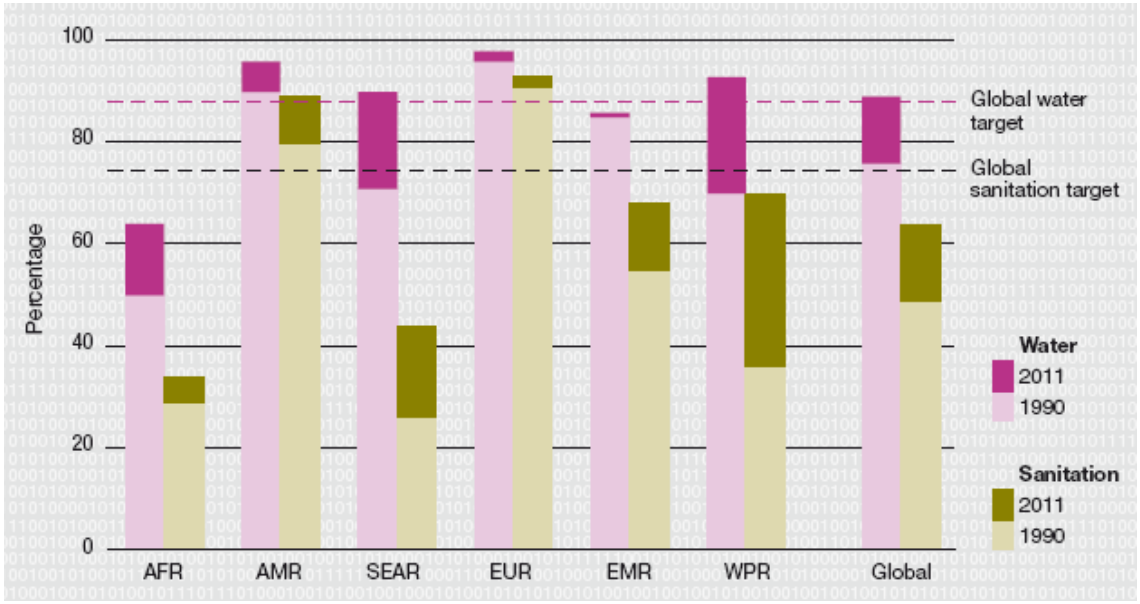
Chapter 30

Health and Family Welfare

30.1 Incorporating Health Concerns Globally : The **right to health** is the economic, social and cultural right to the highest attainable standard of health. It is recognised in the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of Persons with Disabilities . Countries round the world are trying to address the issue of affordable health care for all . Recent 'Obama Care' or the 'Patient Protection and Affordable Care Act' in the US has been making waves of late. Recognition of health as instrumental in the global development goals is also reflected through its inclusion as one of the three component of **Human Development Index** (life expectancy at birth is used as an indicator for assessing health attainments) and in selection of several health indicators for monitoring the health related **Millennium Development Goals (MDG)** viz reducing child mortality, improving maternal health & combating HIV/AIDS, malaria & other diseases.

30.2 As per **World Health Statistics 2014**, everyday about 800 women die due to complications of pregnancy and birth. However the World has made significant progress in reducing child deaths by 40 % from nearly 12 million deaths in 1990 to less than 7 million in 2011as the child survival rates have improved in all regions of the world over the past decade. Preterm birth is the world's leading killer of newborn babies, causing one million deaths each year. The world is facing a double burden of malnutrition, with under nutrition and overweight impeding survival and causing serious health problems. Almost 10 % of world's adult population has diabetes, measured by elevated fasting blood glucose (≥ 126 mg/dl). The world has reached the global target for drinking water, having halved the number of people in the world without access to improved drinking water sources since 1990. However, global coverage in terms of sanitation facility is currently estimated at just 64 %, leaving one third of the global population without access to improved sanitation facilities even though about 1.9 billion people have gained access to the same since 1990. Fewer people are dying from HIV. In 2012, an estimated 1.6 million people died from AIDS related causes world wide, 30% less than in 2005 . Many low and middle income countries face a scarcity of medicine in the public sector, forcing people to the private sector where prices can be up to 16 times higher. Also there are wide inequities in access to health services within the population due to factors including education and income level, geographic location, gender etc.

30.3 Proportion of population with access to improved drinking water sources and improved sanitation, globally and by WHO region – 1990-2011



AFR: African Region AMR : America SEAR : South East Asia Region EUR: European Region EMR : Eastern Mediterranean Region WPR Western Pacific Region .

Comparison of Expenditure (at average Exchange Rate USD) On Health During 2011

WHO Region/Country	Per Capita Govt Expenditure on Health	Per Capita Total Expenditure on Health
Global	614.8	1029.6
Europe	1786.3	2373.4
Americas	1695.7	3537.3
Africa	49.2	99.4
South-East Asia	24.5	65.8
China	155.4	**278**
India	**18.3**	**59.1**

WHO Region/Country	Total Expenditure on Health as Percentage of GDP	General Govt Expenditure on Health as Percentage of Total Govt Expenditure
Global	9.2	15.3
Europe	9.1	14.9
Americas	14.3	18.8
Africa	6.0	9.8
South-East Asia	3.7	8.2
China	5.2	**12.5**
India	**3.9**	**8.1**

Source WHO database

History of Health Planning in India:

30.4 Pre Independence : Probably the first document of 'public health policy' in British India was the 1863 report of the Royal Commission on the sanitary state of the British Army in India (Harrison, 1994). Concern about threats to the health of the Indian Army, particularly after the rebellion of 1857, motivated a wide-ranging inquiry into health conditions in the country. If India did not experience the massive decimation of indigenous populations through disease and warfare that the 'New

World' witnessed, there were nevertheless many episodes of sharp rises in mortality, associated with the violence and social disruption of conquest and conflict, most notably the Bengal Famine of 1770. A century later, the great famines of the 1870s and 1890s caused both mass mortality and mass migration; it was fear of unrest and social disruption that caused the colonial state, belatedly, to take some interest in famine relief and public health (Dreze, 1988; Hodges, 2004). It was for a long time a commonplace that one of the 'benefits' of colonial rule in Asia and Africa was the advent of modern medicine. Institutions of public health—hospitals, health centres, medical research laboratories, pharmaceutical production facilities—were amongst the new colonial institutions that appeared in South Asia, along with the railways, the telegraph and new forms of land tenure and law. As an 'extractive' colonial state, public health and social welfare were never near the top of the Raj's priorities as it focused on keeping epidemics at bay, responding to crises and not much more. A crucial institutional innovation came in the 1880s (Jeffery, 1988), when much of the responsibility for local health and sanitation was devolved to partly elected local government bodies, a responsibility shared by the 1920s with provincial governments an arrangement that continues more or less till present day Nonetheless, it was at the level of local sanitation that the most tangible improvements in public health were found in early 20th-century India. Cholera, the great scourge of India in the 19th century, saw a significant decline, as a result of the provision of clean drinking water at major sites of pilgrimage (Arnold, 1993).However due to weakness of infrastructure, 'local authorities at best could only select the most pressing cases for relief; at worst the slender local funds were dissipated in tiny sporadic ventures from which no permanent benefit was derived' (Tinker, 1954: 287). The nature of the colonial state's engagement with questions of public health can best be described as ambivalent. This left much scope for 'civil society' or voluntary initiatives in health. Devolving responsibility to charities and voluntary bodies suited the colonial state, In the view of Dr Nil Ratan Sircar, a prominent nationalist and member of the Indian Medical Association, 'medical backwardness' was a consequence of imperialism.

Post Independence :

30.5 The serious crises of the 1940s, with the massive influx of refugees during and after Partition, revealed the fragility and weakness of India's health infrastructure. Independence arose great expectations amongst people. However, the long legacy of **under-investment in health institutions**, made the promises and expectations related to public health unrealistic as plethora of issues competed for support and resources. When, by the 1960s, external resources for population control proliferated, and the old argument re-asserted itself that population control may be a more 'cost-effective' way of achieving the same ends as public health, the level of resources devoted to public health dropped significantly (Rao, 2005), and there was surprisingly little discussion or dissent. The post-colonial Indian state population policy reached its sordid climax in the forced sterilisations of the Emergency period . It is in the gap between expectations of health and the availability of health facilities that we can look for an explanation of why, despite the centrality of the state to public health policy in India since independence, India has developed one of the most extensive, and least regulated private markets in health in the world. Indian state was engaged with public health in the period since independence—emphasising single diseases, and techno-centric interventions on a large scale— eg National Malaria Control Programme resulting in relative neglect of issues like sanitation.

30.6 However, significant **regional variations** have been observed in the ways in which the national (and international) disease control campaigns affected local health services. Health, in mid-20th century **Kerala**, was championed as a 'people's right', in a way almost without parallel in the region. The broad politicisation of questions of public health led to a heightened awareness among the poor that 'health services were their right and not a boon conferred upon them'. This was aided by vigorous popular press—newspapers, women's magazines—in a highly literate and informationally dense society of Kerala where female labour-force participation was high (Devika, 2002). In the more recent past, the neighbouring state of **Tamil Nadu** has also chalked up significant achievements in the field of health. A particularly noteworthy intervention in this case was the institution in 1982 of the Mid-Day Meals scheme, which has guaranteed one meal a day to children in government-aided schools. More generally, and again in contrast to the pattern across large parts of north India, local health services in Tamil Nadu are broadly of good quality, and widely accessible. Civic activism in health has shaped the policies in these states eg People's Science Movement in Kerala, focussed initially on literacy, but by the 1990s turned to public health. The Tamil Nadu Science Forum's health movement, the Arogya Iyakkam , has been active in 500 villages, spreading awareness and education about public health.

30.7 By the mid-20th century the notion that health was a right gained ground. Yet the institutional legacies of the colonial state, in terms of the medical infrastructure and fiscal structure of the new state, acted to constrain the extent to which the 'desirable' (a vast reduction in disease and human suffering) could be realised.

30.8 The political economy of health care in India has been characterised by **widespread privatisation**, and the large, perhaps dominant, role of the private and informal sector in providing healthcare, even to the very poor. Marked regional variations are observed in health outcomes, and in the degree and the extent to which healthcare is publicly available. Emphasis on health in terms of public expenditure, access to public health services and its quality , penetration & access of health services, still leaves much to be accomplished.

30.9 National Health Policy document (Government of India, 2002) summarised the same . "Given a situation in which national averages in respect of most indices are themselves at unacceptably low levels, the wide inter-state disparity implies that, for vulnerable sections of society in several states, access to public health services is nominal and health standards are grossly inadequate".

30.10 Sen & Dreze pointed out the stark comparisons while analyzing India's performance in health about a decade ago . Only in the last few years has public expenditure on health in India risen above the level of 0.8 or 0.9 percent of GDP, which is India's historical average, lower than almost any other country in the world (Sen and Dreze, 2002: 202). The share of public expenditure to total health expenditure in India is around 15 percent: the average for sub-Saharan Africa is 40 percent, and for high-income European countries, over 75 percent (Sen and Dreze, 2002: 204)

30.11 Even presently, as revealed by WHO database, per capita health expenditure in India is quite low both in terms of government expenditure & total expenditure on

health. Besides being significantly lower than the global average, it falls much short even compared to the average for Africa. (The comparisons have been tabulated earlier in the chapter). The low per capita expenditure can't be attributed to India's higher population only (which is higher in case of China also but China performs far better) since the indicators pointing to relative importance of health (expenditure on health as per cent of GDP and government expenditure on health as per cent of total government expenditure) also do not compare well with the global average or even that of the Africas.

Recent Govt Initiatives & Achievements :

30.12 **Health Policy :** The policy directions of the Health for All declaration became 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) were to emphasize a) the need to increase the total public health expenditure from 2 to 3% of the GDP, b) 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. **The National Population Policy** (2000) not only focused on the unmet needs of contraception, but also stressed the need for an integrated service delivery for basic reproductive and child health care. It was in this context that the **National Rural Health Mission** was launched and this was the main programme of the 11th Plan period.

30.13 **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.

- **Prerna Strategy :** The strategy was launched by JSK in 2008 and is in operation in seven high focus states of Odisha, Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand and Rajasthan. The strategy recognizes and awards the eligible young BPL couples from backward districts of the country, who have broken the stereotype of early marriage and early child birth and helped change mindsets.
- **Santushti Strategy:** Santushti is a scheme of Jansankhya Sthirata Kosh (JSK) for high populated states of India viz Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh & Odisha. Under this scheme, Jansankhya Sthirata Kosh, invites private sector gynaecologists and vasectomy surgeons to conduct operations in Public Private Partnership mode.

30.14 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 and quality health care services that are accountable and responsive to peoples need.

30.15 The National Rural Health Mission (NRHM) was launched by Government of India in 2005 . NRHM seeks to provide accessible, affordable and quality health care to rural population especially the vulnerable group. It places considerable emphasis on strengthening rural health infrastructure including physical infrastructure, manpower and other facilities and consists of following components:

(i) Health System Strengthening: Mobile **Medical Units (MMUs)** are being operated to provide outreach services in rural and remote areas. Emergency Medical Transport System - A fleet of EMRI vehicles to provide basic and advanced life support to the beneficiaries have also been given to states. This is popularly also known as the 108 type ambulance. **National Ambulance Services:** 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. Support is being provided to the States for new construction/ up-gradation/renovation of healthcare facilities. Strengthening First Referral Units and Operationalisation of more 24x7 Facilities is also being carried out. As part of infrastructure establishment, dedicated 100 bedded **Mother & Child Health (MCH) wings** are being constructed in 148 District Hospitals while 50/30 bedded dedicated MCH wings are being constructed in 110 CHC/Sub District Hospitals. Augmenting human resource in health sector by encouraging the States for engaging health personnel including doctors, nurses and .paramedics etc are other activities envisaged under the component of strengthening of health system. **National Health Systems Resource Centre (NHSRC)** at the National level and Regional Resource Center in Guwahati for NE, have been set up and the State Resource Centres are being set up by States.

(ii) **Reproductive, Maternal, Newborn, Child and Adolescent Health (RCMNH+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 services itself. Family Planning : In 1952, India launched the world's first national program emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy". Since then, the family planning program has evolved and the program is currently being repositioned to not only achieve **population stabilization** but also to promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity.** The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family

welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others). Both spacing (IUCD, Oral Comntraceptive Pills, Condoms) and limiting methods (Minilap, laproscopic sterilization, no scalpel Vasectomy) , are being promoted . Strengthening community based distribution of contraceptives by involving ASHAs and Focussed IEC/ BCC efforts for enhancing demand and creating awareness on family planning. *Contraceptives like oral contraceptive pills OCPs, Condoms are also provided through Social Marketing Organizations.*

- **Family Planning Insurance Scheme (FPIS)** for treatment of post operative Complications, or Death attributable to the procedure of sterilization was introduced w.e.f 29th November, 2005. Compensation scheme for acceptors of sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization has also been revised.The Government of India has made a provision for development of **Health Insurance Scheme** for below Poverty Line (BPL) families under the framework of National Rural Health Mission (NRHM). The Ministry of Health and Family Welfare subsidizes the cost of the annual premium up to 75% subject to a maximum of Rs. 300 per BPL family for this Scheme .The Rastriya Swasthya Bima Yojana (RSBY) being administered by Ministry of Labour & Employment provides for smart card based cashless health insurance cover for Rs. 30000 per annum to BPL families (a unit of five) in the unorganized sector. The scheme is presently being implemented in 25 States/UTs.
- **Child Health & Immunization: Facility Based Newborn & Child care:** Setting up of facilities for care of Sick Newborn such as Special New Born Care Units (SNCUs), New Born Stabilization Units (NBSUs) and New Born Baby Corners (NBCCs) at different levels is a thrust area under NRHM. **Janani Shishu Suraksha Karyakram** (JSSK) was launched on 1st June 2011and has provision for both pregnant women and sick new born till 30 days after birth are (1) Free and zero expense treatment, (2) Free drugs and consumables, (3) Free diagnostics & Diet, (4) Free provision of blood, (5) Free transport from home to health institutions, (6) Free transport between facilities in case of referral, (7) Drop back from institutions to home, (8) Exemption from all kinds of user charges. All the 35 States and Union Territories are implementing this scheme.
- **Integrated Management of Neonatal & Childhood Illness** : 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 at the facility. Facility based IMNCI focuses on providing appropriate skills for inpatient management of major causes of Neonatal and Childhood mortality such as asphyxia, sepsis, low birth weight and pneumonia, diarrhea, malaria, meningitis, severe malnutrition in children. This training is being imparted to Medical officers, Staff nurses and ANMs at CHC/FRUs and 24x7 PHCs where deliveries are taking place.
- **Navjat Shishu Suraksha Karyakram** : objective of this new initiative is to have a trained health personal in Basic newborn care and resuscitation at every delivery point. Infant & Young Child feeding is encouraged and for reduction in morbidity & mortality due to acute respiratory infections (ARIs) & Diarrhoeal diseases

: promotion of zinc and ORS supply is ensured . Nutritional Rehabilitation Centres (NRCs) are being set up in the health facilities for inpatient management of severely malnourished children, with counselling of mothers for proper feeding and once they are on the road to recovery, they are sent back home with regular follow up.

- Services of 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.**ASHAs** were useful in Intense monitoring of Polio Progress.
- **Institutional Delivery: 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.
- **Mother and Child Tracking System:** 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. 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.
- **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) 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.

(iii) National Diseases Control Program: This includes Iodine deficiency disorders control programme, vector borne diseases control programme, TB Control Programme, National Programme for control of blindness, leprosy eradication programme etc . **Integrated Disease Surveillance Project (IDSP)** was launched with World Bank assistance in November 2004 to detect and respond to disease outbreaks quickly. The project was extended for 2 years in March 2010. From April 2010 to March 2012, World Bank funds were available for Central Surveillance Unit (CSU) at NCDC & 9 identified states (Uttarakhand, Rajasthan, Punjab, Maharashtra, Gujarat, Tamil Nadu, Karnataka, Andhra Pradesh and West Bengal) and the rest 26 states/UTs were funded from domestic budget. The Programme continues during 12th Plan under NRHM with outlay of Rs. 640 Crore from domestic budget only.

30.16 **The Village Health Sanitation and Nutrition Committee (VHSNC), Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Societies etc** are also key components of NRHM, assisting through participatory management.

30.17 **Universal Health Coverage:** Moving towards Universal Health Coverage (UHC) is a key goal of the Twelfth 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 of the private sector to close the 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.

30.18 New Initiatives under NRHM:

- **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.

- **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
- **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.
- **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 call and Intercative Voice Response System (IVRS) on a regular basis.
- **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. 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.

30.19 Progress under NRHM during 2013-14 is as follows : (Status as on 31.12.2013)

- **ASHAs:** 8.94 lakh Accredited Social Health Activists (ASHAs) have been selected in the country, of which over 8.32 lakh received training upto 1st Module. Over 8.20 lakh ASHAs have been positioned after training and have been provided with drug kits.

- **Infrastructure:** 93 District Hospitals (DHs), 526 Community Health Centers (CHCs), 2680 Primary Health Centers (PHCs), and 23315 Health Sub-Centers were taken up for new construction. Construction work of 34 DHs, 227 CHCs, 1862 PHCs and 2604 SCs has been completed. 659 District Hospitals, 3132 Community Health Centers (CHCs), 7628 Primary Health Centers and 16954 Health Sub-Centers were taken up for upgradation/renovation, out of which upgradation/renovation of 490 DHs, 1826 CHCs, 5970 PHCs and 11849 SCs was completed. 8760 PHCs were made functional round the clock (24X7) and 2734 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.
- **Mobile Medical Units** 2127 Mobile Medical Units (MMUs) are operational in different States, providing services in the interior areas covering 418 districts.
- **Manpower :** 7659 Doctors, 12357 AYUSH Doctors, 2973 Specialist, 71946 ANMs, 38339 Staff Nurses, 15760 Paramedics and 5336 AYUSH paramedics were appointed on contract by States to fill in critical gaps under NRHM.
- **Institutional Delivery Janani Suraksha Yojna (JSY)** is operationalized in all the States, 7.38 lakh women benefited in the year 2005-06 and 106.48 lakh in the year 2012-13. 78.27 lakh women received benefits in the year 2013-14 upto December 2013.

30.20 National Urban Health Mission: The National Urban Health Mission (NUHM) as a submission 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.

30.21 NUHM would cover all cities/towns with a population of more than 50,000. Towns below 50,000 population will be covered under NRHM. It would cover urban population including slum dwellers; other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers, who may be in slums or on sites. The existing Urban Health Posts and Urban Family Welfare Centres would be taken as existing infrastructure under NUHM and will be considered for up gradation. All the existing human resources will then be suitably reorganized and rationalized.

30.22 **E Governance Initiatives :** For effective delivery of services and monitoring of various programs several steps have been taken in recent past .

- **Mother & Child Tracking System (MCTS)** aims to capture and track all pregnant women and children so that they receive full maternal and child health services. MCTS has been implemented across the country in all the states. MCTS was started in December 2009. It has registered more than 3.3 crore Pregnant

Women/Mother and more than 2.5 crore of Children and their Health Care Services record. More than 2.25 Lakh ANMs and 8.29 Lakh ASHAs have been registered on MCTS Portal.

- **Online Monitoring of TB Patients (NIKSHAY), Computerization of Central Government Health Scheme** (**CGHS**), **MIS for Online Clinical Establishment Registration and Regulation, National Programme for Control of Blindness (NPCB) MIS** and **e-Hospital – A Hospital Management System from NIC** (a patient-centric system rather than a series of add-ons to a financial system) are among other uses of IT towards promoting health .

- In pursuance of the recommendation of National Knowledge Commission, the Ministry has decided to set up and operationalize **National Health Portal (NHP)** which will provide easy to access health related information for various stake holders like common man, health professionals, academicians, Government Departments, etc. in Hindi, English and other major regional languages.

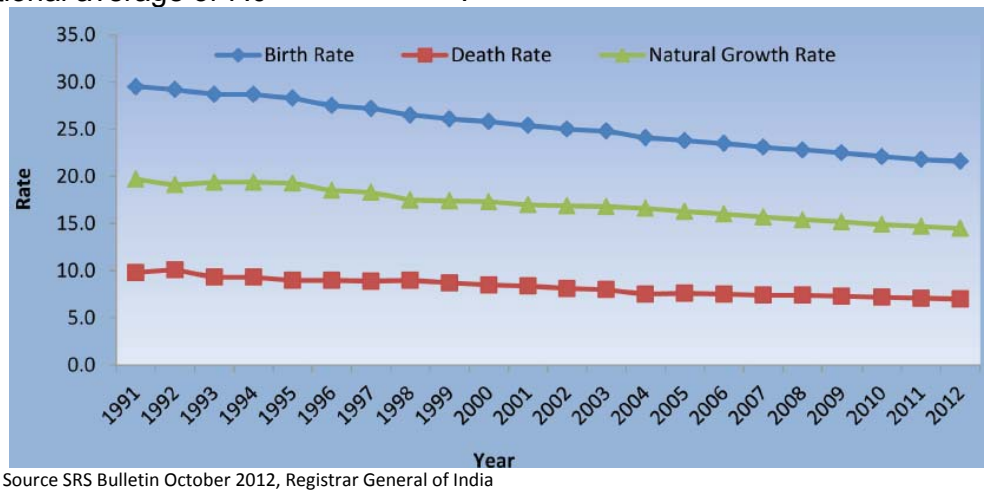
- **Health Management Information System (HMIS)** is a web-based system being implemented by the Ministry. HMIS aims to collect information on some critical indicators related to the health sector. HMIS was launched in October 2008 and initially it was being implemented at District level. More than 99% of the districts are reporting regularly on HMIS portal. However, States / UTs were advised to shift to facility based reporting from April 2011 to facilitate micro planning by States / UTs. While the progress of States / UTs on facility-based reporting is not uniform, more and more Districts are shifting to facility-based reporting.

Performance of India on various indicators related to health & family welfare :
30.23 The demographic and health status indicators have shown significant improvements. Some of them are tabulated below.

Sl. No.	Parameters	1951	1981	1991	2001	Current Levels
1	Crude Birth Rate (per 1000 population	40.8	33.9	29.5	25.4	21.4(2013)
2	Crude Death Rate (per 1000 population)	25.1	12.5	9.8	8.4	7.0(2013)
3	Total Fertility Rate	6.0	4.5	3.6	3.1	2.4 (2012)
4	Maternal Mortality Ratio (per 100,000 live births)	NA	NA	398 SRS (1997-98)	301 (2001-03)	178 (2010-12)
5	Infant Mortality Rate (per 1000 live births)	146 (1951-61)	110	80	66	40(2013)
7	Couple Protection Rate (%)	10.4 (1971)	22.8	44.1	45.6	40.4(2011)
8	Expectation of life at birth (in years) -Male -Female	37.1 36.1 (1951)	54.1 54.7	60.6 61.7 (1991-96)	61.8 63.5 (1999-03)	64.6 67.7(2006-10)

Source: Office of Registrar General of India, except 7 above which is based on estimation done by statistics Division of Ministry of Health and Family Welfare. NA – Not available

30.24 The estimated birth rate declined from 25.8 in 2000 to 21.4 in 2013 , while the death rate declined from 8.5 to 7.0 per 1000 population over the same period . Consequently the natural growth rate declined from 17.3 in 2000 to 14.4 in 2013. Amongst bigger states, in 2013, Bihar recorded highest birth rate (27.6) followed by U.P (27.2) whereas Kerala recorded lowest birth rate of 14.7. MP & Odisha recorded highest death rate of 8.0 and 8.4 respectively, much higher than the national average of 7.0 .



Source SRS Bulletin October 2012, Registrar General of India

30.25 Life expectancy at birth has been increasing since 1911-20 when it hovered around 20 both for male and female to the present range of 65-70 years, both for male & females.

EXPECTATION OF LIFE AT BIRTH

Census Year		Male	Female
1		2	3
1901-10		22.6	23.3
1911-20		19.4	20.9
1921-30		26.9	26.6
1931-40	(a)	32.1	31.4
1941-50		32.4	31.7
1951-60		41.9	40.6
1961-70		46.4	44.7
1970-75		50.5	49.0
1976-80	(b)	52.5	52.1
1981-85		55.4	55.7
1986-90		57.7	58.1
1991-96		60.6	61.7
1996-01	(c)	62.3	65.3
2001-05		63.8	66.1
2006-10		65.8	68.1
2011-15	(d)	67.3	69.6
2016-20		68.8	71.1
2021-25		69.8	72.3

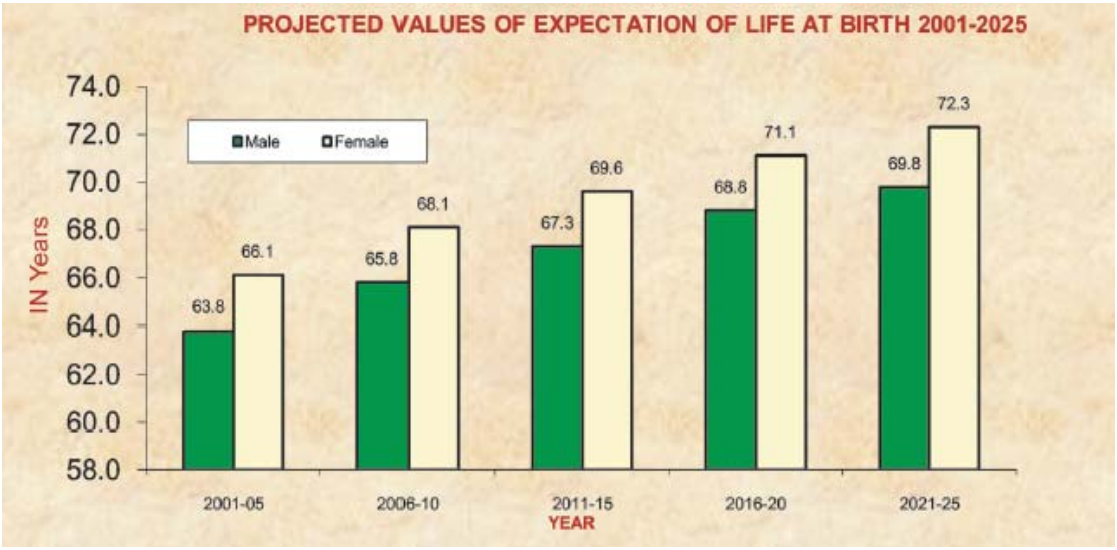
Source:

(a)Office of the Registrar General, India.

(b)Occational Paper SRS No. 3 of 1995

(c)Report of the Technical Group on Population Projections, 1996-2016(Registrar General, Ind

(d)Report of the Technical Group on Population Projections, 2001-2026 :
M/O Health & Family Welfare

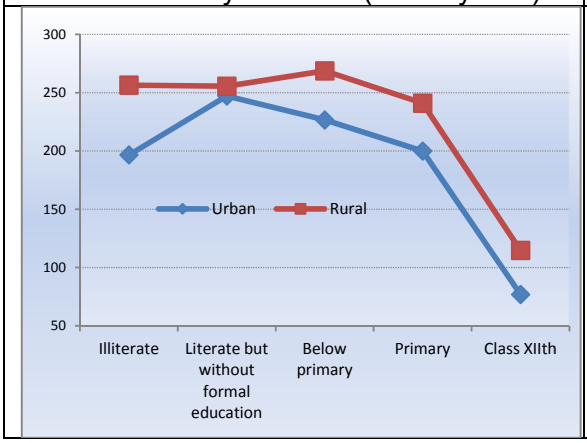


Source : Report of Technical Group on Population Projections May 2006 , National Commission on Population , Ministry of Health & Family Welfare.

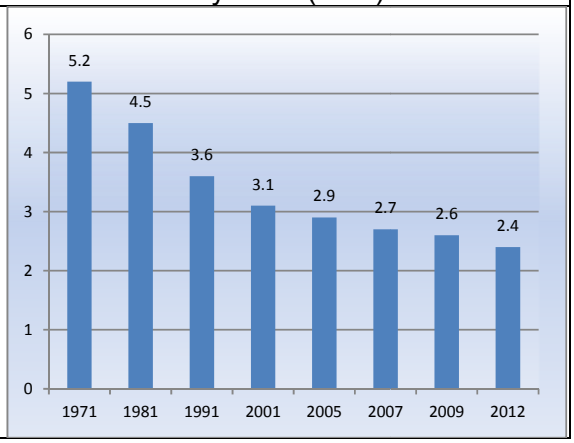
30.26 Fertility Indicators : Age Specific Fertility Rates (ASFR) & Total Fertility Rates(TFR) (2012) : The data reveals that fertility in all the age groups is higher in rural areas than in urban areas. The fertility reaches the peak in the age group 20-24 and usually declines thereafter, irrespective of the place of residence (except for a few states). ASFR curve for urban areas falls under the ASFR curve of rural areas. Rural ASFR curve has declined very steeply after attaining peak for age 20-24 where as urban ASFR curve has gradually declined up to the age 25-29 after attaining peak at age group 20-24.Since 2004, the age group 20-24 continued to have peak fertility rates in urban & rural areas, with the values being lower in urban areas as compared to rural areas. During the last decade decline in fertility rates is more in urban areas compared to rural areas except in the age groups 25-29, 30-34 and 35-39. The decline is perceptible for the higher age groups 40-49 in urban areas. During the last decade, the fertility declined by 61.1 per cent in the age groups 40-44 in urban areas as compared to 55.7 per cent in rural areas. It is slower in the middle age groups 20-29 for both the areas. The minimum decline of 9.5 per cent has been noticed in the age group 20-24 at National level. Except for Jammu & Kashmir, Kerala, Punjab and Uttar Pradesh where fertility reached its peak in the age group 25-29, the highest fertility in all the other bigger States has been attained in the age group 20-24

30.27 Total Fertility Rate (TFR) for the country remained constant at 2.6 during 2008 and 2009 and declined to 2.4 during 2011 and 2012 with Bihar reporting the highest TFR in 2012 at 3.6, followed by UP with TFR at 3.4 while West Bengal & Tamil Nadu continued their outstanding performance with the lowest TFR of 1.7 . TFR in case of rural women was higher (2.6) as compared to the urban women (1.8).

Level of Literacy & ASFR (20-24 years)



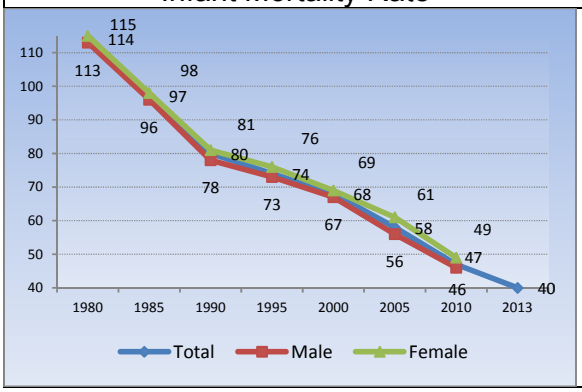
Total Fertility Rate (TFR)



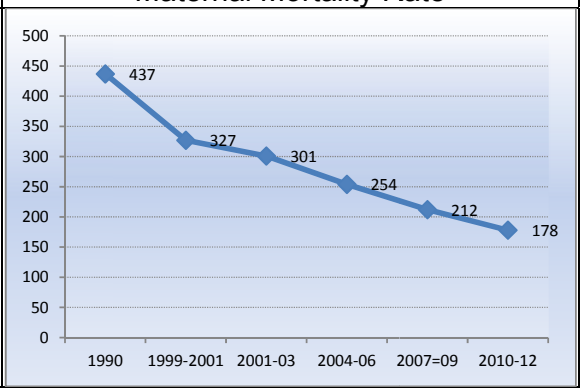
Chapter on Millennium Development Goals & Population may also be seen for Mortality & Fertility related information.

30.28 Maternal & Child Health : India has accepted targets for reduction in **child & maternal mortality** under MDGs & considerable progress has been made though it is likely to miss both the targets as per historical trend. Infant mortality rate has declined significantly (40 per 1000 live births in 20131), however urban (27) – rural (44) differentials and those between male & female infants death are still high .

Infant Mortality Rate



Maternal Mortality Rate



30.29 During 2012-13, 27.7 million women got registered for ante natal care (ANC) check up compared to 28.3 million in the previous year whereas the number in case of women who underwent 3 check ups during the pregnancy period remained at 20.7 million. The institutional deliveries to total deliveries (Institutional + home) increased from 56.7 % in 2006-07 to 79.1% in 2010-11, 81.7 % in 2011-12 and 82.9 % in 2012-13 . Kerala, Tamil Nadu & Goa (99.8% each) were the best performing states in the country during 2012-13. Even with the increase in deliveries attended by skilled personnel, the targeted universal coverage might still be elusive. As per **District Level Health Survey (DLHS)** 2007-08 about 49.8 % of Indian mothers received three or more ante natal check ups , 47 % deliveries were conducted in medical institution while total safe delivery was 52.7 %.

Comparison of Maternal Health Indicators in DLHS, Coverage Evaluation Survey CES & Sample Registration System , SRS

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*	-

30.30 Immunization: In India, under **Universal Immunization Programme (UIP**) vaccines for six vaccine-preventable diseases (TB, diphtheria, pertussis, tetanus, poliomyelitis and measles) are provided free of cost to all. 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.

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 given in next box.

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

Figures are in Lakhs

30.31 Status of Universal Immunization Programme :

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.

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 percentage

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

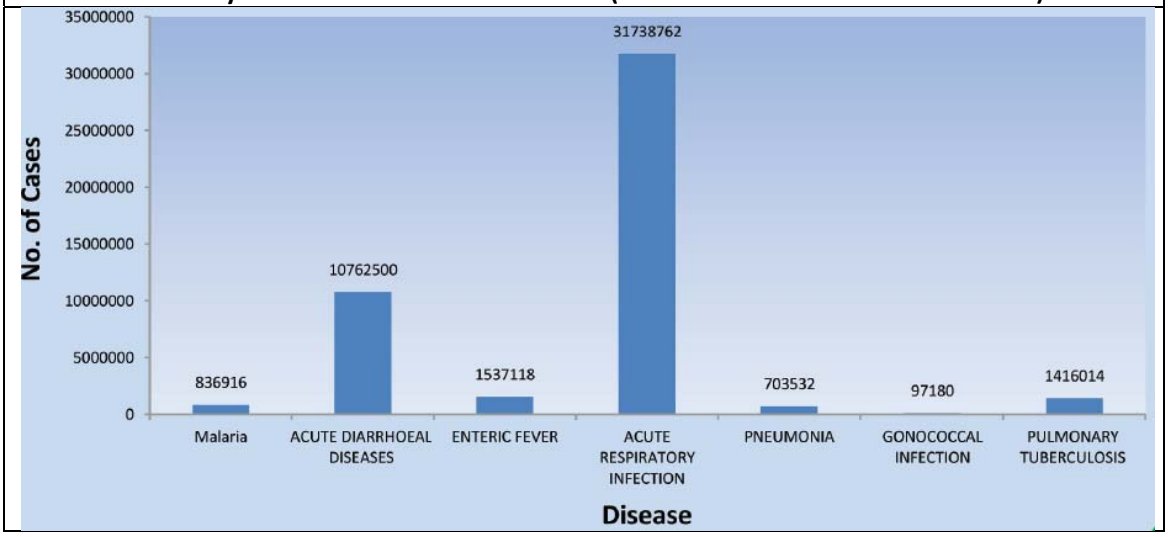
30.32 During 2013-14, 19.26 million children were immunized for DPT and 10.99 million received 2nd booster immunization whereas about 23-24 million immunization (in each case) was administered to children for Polio , BCG and measles and to expectant mothers for tetanus. On 27th March 2014, India along with South-East Asia Region of WHO has been certified **polio free** by Regional Certification Commission for polio eradication.

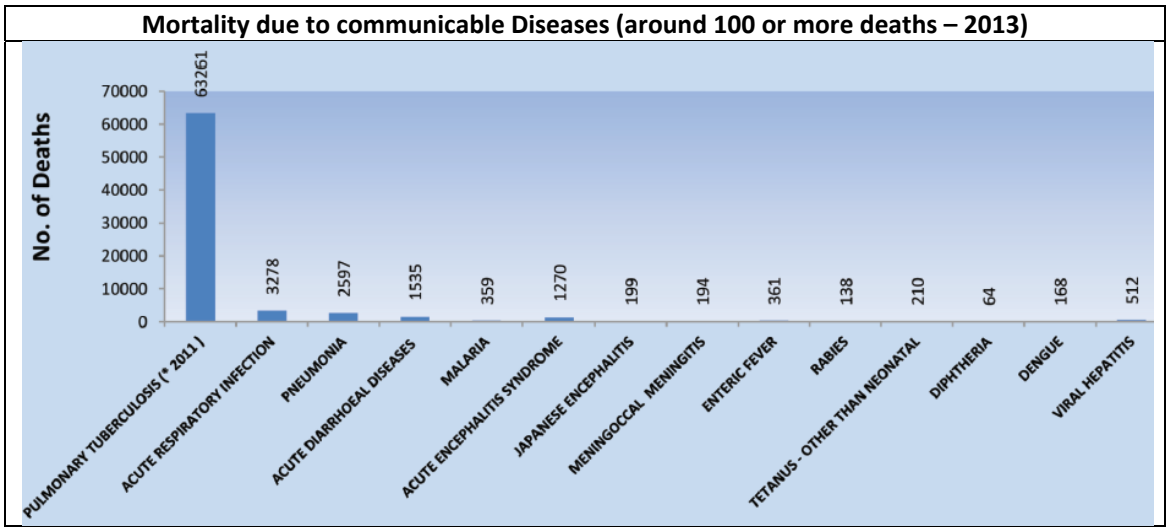
Disease burden indicators: Communicable, non communicable diseases

30.33 Among the various communicable diseases reported by the States/UTs during the year 2011, while taking a cut off of one lakh or more cases; the following communicable diseases accounted for the maximum number of cases & fatalities reported.

Morbidity & Mortality due to communicable diseases 2013

Morbidity due to communicable Diseases (around 1 lakh or more cases – 2013)





30.34 About 1.3 lakh new cases of leprosy were detected during 2013-14 and the overall prevalance rate for India was 0.68 along with 9.98 ANCDR(Annual New Case Detection Rate) . India is highest TB burden country in the world, accounting for about 23.3% of the global prevalence. As per WHO estimations, Tuberculosis prevalence in India per lakh population has reduced from 465 in year 1990 to 230 in 2012. In absolute numbers, prevalence has reduced from 40 lakhs to 28 lakhs annually. Incidence per lakh population has reduced from 216 in year 1990 to 176 in 2012 and Tuberculosis mortality per lakh population has reduced from 38 in year 1990 to 22 in 2012. In absolute numbers, mortality due to TB has reduced from 3.3 lakhs to 2.7 lakhs annually. There has been considerable rise in cases and deaths due to swine flu in 2012 & 2013 (72.6 % increase in number of deaths in 2013 compared to 2012). Malaria death rate has reduced from 0.09 deaths per lakh in 2000 to 0.04.The total positive cases of malaria and deaths have shown decline since 2011 and 2010 respectively.

30.35 Bihar accounted for most cases and deaths by Kaala Azar in 2013 whereas maximum number of Malaria cases were registered in Odisha along with maximum deaths due to malaria in Maharashtra .

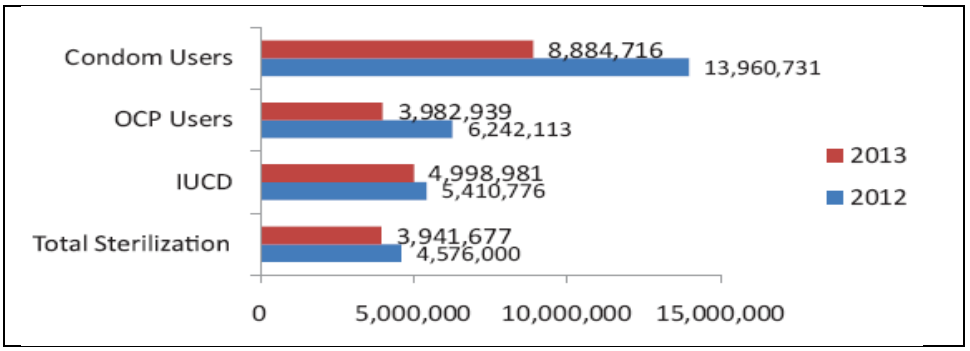
30.36 Diseases with high case Fatality Rate (about 1% or above) during 2013 are tabulated below

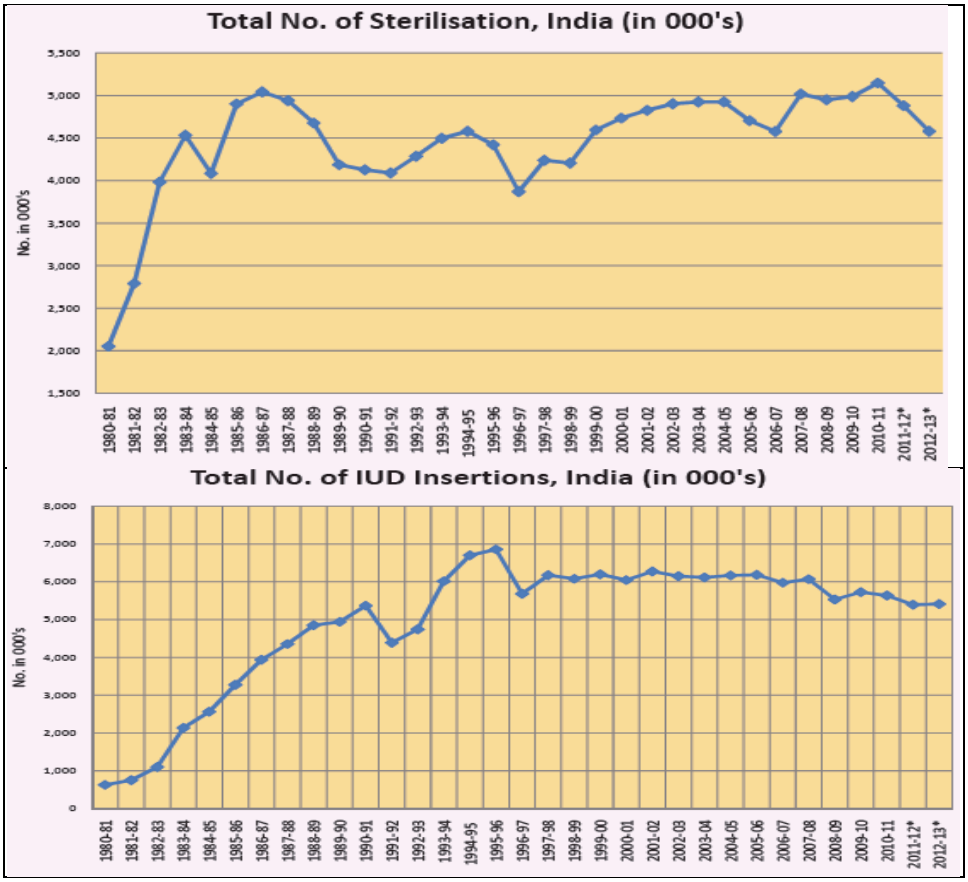
Sl. No.	Diseases	cases	Deaths	Case Fatality Rate (%)
1	RABIES	138	138	100
2	ACUTE ENCEPHALITIS SYNDROME	7465	1270	17.01
3	TETANUS - OTHER THAN NEONATAL	3304	210	6.36
4	MENINGOCCAL MENINGITIS	3758	194	5.16
5	PULMONARY TUBERCULOSIS (2012)	1467585	63261	4.31
6	H1N1 (SWINE FLU)	5253	699	13.31
7	TETANUS - NEONATAL	528	22	4.17
8	DIPHTHERIA	4090	64	1.56

30.37 According to National AIDS Control Organisation (NACO) 7,47,175 patients have ever started anti retroviral therapy (ART) in the country till December 2013 . As per the database maintained by HIV Sentinel Surveillance , trend reversal in prevalence of HIV/AIDS continues since 2005 even though the reduction in prevalence has become less noticeable after 2007 with HIV prevalence among pregnant women aged 15-24 years (in %) since 2004 to 2008 being 0.86, 0.89, 0.57, 0.49 and 0.48 respectively . The prevalence has dropped further to 0.39 in 2010-11. National adult(15-49 years) HIV prevalence was estimated at 0.27 % in 2011 while that among the young population (15-24 years) was at 0.11 %.

30.38 Amongst non communicable diseases coronary heart disease, diabetes, hypertension, blindness and mental disorders were the major ones. The number of cases of coronary heart disease was estimated to be nearly 3.6 crore during 2005 and the same is expected to reach about 6.1 crore by 2015 whereas that of diabetes is expected to increase from 3.1 Crore to nearly 4.6 Crore during the same period. Prevalence of hypertension in India among adults is nearly about 159.46 per thousand and the case load ratio in respect of major mental disorders has been calculated to be about 1% of population whereas the same is about 5% in case of minor mental disorders.

30.39 Family Planning: Out of the total of about 3.9 million sterilizations in 2013-14 , 3.8 million pertained to females being sterilised. During 2013-14 (Upto September 2013) , sale of oral contraceptive pills and condoms through social marketing scheme was 125 lakh cycles & 315 million pieces respectively compared to 377 lakh cycles and 648 million pieces in 2012-13 and 472 lakh cycle and 678 million pieces in 2011-12. During 2002-03 to 2007-08 the number of total family planning acceptors was more than 40 million with maximum number of about 49 million acceptors recorded during 2007-08.





30.40 Health Finance Indicators: Percentage of allocation for the health sector against the total planned investment in the country by the central government has increased to some extent in the Eleventh Plan when the Health Research Development was created and the National Rural Health Mission (NRHM) Schemes were started.

30.41 As per **World Health Organization database** during 2012, in case of India, government expenditure on health as a percent of total expenditure on health was 33.1 % whereas out of pocket expenditure and private prepaid plans as percentage of private expenditure on health were 86 % and 4.7 % respectively. Government expenditure on health as a percent of total expenditure on health remained in the range of 21-26 % during 1995- 2008 thereby steadily increasing to cross 30 % in 2011. Out of pocket expenditure as percentage of private expenditure on health remained in a narrower range (90-92 %) during 1995-2005 and has remained around 86 % since 2008. The per capita total expenditure on health at average exchange rate (US$) in case of India decreased to 61.4 during 2012 from 61.8 in the year before though the same has increased much over the years (15.9 in 1995 ; 19.8 in 2000; 31.6 in 2005; 52.2 in 2010) . On the other hand per capita total expenditure on health and per capita government expenditure on health in terms of PPP(intl $), in case of India, have increased from 46.3 & 12.0 in 1995 to 156.9 & 51.9 respectively in 2012.

Pattern of Central Allocation (Total for the country and Union MoHFW) Rs Crore

S. No.	Period		Total Plan Investment Outlay (All Heads of Devp.) of country	Health Sector		AYUSH*	National Rural Health Mission (NRHM)/ NHM	National Aids Control Organization (NACO)	Health Research	Total	% Outlay
				Health	Family Welfare						
1	First Plan (1951-56)	(Actuals)	1960.0	65.2 (3.3)	0.1 (0.1)	-				65.3	3.4
2	Second Plan (1956-61)	(Actuals)	4672.0	140.8 (3.0)	5.0 (0.1)	-				145.8	3.1
3	Third Plan (1961-66)	(Actuals)	8576.5	225.9 (2.6)	24.9 (0.3)	-				250.8	2.9
4	Annual Plans (1966-69)	(Actuals)	6625.4	140.2 (2.1)	70.4 (1.1)	-				210.6	3.2
5	Fourth Plan (1969-74)	(Actuals)	15778.8	335.5 (2.1)	278 (1.8)	-				613.5	3.9
6	Fifth Plan (1974-79)	(Actuals)	39426.2	760.8 (1.9)	491.8(1.2)	-				1252.6	3.1
7	Annual Plan 1979 - 80	(Actuals)	12176.5	223.1 (1.8)	118.5 (1.0)	-				341.6	2.8
8	Sixth Plan (1980-85)	(Actuals)	109291.7	2025.2 (1.8)	1387 (1.3)]	-				3412.2	3.1
9	Seventh Plan (1985-90)	(Actuals)	218729.6	3688.6 (1.7)	3120.8 (1.4)	-				6809.4	3.1
10	Annual Plan (1990-91)	(Actuals)	61518.1	960.9 (1.6)	784.9 (1.3)	-				1745.8	2.9
11	Annual Plan (1991-92)	(Actuals)	65855.8	1042.2 (1.6)	856.6 (1.3)	-				1898.8	2.9
12	Eighth Plan (1992-97)	(Outlays)	434100.0	7494.2 (1.7)	6500 (1.5)	108 (0.02)				14102.2	3.2
13	Ninth Plan (1997-02)	(Outlays)	859200.0	19818.4 (2.31)	15120.2 (1.76)	266.35 (0.03)				35204.95	4.09
14	Tenth Plan (2002-07)	(Outlays)	1484131.3	31020.3 (2.09)	27125.0 (1.83)	775 (0.05)				58920.3	3.97
15	Eleventh Plan (2007-12)	(Outlays)	2156571.0	136147.0 # (6.31)		3988.0 (0.18)				140135.0	6.50
16	Twelth Plan (2012-17)	(Outlays)		75145.29		10044.0	193405.71	11394.00	10029.00	300018.0	
17	Annual Plan (2012-13)	(Outlays)		27127µ		990.00	20542.00	1700.00	460.31	30477.00	
18	Annual Plan (2013-14)	(Outlays)		8166.00		1069.00	20999.00	1785.00	726.00	32745.00	
19	Annual Plan (2014-15)	(Outlays)		8233.00		1069.00	21912.00	1785.00	726.00	33725.0	

Figures in brackets indicate percent to total plan investment outlay

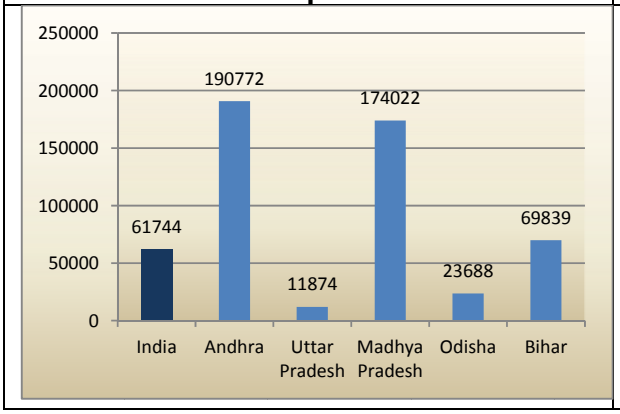
30.42 Infrastructure Indicators: As per National Health Profile 2013 published by CBHI the developments in health infrastructure in terms of educational & service infrastructure are as follows:

30.43 Educational Infrastructure: Medical education infrastructures in the country have shown rapid growth during the last 20 years. The country has 381 medical colleges and 301 dental colleges. Total admission of 43,576 in 381 medical colleges & 25,320 in BDS was reported during 2013-14 . There were 2670 Institution for General Nurse Midwives with admission capacity of 1,09,224 and 686 colleges for pharmacy (diploma) with an intake capacity of 40,898 as on 31st March 2013.

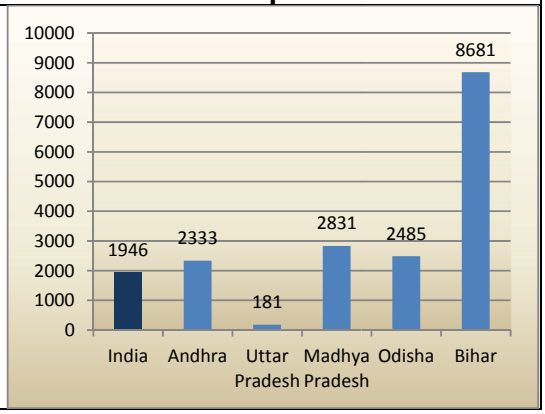
30.44 Services Infrastructure: As per National Health Profile 2013, there are 19,817 hospitals having 6,28,708 beds in the country . Out of them, 15,398 hospitals are in rural area with 1,96,182 beds and 4,419 hospitals in urban area with 4,32,526 beds. There were 1,51,684 Sub Centers, 24,448 Primary Health Centres and 5,187 Community Health Centres in India as on March 2013. 26,107 dispensaries and 3,167 hospitals were providing medical care facilities under AYUSH as on 1.4.2013 and the total number of licensed blood banks in the country as on December 2013 was 2,545 whereas the number of functional eye banks as on 31st December 2013 was 249.

30.45 There is large disparity in the health care infrastructure indicators across the Indian states when compared to the national average.

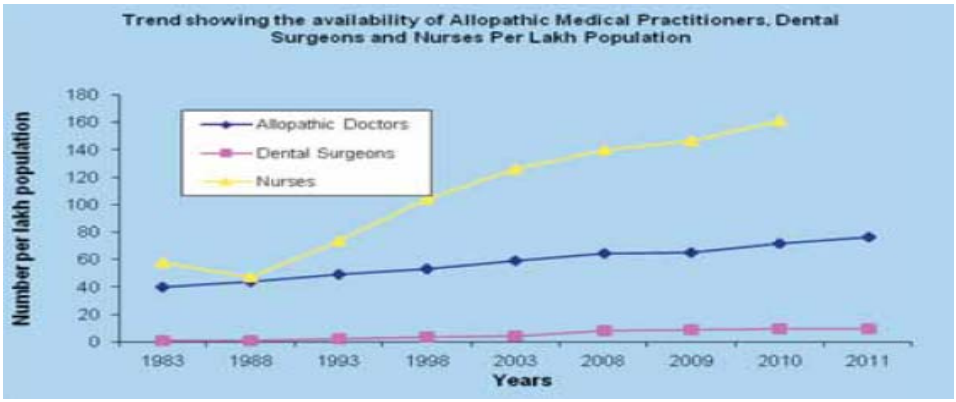
Average Population Served per Govt. Hospital



Average Population Served per Govt hospital bed



30.46 HR Indicators : Number of allopathic doctors possessing recognized medical qualifications (Under MCI Act) and registered with State medical councils for the year 2012 & 2013 were 30,017 & 26,878 respectively whereas the number of Dental Surgeon registered with Central/State Dental Council of India upto 31.12.2012 were 1,20,897 .The number of registered Ayush doctors in India as on 1.1.2013 was 6,86,319 with about 57 % dealing with Ayurveda & 35 % with Homeopathy. There is an increase in availability of Allopathic Medical Practitioners, Dental Surgeons & Nurses per lakh population over the years.



Total Population of India served per Medical Personnel

S. No.	National Councils Registered (Latest)	Population Served per Doctor/Dental surgeon/ AYUSH/ Nurse/Phamacist*
1	Per Doctor both Allopathic and AYUSH	1217.84
1.1	Allopathic Doctor	1384.43
1.2	AYUSH Doctor	1783.21
2	Dental Surgeon	10120.85
3	Nurse	531.79
4	Pharmacist	1986.94

Source : National Health Profile

30.47 Financing Mechanism: Private funds account for maximum fund flow to health sector in India and the same largely constitutes spending by households. Social insurance funds, firms , NGOs etc comprised a small portion of private funds. However, the reforms brought on by the economic policies of the 1990's, helped India attract a lot of interest and investment from foreign sources. Private equity, venture capital, external commercial borrowings, etc brought in new funding options besides long-term debt which was used as the primary mechanism to finance hospitals in India. Government expenditure on health has also grown as India aims at universal health coverage. It includes funds allocation by both Central & State Governments besides Local Bodies and as per WHO database, government expenditure on health during 2012, in case of India, was about one third of total expenditure on health.

Avenues for healthcare funding in India

Private	Public	Others
Debt financing - long term bank loan	Annual govt budget for rural health	Foreign donations
Foreign direct investment	Annual govt budget for urban health	PPP project funding
External commercial borrowing	Govt. funding for community programmes	
Private equity funds	Incentives and subsidies	
Individual investors	Govt. sponsored schemes	
Foreign institutional investors	Community based schemes	
Venture capital funds		

30.48 Sources of Health Statistics in India: Health-related data provides insights into following areas:

(a) Demographic data: population by age and sex, rural/urban classification, geographical distribution, occupational classification, literacy, religion, marital status, migration, etc.;

(b) Vital statistics: birth and death rates, infant mortality rates, life tables, general fertility rates, etc.;

(c) Diseases: mortality rates by age and cause of death, morbidity data by age, sex, prevalence of communicable diseases, deliveries and statistics of anti-natal and post-natal care.;

(d) Facilities: hospitals, dispensaries, clinics, nursing homes, diagnostic centres, laboratories, equipments-X-ray and other diagnostic equipments, ambulances, beds, etc.;

(e) Manpower : doctors, specialists and practitioners in allopathic , homeopathy and other Indian systems of medicines, nurses , pharmacists, lab technicians other supporting staff (their number, qualification, geographical distribution, availability per unit o f population);

(f) Finance: Government Revenue and Expenditure, allocation for health-Plan Outlays, sources of health finance, public and private expenditure on health, external

flows, coverage under private health insurance, expenditure on health by households etc.

30.49 Ministry of Health & Family Welfare is the chief agency involved in Health sector schemes & statistics for monitoring them and situation assessment. It consists of following Departments :

- Department of Health & Family Welfare
  - Directorate General of Health Services(DGHS)
    - Central Bureau of Health Investigation (CBHI)
- Department of AYUSH
- Department of Health Research
- Department of AIDS Control

30.50 Directorate General of Health Services (DGHS) an attached office of **Department of Health & Family Welfare** renders technical advice on all medical and public health matters and is involved in the implementation of various health services. To coordinate and advise on the development of **health information** in the country, at the national level, a small Bureau existed since 1937. This bureau was organized in 1961 into the **Central Bureau of Health Intelligence** (CBHI) in the **Directorate General of Health Services**(DGHS) an attached office of **Department of Health & Family Welfare,** Ministry of Health & Family Welfare. At the national level, it is the sole organization dealing with collection, compilation, analysis and dissemination of health data for the country as a whole. Since 2005, CBHI disseminates this information regularly in a form of regular publication "**National Health Profile** (NHP), besides bringing out several other occasional publications. National Health Profile provides country overview on demographic, socio economic, health status and health finance status indicators besides that on human resources in health sector and health infrastructure . CBHI is also responsible for Health Sector Policy Reform Options Database (HS-PROD), inventory & GIS mapping of Govt. health facilities in India , reviewing the progress of Health sector Millennium Development Goals(MDG) in India etc. Apart from CBHI, the Rural Health Division of DGHS compiles and publishes **Rural Health Statistics in India** . This is a six-monthly bulletin, containing information on Government health infrastructure and manpower deployment in the rural areas. This publication also presents data at State and UT level.

30.51 The **National AIDS Control Organisation (NACO)** under **Department of Aids Control** collects data on cases and deaths due to AIDS/STD and publishes these in its Annual Update.

30.52 The **Department of Health & Family Welfare** is responsible for implementing programmes for population control and maternal and child health now renamed as Reproductive and Child Health. The Family Welfare programme is a Centrally-

sponsored programme implemented by the respective States and UTs. The information flow starts from the peripheral level where the service delivery takes place. In the sub-centers, ANMs are responsible for the maintenance of records in respect of acceptance of family planning methods, services to pregnant women and immunization for vaccine preventable diseases in respect of infants. The information flows to PHCs, and from PHCs to districts where it is consolidated for the district. From the district, the information in the prescribed form is expected to flow to the State and Centre through NICNET. While in general, data on **medical and health infrastructure** (education and treatment) and manpower information are generated as a **by-product** of **administrative and regulatory procedures**, a source for morbidity data is the notification of Communicable Diseases, which is primarily meant for preventive control. Presently, data are also collected from selected surveillance centres in the country on the prevalence of HIV positive rate from random blood samples in the adult population. The hospital returns are analysed according to the list of diseases provided in the International Classification of Diseases (ICD) and a number of case-finding programmes for detection of cases on specified diseases like malaria, filarial, trachoma, goitre and leprosy are also available. **Family Welfare Statistics In India** is a publication being regularly brought out by Department of Health & Family Welfare**.** It contains information on vital statistics, immunization, family Planning , findings of DLHS, NFHS ,Facility Survey , Annual Health survey & Coverage Evaluation Survey (UNICEF) infrastructural facilities and outlay & expenditure on family welfare.

30.53 Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homeopathy (AYUSH) maintains information on infrastructure, manpower**,** College / Institutions, expenditure etc related with these systems of medicine as an ancillary activity of promoting them & monitoring the progress of various schemes.The license registers for various categories of doctors, dentists, pharmacists, nurses, health visitors, etc provide data about **manpower** and are consolidated by **statutory councils** such as the **Medical Council of India, Dental Council of India, Nursing Council** etc.

Note : The regularly reported data related to health & Family Welfare is by and large from Government Health Facilities, it may have limitations in terms of its completeness as private medical & healthcare institutions still need to strengthen their reporting to their respective government health units.

30.54 Besides the regular flow of Data from the administrative set up, information is also collected through surveys:

30.55 International Institute for Population Sciences (IIPS) has been declared as the nodal agency (for coordinating & providing technical guidance for the survey) by Ministry of Health & Family welfare for two important health surveys viz. **National Family Health Survey (NFHS) & District Level Household & Facility Survey (DLHS).**

30.56 The **National Family Health Survey (NFHS)** is a large-scale, multi-round survey conducted in a representative sample of households throughout India. Three rounds of the survey have been conducted since the first survey in 1992-93. The survey provides state and national information for India on fertility, infant and child

mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services. The funding for different rounds of NFHS has been provided by USAID, DFID, the Bill and Melinda Gates Foundation, UNICEF, UNFPA, and MOHFW, GOI. The first survey **($NFHS_1$)** was conducted in 1992-93, second **($NFHS_2$)** in 1998-88, third **($NFHS_3$)** in 2005-06 and the fourth one **($NFHS_4$)** is planned in 2014-15.

30.57 District Level Household & Facility Survey (DLHS) was initiated in 1997 with a view to assess the utilization of services provided by government health care facilities and people's perception about quality of services. $DLHS_3$ (2007-08) is the third in the series of district surveys, preceded by **$DLHS_1$** in 1998-99 and **$DLHS_2$** in 2002-04. Like tow earlier rounds $DLHS_3$ provides estimates on important indicators on maternal & child health, family planning & other reproductive health services . In addition it provides information on important interventions of National Rural Health Mission (NRHM) and interviewed ever married women (age 15-49) and never married women (age 15-24) besides currently married women(age 15-44), the only category of women interviewed in earlier rounds. **$DLHS_4$** was also planned in 26 states where Annual Health Survey (AHS) is not being done.

30.58 Besides Ministry of Health & Family Welfare, several other agencies / Ministries collect and disseminate health related statistics.

30.59 The **National Sample Survey Office, Ministry of Statistics & PI** also conducts demographic surveys, which have been providing information on some aspects of mortality and morbidity and **household expenditure on health services** and facilities.

30.60 Occasional surveys like **Coverage Evaluation Survey 2009 (CES-2009)** conducted by **UNICEF** also provide valuable insights. CES 2009 was a nationwide survey covering all States and Union Territories of India, conducted during November 2009 to January 2010. It was funded by IKEA Social Initiative and ORG – Centre for Social Research carried out the survey in the field. UNICEF had conducted the survey, at the request of Government of India, to assess the impact of NRHM strategies on coverage levels of maternal, newborn and child-health services including immunization among women and children.

30.61 Office of Registrar General of India, Ministry of Home Affairs provides much information on vital statistics through its system of **Civil Registration** (mandatory registration of births & deaths : latest report : 2009) **(CRS)** & **Sample Registration** (latest report 2010)**(SRS)-** dual record household panel survey with sampling units retained for about ten years . These provide information on fertility, mortality (infant & maternal mortality) , sex ratio at birth etc. However, only **state level estimates** are provided by **SRS** which constrained decentralized district based health Planning in view of the large inter district variations . Consequently **Annual Health Survey** was conceived in 2005 with an aim to have "Survey of all districts which could be published/ monitored and compared against benchmarks" . The objective was to monitor the performance and outcome (at **district level**) of various

health interventions of the Government including those under National Rural Health Mission (NRHM), Ministry of Health & Family Welfare at closer intervals through these benchmark indicators. AHS has been designed to yield benchmarks of core vital and health indicators at the district level on fertility and mortality; prevalence of disabilities, injuries, acute and chronic illness and access to health care for these morbidities; and access to maternal, child health and family planning services. AHS has been implemented by the Office of Registrar General, India in all the 284 districts (as per 2001 Census) in 8 Empowered Action Group States (Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Orissa and Rajasthan) and Assam for a three year period during XI Five Year Plan period. The fieldwork for Baseline Survey was carried out during July, 2010 to March, 2011. The second round of AHS (2011-12) is to cover additional parameters through a separate questionnaire on on Clinical, Anthropometric & Biochemical (CAB) tests and measurement in addition to the indicators covered in AHS first round.

30.62 Report on **Medical Certification of Cause of death** based on Civil Registration System is also brought out by O/o Registrar General of India.

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