Smear-positive is defined as a case of TB where Mycobacterium tuberculosis bacilli are visible in the patient's sputum when properly stained and examined under the microscope.

'New Case' denotes a patient who has never taken TB treatment in the past or has taken anti TB treatment, but for less than 1 month.

New Smear positive case detection rate is calculated by dividing the number of new smear positive cases notified in the specific cohort (quarter/year) by the estimated number of new smear positive cases in the population for the same quarter/year expressed as a percentage.

The term new smear positive treatment success rate denote the proportion of new smear positive TB cases cured or treatment completed to the total number of new smear positive TB cases registered in the specific cohort (quarter/year).

g) District Mental Health Programme (DMHP)

The main objective of DMHP is to provide basic mental health services to community & to integrate these with general health services. It envisages a community based approach to the problem, which includes:

- Provide service for early detection & treatment of mental illness in the community (OPD/Indoor & follow up).
- Training of mental health team at identified nodal institutions.
- Increase awareness & reduce stigma related to Mental Health problems.

LIST OF ABBREVIATIONS

Sl.No.		
1	ABER	Annual Blood Examination Rate
2	ACDR	Annual Case Detection Rate
3	ANM	Auxiliary Nurse Midwife
4	API	Annual Parasite Incidence
5	ART	Anti Retroviral Therapy
6	ASHA	Accredited Social Health Activist
7	AWW	Anganwadi Worker
8	AYUSH	Ayurveda Yoga-Naturopathy Unani Siddha & Homoeopathy
9	BPHCs	Block Primary Health Centres
10	BSS	Behaviour Surveillance Survey
11	CCEA	Cabinet Committee on Economic Affairs
12	CGHS	Central Government Health Scheme
13	CHC	Community Health Centre
16	DHF	Dengue Hemorrhagic Fever
17	DLHS	District Level Household Survey
18	DOTS	Directly Observed Treatment Short course
19	DPMR	Disability Prevention and Medical Rehabilitation
20	DPMU	District Programme Management Unit
21	EFC	Expenditure Finance Committee
22	ELF	Elimination of Lymphatic Filariasis
23	ELISA	Enzyme - linked Immunosorbent Assay
24	EMoC	Emergency Obstetric Care
25	EPW	Empowered Procurement Wing
26	FRU	First Referral Unit
27	FMG	Financial Management Group
28	GNM	General Nursing and Midwifery
29	HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immuno Deficiency Syndrome
30	ICMR	Indian Council of Medical Research
31	ICTCs	Integrated Counseling and Testing Centre
32	IDSP	Integrated Disease Surveillance Project

33	IEC	Information, Education & Communication
34	IFPS	Innovations in Family Planning Service
35	IMNCI	Integrated Management of Neonatal & Childhood Illness
36	IMR	Infant Mortality Rate
37	IT	Information Technology
38	IUD	Intra Uterine Devices
39	JSY	Janani Suraksha Yojana
40	JE	Japanese Encephalitis
41	LHV	Lady Health Visitor
42	LSAS	Life Saving Anaesthetic Skills
43	MDA	Mass Drug Administration
44	MPW	Multi Purpose Health Worker
45	MBA	Management Business Administration
46	MDR-TB	Multi Drug Resistance - Tuberculosis
47	MIS	Management Information System
48	MMR	Maternal Mortality Ratio
49	MMU	Mobile Medical Unit
50	MO	Medical Officer
51	MOU	Memorandum of Understanding
52	NACO	National AIDS Control Organization
53	NCD	Non Communicable Diseases
54	NCMP	National Common Minimum Programme
55	NEIGRIMS	Institute of Health & Medical Science for the North Eastern Region
56	NFHS	National Family Health Survey
57	NGO	Non-Government Organization
58	NHP	National Health Policy
59	NHRC	National Health Resource Centre
60	NIC	National Informatics Centre
61	NID	National Immunization Days
62	NIPS	National Institute of Paramedical Sciences
63	NLEP	National Leprosy Eradication Programme
64	NPCB	National Programme for Control of Blindness

65	NRHM	National Rural Health Mission
66	NSV	Non Scalpel Vasectomy
67	NVBDCP	National Vector Borne Disease Control Programme
68	PHC	Primary Health Centre
69	PIP	Project Implementation Plan
70	PMSSY	Pradhan Mantri Swasthya Suraksha Yojana
71	PPP	Public Private Partnership
72	PR	Prevalence Rate
73	PRI	Panchayati Raj Institutions
74	RCH	Reproductive & Child Health
75	RHRC	Regional Health Resource Centre
76	RKS	Rogi Kalyan Samiti
77	RNTCP	Revised National Tuberculosis Control Programme
78	SBA	Skilled Birth Attendant
79	SC	Sub Centre
80	SHRC	State Health Resource Centre
81	SNID	Sub National Immunization Days
82	SNs	Staff Nurses
83	SOE	Statement of Expenditure
84	SPMU	State Programme Management Unit
85	SRS	Sample Registration System
86	TB	Tuberculosis
87	TFR	Total Fertility Rate
88	TI	Targeted Interventions
89	UC	Utilization Certificate
90	UHC	Urban Health Centre
91	UHP	Urban Health Post
92	UFWC	Urban Family Welfare Centre
93	VHSC	Village Health & Sanitation Committee

Section-5

Specific Performance Requirements from other Departments

Department/ Ministries	Relevant Success indicator	What do you need?	Why do you need it?	How much you need?	What happens if you do not get it?
• Panchayati Raj • Women & Child, • HRD, • Drinking Water • Sanitation • Tribal Affairs, • Home, • Defence, • Youth affairs • AIDS Control, • AYUSH, • Health Research, • Medical Council of India, • Dental Council of India, • Pharmacy Council of India, • Indian Nursing Council	• Numbers of persons trained under main-streaming training. • Increasing scope & coverage of programmes of the Departments/ institutions to promote quality of life impacting health care of citizens of this country. • Numbers of persons trained for providing health services (medical, paramedical & managerial) with adequate skill mix at all levels.	• Guidelines for various Health & Family Welfare schemes and training programmes. • Constant monitoring to promote quality Health & Family welfare services in the country.	To strengthen the national response to promote health care of fellow citizens.	Full support and commitment.	It would hamper the achievement of National targets and programme outcomes.
• All State Governments	• Number of persons provided quality healthcare services with special focus on under-served and marginalized-group. • Number of comprehensive primary healthcare delivery system established & their well-functioning linkages with secondary & tertiary care health delivery system. • Majority Health related parameters.	Implementation and timely reporting the progress of various Health & Family Welfare programmes and outcomes.	To enhance the quality of life of fellow citizens in the country with thrust on health care.	100% commitment & support for effective implementation with constant monitoring.	The progress of implementation will slow down availability of quality healthcare on equitable accessible and affordable basis across regions & communities with special focus on under-served population & marginalized groups.

SECTION 6-OUTCOME /IMPACT OF ACTIVITIES OF THE MINISTRY/DEPARTMENT

Department of Health & Family Welfare 2012-2013									
Sr. No.	**Outcome/Impact of Ministry/Department**	**Jointly with**	**Success Indicator**	**Unit**	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15**
1	Improved access to health care services	States/UTs	Average number of primary health care centres per 1000 population.	Number	0.0201	0.0201	0.020	0.0199	0.0199
			Average number of primary health care centres per district	Number	36.99	36.99	37.45	37.89	37.89
2	Reduction in Mortality Rate	States/UTs	Infant mortality rate	Per 1000 live births	47	43	39	35	35
			Crude death rate	Per 1000 population	7.2	7.1	7.0	7.0	7.0
3	Improvement in Maternal Health	States/UTs	Institutional Deliveries as a % of Total deliveries	%	78.5	79.0	80.0	81.0	81.0
			Full Immunization (age group 0-12 Month)	%	89.3	70.0	80.0	80.0	80.0
4	Reduction in growth rate of population	States/UTs	Total Fertility Rate	children born per woman	2.5	2.4	2.4	2.4	2.4
5	Reduction in the burden of communicable and non-communicable diseases	States/UTs	Annual Parasite Incidence (Malaria)	Per 1000 population	1.10 (Provisional)	1.30	1.30	1.30	1.30
			New Sputum positive (NSP) Success rate	%	88	90	92	92	92
6	Development of human resources	States/UTs	Number of doctors per 1000 population	Number	0.074	0.075	0.076	0.076	0.076

Note:

The indicator Infant Mortality Rate (IMR)- Point decline over per 1000 live births

The indicator Crude death rate - Point decline over per 1000 population