

NINTH EDITORS' CONFERENCE
ON
SOCIAL SECTOR ISSUES

3RD - 4TH FEBRUARY 2009

VENUE

PRESS INFORMATION BUREAU
SHASTRI BHAVAN
NEW DELHI



Ministry of Health and Family Welfare
GOVERNMENT OF INDIA

CONTENTS			
Sl.No.	Name of the Programme/Scheme	From	To
1.	Overview	1	4
2.	New Initiative	5	6
BACKGROUND PAPER			
3.	Introduction	7	8
4.	National Rural Health Mission	9	23
5.	Reproductive Child Health	24	
6.	Integrated Disease Surveillance Project	25	26
7.	National Tuberculosis Control Programme	27	28
8.	National Vector Borne Disease Control Programme	29	32
9.	National Control Programme for prevention of Deafness	33	
10.	National Tobacco Control Programme	34	
11.	National Leprosy Elimination Programme	37	39
12.	National Cancer Control Programme	40	41
13.	National Control Programme for Prevention of Blindness	42	43
14.	Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)	44	47
15.	Food Safety and Standards Authority of India	48	49
16.	National Aids Control Programme	50	63
17.	Family Welfare	64	91

Ministry of Health & Family Welfare
Department of Health & Family Welfare

MATERIAL FOR 9TH SOCIAL EDITORS' CONFERENCE

Overview

Largely on account of the significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and maternal mortality over the last few decades, our country is in the midst of an epidemiological and demographic transition. This adds to the already daunting challenge of reaching quality health care to every household in a country of over a billion people living in over a million cities, towns, villages and hamlets.

The National Rural Health Mission (NHRM) is one of the flag ship initiatives of the UPA Government. Over the last three years of implementation, the NHRM has brought about comprehensive rejuvenation of Public Health System in the country. This rejuvenation has addressed the fundamental issues encumbering the health system. The Central Government has substantially increased the financial support to the health sector. The funds are being utilised through the process of decentralised planning and implementation to ensure the ownership

Achievements

1. *The states have reported selection of over 5.4 lakh ASHAs/Link Workers out of which over 4.62 lakh have been trained. 1,86,606 ASHAs/ Linkworkers have been provided with drug kits.*
2. *1,77,924 Village Health & Sanitation Committees have been made functional and untied grant of Rupees 10,000 given for them.*
3. *The states have rejuvenated the Sub Centres with over 1.24 lakh joint accounts between ANM and Gram Pradhan. 14,440 SCs with positioned an additional ANM on contract under NRHM.*
4. *Before the launch of NRHM (as on 31 March 2005), out of 22,669 PHCs only 1634 were reported 24x7. This number has now increased to 8756 PHCs working on 24x7 basis. The states have reported appointment of 11537 contractual Staff Nurses, 6232 Doctors, 3882 AYUSH practitioners & 4380 other Para medics. Now, over 2852 PHCs have positioned three staff nurses to provide 24x7 services. AYUSH has been co located at 4919 PHCs.*
5. *The states have reported contractual appointment of 2282 Specialists at CHCs. Facility survey has been completed for 2335 CHCs and upgradation work completed in 441 CHCs.*
6. *The states have identified 323 District Hospitals for upgradation and amount of Rs. 20 lakh have given to all DHs for basic services.*
7. *The states have set up Rogi Kalyan Samitis in 551 DH, 4066 CHCs/SDH & 12983 PHCs (total 17,600). As part of state PIPs an annual corpus grant of Rs. 1 lakh is allocated to the RKS at subdistrict level and Rs. 5 lakh allocated for district level RKS.*
8. *The first Integrated District Health Action Plans have been finalised in 509 districts and State PIP for 07-08 were appraised and approved for all 35 States/UTs by the National Programme Coordination Committee.*
9. *Provided to every institution*
10. *Untied funds have been provided under NRHM to all VHSCs, Sub Centres, PHCs, CHCs.*
11. *The NRHM has shown rapid progress in the North Eastern states. Over 40 thousand ASHAs have been selected, RKS constituted in 79 DH/SDH, 189 CHCs & 1166 PHCs. Five new DH & 8 new GNM Schools have been approved under NRHM. State Civil Hospitals at Itanagar and Pasighat have also been assisted to the tune of Rs. 1 crore each. IDHAP has been finalised for 84 districts. 6248 (out of 7758) SCs are functional with Joint Accounts and 2545 have positioned two ANMs. 678 (out of 1106) PHCs are reported operational on 24x7 basis and 244 PHCs have AYUSH MOs co-located in them. Facility surveys has been completed in 205 (out of 216) CHCs, upgradation works completed in 91 CHCs. 86 CHCs are reported operational as FRUs.*
12. *JSY has rapidly increased the demand for Institutional deliveries & off take of funds has substantially expanded. During FY 05-06 states had reported 7.38 lakh beneficiaries, during FY 06-07 states reported 31.44 lakh beneficiaries and during FY 07-08 (Upto Oct 07) 39.48 lakh beneficiaries have already been reported.*

of respective state Governments in the reform process. At the same time, the community based monitoring and proactive roles to Village Health & Sanitation Committees and Rogi Kalyan Samitis has restored the confidence of the community in the Public Systems. Pro poor partnerships between private service providers and Public Systems has facilitated quick improvements in service delivery, diagnostics, referral transport and capacity building. Since the implementation of NRHM, the Health System has become more decentralised, more efficient and more responsive to the needs of the citizens. The Accredited Social Health Activists have become critical link between the health system and the citizens. This has had a positive impact on health seeking behaviour of the community. Schemes like Janani Suraksha Yojana have rekindled the trust of the citizens in the Public Health System. Through the process of decentralised Integrated Planning and inter-sectoral convergence, the states are able to address the expectations of the citizens and lead the country towards a healthier future.

In partnership with States and through state led innovations, NRHM is rapidly expanding accessible, affordable and accountable quality care for every household in the country. More than 6.28 lakh ASHAs and Link Workers are connecting households to health facilities. The presence of community volunteers on this unprecedented scale has resulted in people's growing pressure on utilization of services from the public sector health system. States across the country are reporting significantly higher utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care. Large scale demand side financing under the Janani Suraksha Yojana has brought poor households to public sector health facilities on a scale never witnessed before. More than 2.97 lakh Village and Sanitation Committees have been made functional to bring about community ownership and planning in health sector. Rogi Kalyan Samitis set at various levels have been made the custodians of the untied funds and annual maintenance grant for health facilities. Untied funds at various levels have introduced functional flexibility in

proper upkeep of health institutions and ensuring the availability of the quality services to the citizens. Detailed integrated District

Reproductive and Child Health Programme is a major component of NRHM and aims at reduction of Infant Mortality Rate to 30/1000, Maternal Mortality Ratio to 100/100000 live births and Total Fertility Rate 2.1 are to be achieved by 2010. Against these goals, IMR of 55/1000 live births,(SRS 2007) MMR of 301/100000 live births (SRS 2006) and Total Fertility Rate of 2.8 (SRS 2006) have been achieved.

Health Action Plans have been prepared in over 541 districts, and convergence of key health and health related initiatives is being ensured through the District Health Missions and the State Health Missions. Substantively higher funding for health sector by the Government of India and commensurate response by various State Governments has ensured that the allocation for health in the public domain keeps up with the expanding economy and remains on course for reaching two to three per cent of the Gross Domestic Product by 2012.

Rapid urbanization has led to rapid increase in the number of urban poor population, majority of who live in slums. In order to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections by facilitating equitable access to quality health care with the active involvement of the Urban Local Bodies (ULBs) in cities with population of one lakh and above and State Capitals, the National Urban Health Mission (NUHM) has been planned. The NUHM would be covering 21.07 crore urban population with a special focus on 6.25 crore urban poor living in slums and beyond, spread over 430 cities. The proposed financial outlay is Rs.6207.84 crore.

The Integrated Disease Surveillance Project launched in 2004 with the objective to detect early and respond to warning signals of disease outbreaks has established an IT network in 317 of the 400 sites with the help of NIC and ISRO connecting all States, District HQ and Government medical colleges and certain national institutions involved in disease surveillance and response. In addition, a 24x7 Call Centre in February 2008 which receives disease alert from the country on toll free number 1075 and a *total of 27061 calls have been received till December 2008.*

Prevention and control of vector borne diseases such as Malaria, Filariasis, Kala-azar, Japanese Encephalitis, Dengue & Chikungunya have direct link with economic & social development of community. The malaria incidence in the country was brought down from 6.4 million cases in 1976 to 1.86 million cases in 2003 since then it has been kept below 2 million cases. However, malaria still continues to be a major public health problem in many tribal areas as well as hilly and forested areas; this requires focused attention for the country. Kala-azar & Lymphatic Filariasis have been targeted for elimination by 2010 & 2015 respectively and the goal of elimination must be achieved to make our country free from these diseases affecting the health of a large number of population. The viral diseases like Japanese Encephalitis, Dengue and newly re-emerged disease Chikungunya require more attention on awareness generation for prevention and control of mosquitogenic conditions. Because of multiple determinants like environment, human activities, changing life styles responsible for the distribution of vector borne disease, a multi-sectoral approach and community participation is to be ensured for prevention and control.

Tuberculosis is a major public health problem in India. About 3.25 lakh persons die of TB every year in the country. The Revised National TB Control Programme (RNTCP), using Directly Observed Treatment Shortcourse (DOTS) strategy, with the objective of curing at least 85% of new sputum patients put on treatment and detecting at least 70% of such patients is being implemented in the country in a phased manner from 1997 and the entire country has been covered by March 2006. Overall performance of RNTCP has been excellent with cure/treatment completion rate consistently above 85% and death rate less than 5% among the registered patients. The prevalence of multi-drug resistant TB is approximately 3% among new cases and about 12-17% among non-treatment cases. The programme is in the process of establishing a network of 27 accredited Culture and Drug Susceptibility testing Intermediate Reference Laboratories (IRL) across the country in a phased manner for diagnosis and follow-up of MDR TB patients. Currently more than 250 patients have been initiated on treatment under MDR in 5 States of the country. It is expected that the whole country will be covered by 2010.

As part of the continued efforts to achieve leprosy elimination in six States/UTs viz, Bihar, Chattisgarh, West Bengal, Jharkhand, Chandigarh and D&N Haveli as well as provide support for Disability Prevention and Medical Rehabilitation for these States, and *29 States/UTs which have achieved leprosy elimination*, support is being provided for Reconstruction Surgery (RCS) and for intensive IEC campaign "Towards Leprosy Free India" aimed at further reduction of leprosy burden in the community, early reporting of cases and their treatment completion, provision of quality leprosy services and reduction of stigma and discrimination against leprosy affected persons and their family members.

Cancer is a major public health concern in India and has become one of the ten leading causes of death in the country. It is estimated that there are about 2.5 million cases of cancer at any particular point of time with 8 to 9 lakh new cases being detected every year. About 4 lakh deaths occur annually in the country due to cancer. WHO study (2000) conducted on the global burden of disease, evaluating the Disease Adjusted Life Years (DALY) showed that in India, the

DALYS lost due to cancer was 8.7 million, second only to ischemic heart disease. The burden of cancer is expected to further increase due to increase in life expectancy, demographic transitions and the effects of tobacco and other risk factors. *With a total outlay of Rs. 2400.00 crore, the National Cancer Control Programme (NCCP) is proposed to be modified to meet the gap in available cancer care facilities and trained manpower in the country.*

A “State of art Research and Referral Institute” i.e National Cancer Institute with the objective of basic, clinical, experimental and applied research in the field of oncology and related areas at a cost of Rs.850 crore is being planned at Egmore, Chennai. The institute will be the Nodal Institute for activities related to cancer in the country and will have linkages with all RCCs and other cancer institutes within and outside the country. The institute as the premier institute of cancer will identify priority areas for Research & Development in cancer and related subjects in the country and will carry out basic and applied research in molecular biology, genomics, proteomics, cancer epidemiology, radiation biology, cancer vaccines etc. It will evolve model cancer programmes for the developing world and new therapies. The institute will explore, in addition to allopathy system, alternative therapies from medicine systems historically available in India. It will act as a centre for development of human resource in cancer. There will be facilities for Training & Capacity Building. The institute will collaborate with renowned cancer institutes in the international arena. The institute will have 200 beds with dedicated day care facilities which will also conduct clinical research in project related areas. NCI will have equipments with advanced technology to learn more about cancer. Research will also be conducted in RCCs with the assistance of NCI.

Tobacco is the single most preventable cause of death in the country. The Government of India is taking steps to ensure effective implementation of the Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003. The Ministry of Health & FW is also launching the National Tobacco Control Programme in the 11th Five Year Plan to build capacity of the States for the effective implementation of the Tobacco Control Act and of the FCTC. The outlay is Rs. 470 cr. approximately and key components include mass media, school health camps; awareness; building lab capacity for product testing; training/sensitization of health & other work force, etc. *The Pilot Phase of the National Tobacco Control Programme (NTCP) was launched in 2007 in 9 States and 18 Districts.* NTCP also aims at ensuring enforcement of Anti Tobacco Laws and to bring about greater awareness of the harmful and ill effects of tobacco consumption. The Government has revised the smoke free law with effect from 2nd October, 2008. The new rules prohibit smoking in public places. These rules are meant to empower the non-smokers who constitute two-thirds of India’s population. It is hoped that there will be wide spread movement and support for this law, as scientific evidence demonstrates that second hand smoke is as harmful and is therefore a serious public health threat.

In order to achieve address of the major causes of mortality and morbidity in the country in a focused manner, the Government has launched a number of new initiatives. The pilot programme under the *National Programme on Prevention and Control of Diabetes, Cardiovascular diseases and Stroke last year has been expanded to 10 States* and aims at using health promotion and health education, advocacy, early detection of persons with high risk factors (at the risk of developing disease) through opportunistic screening and strengthening health systems at all levels to tackle Non-Communicable Diseases and improvement of quality of care. The National Programme on Prevention and Control of Deafness (NPPCD) will be addressing the second most cause of disease morbidity – Hearing impairment/deafness – in the country and covers nearly 80 districts in 2008-09.

In order to reduce the gaps in availability of tertiary healthcare across states, the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) Phase I envisages setting up of 6 new AIIMS like Institutions in the States of Bihar, Chattisgarh, Madhya Pradesh, Orissa, Rajasthan and Uttaranchal and upgradation of 13 existing Government medical college institutions. All the projects have now been taken up after some initial delays in the formulation of the project. GOI now propose to launch Phase II of PMSSY project to set up 2 AIIMS like institutions one in Uttar Pradesh and another in West Bengal at an estimated cost of Rs.823 crore each. It is also proposed to upgrade 5 existing Medical College Institutions viz., Government Medical College, Amritsar, Dr. Rajendra Prasad Government Medical College, Tanda, Himachal Pradesh, Government Medical College, Nagpur, Jawaharlal Nehru Medical College of Aligarh Muslim University, Aligarh and Government Medical College, Madurai at an estimated cost of Rs.150 crore each.

The implementation of reservations for OBC candidates in Central Educational Institutions under the Department of Health & Family Welfare was taken up as per the Central Educational Institutions (Reservation in Admission) Act, 2006 during the year and was implemented in the under-graduate and post-graduate streams in 12 Central Institutions.

NEW INITIATIVE

Rapid urbanization has led to rapid increase in the number of urban poor population, majority of who live in slums. In order to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections by facilitating equitable access to quality health care with the active involvement of the Urban Local Bodies (ULBs) in cities with population of one lakh and above and State Capitals, the National Urban Health Mission (NUHM) has been planned. The NUHM would be covering 21.07 crore urban population with a special focus on 6.25 crore urban poor living in slums and beyond, spread over 430 cities. The proposed financial outlay is Rs.6207.84 crore

Nursing plays an important role in the health care delivery system. In order to strengthen and expand Nursing Services to provide Health Services to the rural people, Government of India has taken Nursing as a priority programme in the 11th Plan. A new scheme namely Human Resource (Health) Services which inter alia include upgradation/strengthening of Nursing Services at a cost of Rs. 200 crore during the 11th Plan period has been approved. In order to establish a Paramedical and Physiotherapy Central Council, a Bill has been proposed to be enacted and the Bill was introduced in the Lok Sabha on 4.12.2007. Department related Parliamentary Standing Committee has given its report and suggested certain changes in the Bill. It is now under examination in the DGHS.

A Bill named "Clinical Establishments (Registration and Regulation) Bill, 2007" has been introduced in the Parliament aimed at registration and regulation of clinical establishments in the country (at the district, state and national levels) with a view to prescribe minimum standards of

facilities and services. The Bill has been referred to the Parliamentary Standing Committee for Ministry of Health & Family Welfare. The report of the Committee has been received and is under consideration.

The Transplantation of Human Organs Act was enacted in 1994 to curb commercial transactions in human organs. In the light of experience gathered over the last decades, it is now proposed to amend the law to facilitate genuine cases of organ donation and to prescribe harsh punishment for illegal transactions. A programme to promote organ donation will also be launched shortly.

With the objectives of creating and expanding health manpower in old age care, promoting relevant research to provide evidence base for active and healthy ageing and providing integrated, comprehensive and quality health care to older people at all levels of health care; in institutions and community, The National Programme for Healthcare of Elderly is proposed to be launched in 2009. Under it, two National Institutes of Ageing will be established, one each at Delhi and Chennai respectively. These will provide training in geriatrics/gerontology for manpower development, carry out relevant research and provide comprehensive tertiary level care for the health problems of elderly. In addition 25 medical colleges all over the country will be taken up for creating departments of geriatrics and 100 district geriatrics units will be established at the level of district hospitals. Community outreach programme for elderly will be started especially to reach those elderly who are chronically ill and bed ridden. This activity will be undertaken in collaboration with selected NGOs.

During the year 2008-09, concerted efforts were made towards the implementation of the newly enacted Food Safety and Standards Act, 2006 which seeks to integrate the various different existing laws on food. In this regard, the Food Safety and Standards Authority of India (FSSAI) was established which is responsible for effective implementation of the new Act. This authority has 22 members, apart from the Chairman, out of which one third representation has been provided to women. This has been done as per the provision of the Act, which recognizes the important stake of women in the regulation of food in the country. The function of the authority will be to lay down science based standards for different articles of food and associated items. The authority will also be instrumental in getting the provisions of the Act enforced as the Central enforcing agency and through the apparatus of Food Safety Commissioner of various State Governments

Government of India has been seriously considering ways of improving its procurement system in the health sector and intends to encourage States to undertake procurement reforms. To address these issues, it is actively considering setting up an autonomous Central Procurement Agency to procure health sector goods efficiently and distribute them through proper warehouses at State headquarters and district headquarters to enable the service providers to get regular and timely supply of goods.

An 'Integrated Vaccine Complex' (IVC) of international standard in the public sector to make safe and effective vaccines available at affordable prices is also proposed to be set-up. The Ministry of Health & Family Welfare, Govt. of India has engaged Hindustan Latex Limited (HLL), a public sector enterprise under the Ministry, to set up a state of art Integrated Vaccine Complex on top priority for both UIP and non UIP vaccines at Chengalpattu, near Chennai, Tamil Nadu. The proposed Integrated Vaccine Complex would ensure uninterrupted supply of basic vaccines such as DTP, TT, DT, BCG and introduction of new generation vaccines, availability & affordability of vaccines, developing a domestic R&D base in vaccine technologies which is presently non-existent and mainly depends upon external sources.

To boost investment in the Medical devices equipment and manufacturing industry sector, it is proposed to develop an integrated manufacturing hub for medical technology sector called Medi Park in the country with appropriate infrastructure and support facilities. The development of such an exclusive facility with the state-of-art infrastructure would attract the manufacturers (both domestic as well as international) to have a manufacturing base in India.

BACKGROUND PAPER

Introduction

Achieving an acceptable standard of health for general population has been the objective over the plan era in the Health sector. In line with this objective, emphasis has been given to healthcare under the National Common Minimum Programme (NCMP) of the present regime.

The special focus given to Health Sector in the NCMP has formed the core of the programmes formulated under both Health and Family Welfare. The National Rural Health Mission (NRHM) is the key plank for giving effect to the mandate of the NCMP. To effect an architectural correction in the healthcare delivery system, six programmes namely National Vector Borne Disease Control Programme, Revised National TB Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness; Iodine Deficiency Disorders Control Programme and Integrated Disease Surveillance Programme have been integrated with NRHM. Accordingly, special emphasis has been given to the Health sector in terms of financial allocations during later years of the 10th Plan and also in the 11th the Plan.

The National Rural Health Mission has been launched in April, 2005 to effect an architectural correction in the healthcare delivery system with the convergence of six programmes including four disease control programmes namely National Vector Borne Disease Control Programme, Revised National TB Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness; and Iodine Deficiency Disorders Control Programme & Integrated Disease Surveillance Programme. However, the outlay for these programmes was shown under Health till 2005-06. From 2006-07, the outlay of these programmes has been shown under NRHM. Accordingly Demands for Grants has separated into Health (other than NRHM) and NRHM.

In line with this objective, there has been a steady increase in the allocations made for this Sector from the 1st Plan onwards. The allocation for Health & Family Welfare during the 9th Plan was of the order of Rs.20,238 crore. This saw a substantial step up during the 10th Plan with the original outlay being Rs.36,378 crore showing a step up of 81%. Against the actual allocations made for the 10th Plan, the increase is even more significant with the step up being 105%. In the table below is captured the financial outlays and expenditure for Health & Family Welfare for the 10th Plans and 11th plan individual years (2007-2012).

(Rupees in Crore)

Plan Period	Approved Outlay			Expenditure		
	Health	FW	Total	Health	FW	Total
10 th Plan						
Original Outlay	9253.00	27125.00	36378.00			
Revised Outlay	10252.00	26126.00	36378.00			
Existing Status	10521.00	31064.00	41585.00			
2002-03	1550.00	4930.00	6480.00	1359.82	3916.63	5276.45
2003-04						
2004-05						
2005-06	2908.00	6424.00	9332.00	2253.72	5672.5	7926.25
2006-07	2305.00	9000.00	11305.00	3330.02	7518.5	10848.57
11 th Plan (2007-12)						
2007-08	4365.50	10930.0	15295.50			

*: Revised Estimate

\$. Figures shown as Health and NRHM from 2006-07

P: Proposed

Healthcare is one of the seven thrust areas under the National Common Minimum Programme. The special emphasis given to the Health sector in the CMP has been very clearly reflected in terms of financial allocations received during the last two years of the 10th Plan. The CMP has inter-alia focused on increased public spending on health to at least 2-3% of GDP over the next 5 years with focus on primary healthcare. Accordingly, a National Rural Health Mission has been launched in April, 2005 to effect an architectural correction in the healthcare delivery system with the convergence of six programmes including four disease control programmes namely National Vector Borne Disease Control Programme, Revised National TB Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness; and Iodine Deficiency Disorders Control Programme & Integrated Disease Surveillance Programme. However, the outlay for these programmes was shown under Health till 2005-06. From 2006-07, the outlay of these programmes has been shown under NRHM. Accordingly Demands for Grants has separated into Health (other than NRHM) and NRHM

NATIONAL RURAL HEALTH MISSION

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

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

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

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

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

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

d) ***Innovations in human resources development for the health sector*** : The central challenge of the NRHM is to find definitive answers to the old questions about ensuring adequate recruitment for the public health system and adequate functionality of those recruited. Contractual appointment route to immediately fill gaps as well as ensure local residency, incentives and innovation to find staff to work in hitherto underserved areas and the use of multi-skilling and multi-tasking options are examples of other innovations that seek to find new solutions to old problems. Expansion of professional and technical education and increasing access of weaker sections to such education are also a core strategy.

Many path breaking initiatives have been operationalised under the NRHM.

More than 6.28 lakh Accredited Social Health Activists (ASHAs) and link workers are connecting households to health facilities. The presence of community volunteers on this unprecedented scale has resulted in people's growing pressure on utilization of services from the public sector health system. States across the country are reporting significantly higher utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care. Large scale demand side financing under the Janani Suraksha Yojana (JSY) has brought poor households to public sector health facilities on a scale never witnessed before. Over 50 lakh women have been covered under JSY so far since its introduction in 2005.

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

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

The untied grants to sub-centres has given a new confidence to our ANMs in the field who are far better equipped now with Blood Pressure measuring equipment, stethoscope, the weighing machine etc.. They can actually undertake a proper ante-natal care and other health care services. Sub Centres look like sub-centres and provide services which many of them were not doing on account of lack of regular resources. The constitution of the Village Health and Sanitation Committees itself is taking a little time in many States as the effort is to set up these Committees within the umbrella of Panchayati Raj Institutions. The intention of NRHM is inter-sector convergence and the effort in all the States is to bring Health, Sanitation, Nutrition, Water and Education together on a common platform within the framework of PRIs, at the village level. The untied funds to Village Committees are a great boon for public health action as was demonstrated in Kerala in Alleppey District where large scale vector control measures could be taken up with untied funds.

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

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

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

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

Improved Financial Management : Under NRHM, Electronic Transfer of Funds (ETF) has been started from GoI to States and also States to Districts. This has reduced the time lag in transfer of funds from 1-2 months to 1 to 2 days. E Banking has been operationalised for real time financial reporting & monitoring. As a result of this the Financial management Reports are now being received on time. Detailed guidelines for Delegation of Administrative & Financial powers under NRHM have been given to states. Financial Managers and accountants have been recruited at State & District levels under NRHM. A system for concurrent Audit has been set up in SHS & DHS.

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

IMPROVEMENT IN THE QUALITLY OF HEALTH CARE

i. The improvement in the quality of health care over the years is reflected in respect of some basic demographic indicators. The Crude Birth Rate (CBR) declined from 40.8 births per thousand population in 1951 to 29.5 in 1991 and

ii. further to 23.5 in 2006. Similarly there was a sharp decline in Crude Death Rate (CDR) which decreased from 25.1 deaths per thousand population in 1951 to 9.8 in 1991 and further to 7.5 in 2006. Also, the Total Fertility Rate (average number of children likely to be born to a woman between 15-40 years of age) has decreased from 6.0 in 1951 to 2.9 in 2005 as per the estimates from the Sample Registration System (SRS) of Registrar General India (RGI), Ministry of Home Affairs.

iii. The Maternal Mortality Rate has also declined from 437 per one lakh (100,000) live births in 1992 – 93 to 301 in 2001-03, according to the Report brought out by RGI.

iv. Infant Mortality Rate, which was 110 in 1981, has declined to 57 per 1000 live births in 2006. Child Mortality Rate has also decreased from 57.3 in 1972 to 17.3 in 2005.

v. Medical Termination of Pregnancy (MTP).

During 2006-07, provisionally 6.40 lakh cases of termination of pregnancy were done at national level. Since the inception of the programme in April 1972, in all 18.19 million cases under MTP have been effected upto March 2007

MATERNAL HEALTH PROGRAMME

Promotion of maternal and child health has been one of the most important objectives of the Family Welfare Programme in India. The current Reproductive and Child Health Programme (RCH) Phase - I was launched in October 1997. The RCH Programme incorporates the components covered under the Child Survival and Safe Motherhood Programme and includes an additional component relating to reproductive tract infection and sexually transmitted infections. This policy recommends a holistic strategy for bringing about total intersectoral coordination at the grass root level and involving the NGOs, Civil Societies, Panchayati Raj Institutions and Women's Group in bringing down Maternal Mortality Ratio and Infant Mortality Rate. The National Population Policy 2000 and National Health Policy 2002 have set the goal of reducing MMR to less than 100 per 100,000 live births by the year 2010. Accordingly, schemes and programmes have been developed and various interventions focused on reducing maternal deaths. Over 77,000 women in India continue to die of pregnancy related causes every year. The Maternal Mortality Ratio in India is 301 per 100,000 live births (SRS, RGI: 2001-03 Maternal Mortality Report). However, reliable estimates of maternal mortality are not available.

Maternal Mortality Ratio (MMR)

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

MMR India: The national average of MMR is 301 per 100,000 live births, which in itself is very high compared to the international scenario like Sweden (8), UK (10), Greece (2) and even in neighbouring countries like Sri Lanka (60), China (60) and Thailand (54). Some of the States with high Maternal Mortality are: UP (517), Rajasthan (445), MP (379), Bihar (371) Assam (490)

Causes of Maternal Mortality: Maternal Mortality is a cause of great concern. The major causes of these deaths have been identified as hemorrhage (both ante and post partum), toxemia (Hypertension during pregnancy), anemia, obstructed labor, puerperal sepsis (infections after delivery) and unsafe abortion.

As can be seen Hemorrhage accounts for more than one- third of all deaths followed by puerperal sepsis and abortion. Besides these, anemia which has been included in "other conditions" is a major contributory factor. Most of these deaths are preventable with good ante natal care, timely identification and referral of pregnant women with complications of pregnancy and timely provision of emergency obstetric care.

Maternal Health Indicators:

The estimates of maternal mortality at State/UTs levels not being very robust, MMR can only be used as a rough indicator of the maternal health situation in any given country. Hence, other indicators of maternal health status like antenatal check up, institutional delivery and delivery by trained personnel etc. are used for this purpose. These reflect the status of the ongoing programme

interventions as well as give a reflection on the situation of Maternal Health. All India figure for these indicators as per the National Family Health Survey (NFHS III) conducted in the period *2003-2005 and the District Level Household Surveys (DLHS II) in 2002-04 are:

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

SCHEMES FOR IMPROVING OBSTETRIC CARE SERVICES

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

❖ This includes antenatal care, institutional / safe delivery services and post natal care. For timely and early detection of emergencies it is of utmost importance that minimum of three ante-natal checkups be conducted wherein all the components of essential obstetric care be provided to the women. Government has instructed all states and UTs to focus on these services and monitor it closely.

❖ **Provision of 24 Hrs Delivery Services at PHC:** Under RCH – II, all the CHCs and 50% of the PHCs are proposed to be operationalized for providing round the clock delivery services. The States and UTs have been advised to make a comprehensive plan and the central Government is investing large amount of money for operationalizing these PHCs.

❖ **Post natal care for mother and newborn:** Ensuring post natal care within first 24 hours of delivery and subsequent home visits on day 3 and 7 are the important components for identification and management of emergencies occurring during post natal period. The ANMs, LHV's and staff nurses are being made aware of and also oriented for tackling emergencies identified during these visits.

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

Provision of Emergency Obstetric and Neonatal Care at FRUs:

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

❖ **Referral Services at both Community and Institutional level:** Establishing referral linkages between the community and First Referral Units is an essential component for utilization of services particularly during Emergencies. Since emergencies during the process of birth can not be predicted, it is essential to place effective referral linkages which can be accessed by all pregnant women in case of emergency.

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

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

❖ **In view of this, for effective and better management of Emergency Obstetric needs at the grass root level,** GOI has taken a policy decision and is implementing 18 weeks programme for training of MBBS doctors in anesthetic skills for Emergency Obstetric care at FRU.

❖ The training shall be undertaken for only that number of MBBS doctors who are required for the operationalization of FRUs and CHCs and shall be limited to the requirement of tackling emergency obstetric situations only. In no way, will it be a replacement of the specialist anesthetists who are working after pursuing degree / diploma in the subject.

❖ Guidelines for the training programme have been disseminated to the States for taking initiatives in identifying the medical colleges in the state where this training programme can be conducted.

○ **Obstetric Management Skills:** Government of India has also introduced training of MBBS doctors in Obstetric Management Skills in collaboration with Federation of Obstetric and Gynecological Society of India. It had prepared a 16 weeks training programme in obstetric management skills including Caesarian Section operation, and this is also being implemented.

Safe Abortion Services/ Medical termination of Pregnancy (MTP):

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

The Medical Termination of Pregnancy Act was passed by the Indian Parliament in 1971 and came into force from April 1, 1972. The aim of this Act was to reduce maternal mortality and morbidity due to unsafe abortions. The MTP Act, 1971 lays down the conditions under which a pregnancy can be terminated and the place where such terminations can be performed. A recent amendment to the Act (2003) includes decentralization of power for approval of places, as MTP centers, from the states to the district level with the aim of enlarging the network of safe MTP service

providers. The amendment also provides for specific punitive measures for performing MTPs by unqualified persons and in places not approved by the government.

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

➤ **Strategies:**

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

Guidelines for Manual Vacuum Aspiration (MVA) upto 8 weeks of pregnancy for Medical Officers for performing safe abortions at primary health care facilities have been disseminated to the states for implementation.

The ministry also proposes to develop comprehensive safe abortion guidelines including medical abortion and providing services for medical abortion through the peripheral health care infrastructure.

- Reproductive Tract Infections/Sexually Transmitted Infections (RTIs/STIs) Reproductive tract and sexually transmitted infections (RTI/ STIs) were not recognized as a public health problem until recently. Research conducted in India to document the magnitude of reproductive morbidity, has made the incidence of these infections more visible and brought them into the reproductive health agenda. Several studies conducted in India during the past decade suggest high prevalence of reproductive morbidity among women. As per DLHS-II (2003-2004), about one-third of women reported some symptoms of RTI/ STI, but only 32% sought treatment. The spread of HIV infection and the role that RTI/STI plays in the transmission of HIV have also brought urgency to the problem. The identification and management of reproductive tract infections is an important objective of the RCH Programme.

❖ **Strategies under RCH II:**

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

JANANI SURAKSHA YOJANA

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

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

The scheme focuses on poor pregnant women with special dispensation for states having low institutional delivery rate namely the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Orissa, Rajasthan and Jammu and Kashmir.

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

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

CHILD HEALTH

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

Goals

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

*Estimated

Action being taken

Under the second phase of the RCH programme, the activities being undertaken to achieve the goals of the NRHM are:

- | | |
|-------|--|
| (i) | Integrated management of Neonatal and Childhood Illnesses(IMNCI) |
| (ii) | Home Based Newborn Care (HBNC) |
| (iii) | Promotion of breastfeeding and complementary feeding |
| (iv) | Control of deaths due to acute respiratory infections (ARI) and |
| (v) | Control of deaths due to diarrhoeal diseases and |
| (vi) | Supplementation with micronutrients: Vitamin A & iron. |
| (vii) | Universal immunization programme (UIP), |

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

Integrated Management of Neonatal and Child Hood Illnesses

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

The major components of this strategy are:

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

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

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

As on date (28.09.07) districts all over the country have initiated implementation of IMNCI (list of districts at annexure I). As on date 37,337 health personnel have been trained in IMNCI. The breakup is as below:

Home Based New Born Care

The Government of India has recently approved the implementation of Home Based Newborn Care (HBNC) based on the Gadchiroli model, where appreciable decline in Infant Mortality Rates has been documented on the basis of work done by SEARCH, a NGO. ASHAs will be trained in identified aspects of newborn care during the second year of their training. The modules have been finalized. State sensitization workshops have been held. In the five high focus states to be covered under the Indo Norway Initiative (NIPI), the HBNC shall be implemented by SEARCH with support from ICMR. Permission has been accorded in 2 districts in each of these five states (- MP, UP, Orissa, Rajasthan and Bihar) for ASHAs to use injectable antibiotics for neonatal sepsis and childhood pneumonia.

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

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

Anaemia among children

Iron Deficiency anaemia is widely prevalent in young children. The National Family Health Survey-II (1998-99) revealed that 74.3% children under the age of 3 years were anemic. There is a marginal difference in the prevalence in the rural and urban areas. While 75.3% of rural children were found to be anemic, the prevalence in urban children was 70.8%. The prevalence ranges from 43% in Kerala to 85.7% in Arunachal Pradesh.

Under the National Programme iron folic tablets containing 20 mg of elemental iron and 0.1 mg of folic acid are provided at the sub-centre level. Current programme guidelines instruct health workers to provide 100 tablets to children clinically found to be anemic.

As per the revised policy, infants between 6-12 months are also to be included in the programme as a significant proportion of these infants are anemic. For children 6-60 months, ferrous sulphate and folic acid is to be provided in a liquid formulation. For safety sake, the liquid formulation should be dispensed in bottles so designed that only 1 ml can be dispensed each time. School children, 6-10 year olds and adolescents are also to be included in the national programme. Children 6-10 years of age are to be provided 30 mg elemental iron and 250mcg folic acid per child per day for 100 days. Adolescents are to be supplemented in the same dosage and duration as adults.

Promotion of Infant and Young Child Feeding (IYCF)

A Breastfeeding Partnership involving all the key partners has been formed under the auspices of the Hon'ble MOS . Revival of the Breastfeeding Hospital initiative has been approved and implementation shall be initiated.

Non IMNCI districts

In the districts not implementing IMNCI, the vertical programmes for control of the commonest causes of mortality, i.e diarrhea and pneumonia, shall continue to be implemented. *The incidence of diarrhea is reduced by provision of safe drinking water, and diarrhea cases are managed by Oral Rehydration Salt solution during diarrhea to prevent dehydration.* Pneumonia cases are managed by antibiotics.

Facility Based Newborn Care

As a focal point for providing treatment to the increased numbers of sick newborns/newborns needing special care (LBW/asphyxia) detected due to the increase in institutional deliveries, IMNCI (community aspect) and HBNC, there exists a need to act on the facility based newborn care programme which was operational in RCHI. The programme has been evaluated with the assistance of USAID through INCLEN-PATH and the results have been encouraging. Based on this a Facility Based Newborn Care programme has been formulated and is under submission for consideration. This programme builds on the 13 Sick Newborn Care Units (SNCUs) already approved in the state PIPs. The details of the layout, the staffing pattern and the equipment is placed below. Each unit costs Rs One crore each to set up and roughly one tenth of that would be the running cost annually.

IMMUNIZATION

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

Under the Immunization program vaccines are given to infants and pregnant women for controlling vaccine preventable diseases namely childhood Tuberculosis, Diphtheria, Pertussis, Poliomyelitis, Measles and Neonatal Tetanus. Except polio vaccine, which is administered orally all other vaccines are given as injections.

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

Status of Routine Immunization

To strengthen routine immunization Govt. of India under NRHM has launched newer initiatives as part of the state Program Implementation Plan (PIP), some initiatives are:

- ❖ To ensure injection safety, Auto Disable (AD) syringes introduced throughout country.
- ❖ Support for alternate vaccine delivery from PHC to Sub centers and outreach sessions.
- ❖ Provision for deploying additional manpower to carryout immunization activities in urban slums and underserved areas where services are deficient.
- ❖ Mobility support to SIO, District Immunization Officer and other officer as per State Plan for monitoring and supportive supervision.
- ❖ Review meeting at the State level with the districts on 6 monthly intervals.
- ❖ Training of ANM, Cold Chain handlers, Mid Level Managers, refrigerator mechanics etc.
- ❖ Support for mobilization of children to immunization session sites by Accredited Social Health Activist (ASHA), Women Self Help Groups etc.
- ❖ One Computer Assistant to State Head quarter and each District.
- ❖ Printing of Immunization cards and other tools like tickler bag, tally sheet, monitoring chart, Cold Chain temperature monitoring chart, vaccine inventory charts etc.
- ❖ Implementation of routine immunization monitoring system (RIMS) software.
- ❖ Support for other specific issues.

In addition the central support of the following will continue under immunization as supplies to States-

Strengthening of cold chain system in the state

- ❖ Cold Chain maintenance
- ❖ Supply of vaccines
- ❖ Supply of vaccine van at the rate of one per district

INTRODUCTION OF HEPATITIS-B VACCINE

A pilot project for the introduction of Hepatitis-B Vaccine in the National Immunization Programme was approved by the Government and launched by Hon'ble Prime Minister on 10th June 2002. Under this project Hepatitis-B Vaccine is being administered to infants along with the primary doses of DPT vaccine on 6th 10th and 14th week. The project is presently being implemented in 33 districts and 15 metropolitan cities. The project will end by December, 2007.

Vaccine and syringes are being made available by Global Alliance for Vaccine and Immunization. Expenditure for IEC, training and monitoring budget is being incurred through the domestic funds.

The progress of Hepatitis B project

The implementations of the Hepatitis B vaccination under the project have started in 33 districts. Overall coverage of infants in 33 districts as on 2007 is about 80.97% (767352 children vaccinated for 3rd dose of Hep B against target of 947,687). The coverage in 14 cities is about 58.79% (798632 children vaccinated for 3rd dose of Hep B against target of 1358,421). The coverage of City has been on lower side due to expansion of coverage in city initially from urban slum to entire city.

PULSE POLIO IMMUNIZATION

In pursuance to the World Health Assembly resolution No.1988/41.28 Pulse Polio Immunization (PPI) Programme was started in India from 1997 to eradicate polio from India. Following the successful pilot undertaken in Delhi in 1994, Nation Wide PPI rounds were undertaken in 1997 covering children in the age group of 0-3 years. From 1996-97 the age cohort for vaccination was revised to cover 0-5 years children. Till 1998-99 two rounds used to be organized in the months of December and January each year. From 1999-2000 house to house vaccination of missed children was also introduced to vaccinate children missed during the fixed booth based vaccination of children. This resulted in increasing coverage of 2-3 crore additional children

The annual strategy for polio eradication is decided on the basis of the recommendations of the India Expert Advisory Group (IEAG) consisting of National experts and International Experts from World Health Organization (WHO), United Nations Children's Fund (UNICEF), Centre for Disease Control (CDC) Atlanta. The IEAG reviews the polio epidemiological situation two times a year and recommends the suitable strategies for the country. The National Polio Surveillance Project (NPSP) of WHO provides technical support for high quality Acute Flaccid paralysis (AFP) surveillance and assists the Government in micro planning, training and monitoring of polio immunization campaign.

Since the initiative to eradicate polio from India started in 1997, significant success has been achieved in reducing number of polio cases in the country and total cases declined gradually to only 66 cases in 2007. Out of 37 States & UTs, 33 States in the country were free from indigenous transmission of polio virus since last three years. It is taking more time in UP and Bihar to achieve zero transmission due to factors like high population density and poor sanitation.

In order to achieve the goal of zero transmission at the earliest the strategy in UP and Bihar has been modified to have increased number of polio immunization campaigns with monovalent vaccine type 1 (mOPV1) as per the recommendations of India Expert Advisory Group on Polio to target the polio virus type 1 and poliovirus type 3 sequentially.

As a result of this strategy, there has been a significant decline in the number of cases caused by the most virulent strain of poliovirus type 1 (P1). Only 69 type 1 polio cases have been reported this year as against 648 type 1 last year. The endemic region of Western Uttar Pradesh has reported only five type 1 polio cases this year. The core districts of Moradabad and JP Nagar, the epicenter of the outbreak last year, have not had a single case of P1 for the last one year.

P1 circulation in Bihar is restricted to a small proportion of blocks that have operational difficulties that got worse during the recent floods. Efforts are being made to overcome these operational barriers and it is feasible to stop P1 circulation in Bihar during the low season of 2008.

The number of cases caused by the surviving strain of Poliovirus Type 3 (P3) has risen this year. This is consistent with the immunization strategy recommended by IEAG focusing on curtailing transmission of Polio Type 1 virus and keeping Polio Type 3 virus in check because P1 circulates more widely, has been responsible for international spread and has the propensity to cause large outbreaks.

In order to achieve the goal at the earliest, the implementation strategy has been further strengthened like :

- ❖ 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, through out the country have been intensified. Through these efforts 7 million children in transit have been effectively administered polio drops during each immunization rounds.
- ❖ Migratory population (children) from UP and Bihar in Haryana, Punjab, Gujarat and West Bengal are being immunized during the SNIDs in UP & Bihar.
- ❖ ASHAs have been involved as team member for mobilization and vaccination of children
- ❖ The missed children during SNID are being mobilized by ASHA / AWW and vaccinated during the monthly health days.
- ❖ Strategy to involve the leaders and opinion makers of the underserved community is being adopted in Western UP districts to involve the community better in the programme.

REPRODUCTIVE & CHILD HEALTH II (RCH II)

The RCH II is the flagship Programme of the Government of India on Reproductive, child and maternal health under National Health Rural Mission. This Programme has been re-oriented and revitalized to give it to a pro outcome and pro poor focus. A paradigm shift is envisaged in the manner in which the RCH Program has been conceptualized and implemented based upon key learnings from the first phase of the Programme to make to consistent with the requirements of the National Rural Health Mission.

The key characteristics of RCH-II Programme includes::

- ❖ Adoption of Sector- Wide Approach, which effectively extends the programmes reach beyond Reproductive and Child health to the entire family welfare sector.
- ❖ Building State ownership by involving States and UTs from the outset in development of the Programme.
- ❖ Decentralization through development of District and State level need based plans.
- ❖ Flexible programming with a view to moving away from prescriptive scheme based micro-planning and instead allowing States to develop need based Work plans with freedom to decide upon Programme inputs.
- ❖ Capacity building at the District, State and the Central level to ensure improved Programme implementation. In particular, the emphasis being on strengthening financial management systems and monitoring and evaluation capabilities at different levels.
- ❖ Adoption of the Logical framework as a Programme management tool to support an outcome driven approach.
- ❖ Performance Based Funding to ensure adherence to Programme objectives, reward good performance and support weak performers through enhance technical assistance.
- ❖ Pool Financing by the Development Partners to simplify and rationalize the process of accessing external assistance.
- ❖ Convergence, both inter-sectoral as well as intra-sectoral to optimize utilization of resources as well as Infrastructural facilities.

The Programme Goals are consistent with the National Population Policy, the 10th Five Year Plan and Millennium Development Goals (MDGs). The Ministry has prepared the guidelines to facilitate the states in developing their yearly Programme Implementation Plans(PIPs) as a part of the overall PIP of the National Rural Health Mission (NRHM). The annual PIPs are appraised on the basis of set criteria by a group of experts. The PIPs of all the States/UTs for the year 2007-08 have been appraised and approved by the National Programme Coordination Committee (NPCC).

The European Commission supported Health and Family Welfare Sector investment Programme known as Sector Investment Programme was being implementing as a part of overall RCH Programme. The Programme has been successfully completed and total grant of Rs. 1182.39 Crore received from EC has been fully utilized. Negotiations are going on for the next phase funding by EC for the NRHM/RCH –II Programme.

INTEGRATED DISEASE SURVEILLANCE PROJECT

- ❖ Integrated Disease Surveillance Project (IDSP) is a World Bank assisted Project, launched in November 2004 with the objective to detect and respond to early warning signals of disease outbreaks.
- ❖ The IT network has been established with the help of National Informatics Centre (NIC) and Indian Space Research Organization (ISRO) connecting all State, District HQ and Government Medical Colleges and certain national Institutes involved in disease surveillance & response. Regular video conferencing are being organized for discussion on outbreak investigation, Training and Data transfer.
- ❖ A 24X7 call center was established, in February 2008 which receives disease alerts from the country on a toll free number 1075 and a total of 26756 calls have been received till December 2008. The call center diverts the information to the respective State/District Surveillance Units for initiating appropriate actions..
- ❖ IDSP portal (www.idsp.nic.in) has been developed for data entry and analysis.
- ❖ 50 district and 35 State reference laboratories are being focused for strengthening in the country for laboratory diagnosis of epidemic prone diseases.
- ❖ ICMR has undertaken NCD risk factor surveillance in 7 states of phase I under IDSP during 2008.
- ❖ In the cities of Mumbai, Kolkata & Chennai Urban Surveillance plans have been developed. In Delhi it is part of state plan.
- ❖ 7 Infectious Disease Hospital are part of IDSP network.
- ❖ IDSP presently receives weekly disease surveillance and outbreak reports. On an average 10-15 outbreaks are reported every week to Central Surveillance Unit at National Institute of Communicable Diseases(NICD), Delhi.

Yaws Eradication Programme (YEP) in India

Yaws Eradication Programme (YEP) was launched as a centrally sponsored scheme in 1996-97 in Koraput district of Orissa, which was subsequently expanded to all the endemic states during 9th Plan period. YAWS elimination was declared on 19th Sept. '06 by Hon'ble HFM.

Guinea Worm Eradication Programme (GWEP) in India

WHO certified India as Guinea worm diseases free country in Feb. 2000.

Lymphatic Filariasis & its Control in India

In view of major public health problem, the Govt. of India launched the National Filaria Control Programme in India. NICD undertakes the Research & Trained man – power development.

Pilot Project on Prevention & Control of Human Rabies

To prevent human deaths due to rabies a pilot project has been initiated as a 'New initiative' in the 11th Five Year Plan since March 2008. NICD is a Nodal agency to coordinate various activities under the project and is carried out in five cities, viz., Ahmedabad, Bangalore, Delhi, Pune & Madurai.

Pilot Project on Prevention & Control of Leptospirosis

To prevent morbidity & mortality due to Leptospirosis in humans a pilot project has been initiated as a 'New initiative' in the 11th Five year Plan since March 2008. NICD is a nodal agency to coordinate various activities under the project and is being carried out in three states, viz. Gujarat, Kerala and Tamil-Nadu.

Status of Avian Influenza out-break in Assam in 2008

Unusual poultry deaths (backyard) were first reported on 26th Nov. 2008 in Itazo PPHC in Kamrup (rural) District, Assam. The sample showed the existence of influenza virus of H5N1 strain. No suspected human case has been reported till date.

Status of Avian Influenza out-break in Bengal in 2008

On 15.12.08, the department of Animal Husbandary and Dairying, GOI notified Avian Influenza outbreak in Maldah district, West Bengal. Containment measures have been initiated and microplan is being developed. No suspected human case has been reported till date.

Master in Public Health (Field Epidemiology) course

NICD has been recognised by GGSIP university to conduct two years MPH (Field Epidemiology) course to strength Public Health services by developing a cadre of professional Field Epidemiology for the benefit of the Society.

NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Globally one-fifth of new tuberculosis cases are from India every year. As per the latest estimates, every year there are approximately 18 lakh new cases in the country of which approximately 8 lakh are new smear positive infectious cases. An infectious case if not treated on an average infects 10-15 persons in a year. Annual risk of becoming infected with TB is 1.5% and once infected there is 10% life-time risk of developing TB disease. Two persons die from TB in India every three minutes; more than 1,000 people every day and almost 3, 70, 000 every year.

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

- ❖ Over 55-fold expansion in RNTCP coverage since 1998, leading to total coverage of the country by March, 2006. In terms of treatment of patients, RNTCP is the largest programme in the world. Quality of services has been maintained during this rapid expansion. Sound training materials have been developed for all categories of staff. The training materials are modular in content and have been recently revised keeping in view the new developments in RNTCP. Modular trainings ensure uniform standards and avoid possible subjectivity and bias of the trainers.
- ❖ Diagnostic facilities in nearly 12,000 laboratories throughout the country have been established. As a result, the proportions of sputum positive cases confirmed in the laboratory are double that of the previous programme and are on par with international standards. Quality Assurance protocol implemented in all the states
- ❖ Since its inception, the Programme has initiated over 7.30 million patients on treatment, thus saving nearly 1.3 million additional lives.
- ❖ During the year 2006, sputum positive case detection rate of 66% and treatment success rate of 86% was achieved.
- ❖ Treatment success rates have tripled from 25% to 86%. TB death rates have been cut 7-fold from 29% to 4%.

RNTCP has tripled treatment success in India

Death rates under RNTCP have been cut 7-fold from 29% to around 4%

RNTCP Phase II

- ❖ The RNTCP Phase II of the World Bank project has been approved by the Government for the period Oct 2006 to Sep 2011 for a total outlay of Rs 1,156 Crore (USD 256.9 million) which includes credit from World Bank of Rs 765 Crore (USD 170 million) and commodity assistance of anti-TB drugs from DFID through WHO for Rs 287 Crore (USD 63.7 million) with balance of RS 191 Crore (USD 42.5 million) will be given by GoI. In addition, 385.5 crore is available through GFATM (for 110 million population in Bihar and Uttar Pradesh under Round 2, and 110 million population in the states of Andhra Pradesh and Orissa under Round 4; and 60 million population in the states of

Chhatisgarh, Jharkhand and Uttarakhand from the Round 6) and USAID (for entire 21 million population of Haryana)

- ❖ The second phase of the RNTCP will consolidate, maintain and further improve the achievements of the first phase. Phase II of the RNTCP is a step towards achieving the TB-related Millennium Development Goal (MDG) targets. DOTS remain the core strategy. In addition to the ongoing activities, the following new activities have been envisaged in the second phase.
- ❖ the scaling up of the State-level intermediate referral laboratories (IRL) capacity for nation-wide implementation of external quality assessment (EQA) of sputum smear microscopy services and provision of culture and drug sensitivity testing.
- ❖ Implementation of DOTS-Plus for multi-drug resistant TB cases will occur in a phased manner
- ❖ Procurement and distribution of paediatric drug boxes for improved care of paediatric cases has been initiated.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDCP)

- ❖ The National Vector Borne Disease Control Programme (NVBDCP) is being implemented for prevention and control of vector borne diseases like Malaria, Filariasis, Kala-azar, Japanese Encephalitis (JE), Dengue and Chikungunya. Most of these diseases are epidemic prone and have seasonal fluctuations.

- ❖ Three pronged strategy is being implemented for prevention and control of above diseases, which includes: (i) Disease Detection and Management, (ii) Integrated Vector Management (For Transmission Risk Reduction) and (iii) Supporting Interventions (Behaviour Change Communication, Public-Private Partnership, and Capacity building through training, monitoring and evaluation).

MALARIA: Malaria continues to pose a serious public health problem in different parts of the country, particularly due to *Plasmodium falciparum*, as it leads to complications, if not treated early. The National Health Policy (2002) has set the goal of reduction in mortality on account of malaria by 50% by 2010. The high risk areas of malaria are largely tribal, difficult, remote and inaccessible, forested and forest fringed with operational difficulties. In 1996, there were 3.04 million malaria cases, including 1.18 million were *Plasmodium falciparum* (38.82 %), which declined to 1.77 million malaria cases and 0.82 million Pf cases (46%) in 2006. In 2006, 1703 deaths were reported from the states. During the year 2007, 1.50 million positive cases including 0.73 million *Plasmodium falciparum* and 1194 deaths were reported. During the year 2008 (up to October updated on 25.12.08), 1.22 million positive cases including 0.53 million *Plasmodium falciparum* and 768 deaths have been reported

About 200 districts are identified as high malaria endemic out of which 61 districts are highly malarious with pf predominance. In these districts focused intervention has been initiated which includes: intensified surveillance and use of newer tools for malaria diagnosis viz. Rapid Malaria Diagnostic Tests (RDTs) and complete treatment to clinically diagnosed or confirmed cases. Artesunate Combination Therapy (ACT) has been introduced for treatment of chloroquine resistant cases of *P. falciparum*. The focused intervention also includes intensification of Indoor residual insecticidal spray (IRS); upscaling Insecticide Treated Bed Nets and Larvivorous fish; involvement of local tribal leaders, social activists, SHGs, NGOs as well as ASHA. Full involvement of the State/District administration in programme implementation.

URBAN MALARIA SCHEME About 10% of the total reported cases are from the urban areas where the main vector is *An.stephensi*. There are many high risk factors in the urban areas largely related to the development, lifestyle changes (use of water coolers, water storage containers of multiple sizes, improper disposal of unused tyres, disposable cups, etc), proliferation of construction

activities and migration of labour. Continued and sustained efforts for surveillance and vector control including enactment and enforcement of civic byelaws are necessary.

LYMPHATIC FILARIASIS: Elimination of Lymphatic Filariasis is targeted for elimination in country by 2015 as per the goal set in NHP-2002 document. The strategy for interruption of transmission is Annual Mass Drug Administration (MDA) with single dose of Diethylcarbamazine citrate tablets to all individuals living at risk of filariasis excluding pregnant women, children below 2 years of age and seriously ill persons. The campaign started in 202 endemic districts in 2004 and currently is observed in all the 250 filaria endemic districts. The coverage achieved was 73.19% in 2004, 71.70% in 2005, 61.09% in 2006 and 82.80% in 2007. In 2008, MDA has been observed in 10 states on 11th November and the coverage reported are: Andhra Pradesh (91.96%), Goa (97.46%), Gujarat (99.36%), Jharkhand (49.47%), Karnataka (90.53%), Kerala (93.67%), Andaman & Nicobar Islands (97.01%), Dadra & Nagar Haveli (96.67%). In remaining filaria endemic 10 states it has been rescheduled for December, 08 to January, 09.

KALA-AZAR: Kala-azar is endemic in four states of the country, namely, Bihar, West Bengal, Jharkhand and Uttar Pradesh. However, about 80% of the total cases are reported from Bihar. The incidence of Kala-azar in the country has come down from 77099 cases in 1992 to 37928 cases in 2007 and deaths from 1419 in 1992 to 169 in 2007. During 2008, (up to November updated on 26.12.08), 29702 cases and 137 deaths have been reported. The Government of India reviewed Kala-azar Control Programme in the year 2000 and recommended feasibility of its elimination from the country. The National Health Policy (2002) envisages kala-azar Elimination by 2010. Under the elimination programme the Central Government provides 100% operational cost to the State Governments, besides anti-kala-azar medicines, drugs and insecticides. **The strategy** for elimination of kala-azar are:

- Early case detection & complete treatment
- Vector control by undertaking residual insecticide spraying of houses and cattle sheds in the affected villages and intensification of IEC activities and capacity building.

Govt. of India has accelerated the Kala-azar elimination by intensifying:

1. **Active Case Search:** The frequency of case search has been increased, from a single annual case search to quarterly case search. The active case search for Kala-azar cases is organized in the form of Kala-azar Fortnight, during which the peripheral health workers and volunteers are engaged to make door-to-door visits to detect kala-azar cases and refer cases conforming to case definition of kala-azar and Post Dermal Kala-azar Leishmaniasis (PKDL) to the treatment centres for definitive diagnosis and treatment.

2. **Institutional Surveillance (passive case detection):** Majority of the kala-azar cases are reported from PHC's/district hospitals. Many private practitioner, NGO, FBO's have been motivated to report cases to the district health authorities.

3. **Treatment:** To ensure complete treatment compliance, a Patient Coding Scheme has been put in place in all the treatment centres.

4. **Introduction of rk39**, a rapid diagnostic test and **oral drug miltefosine** for early detection of Kala-azar and better treatment compliance.

5. **Identification of kala-azar activist** amongst the affected communities and mobilization of the community for early reporting and treatment compliance.

6. **Free diet to patient** during the period of treatment in the hospitals.

7. **Intensive monitoring and supervision** of indoor residual spray by deploying teams from GoI and other partner institutions like ICMR & medical colleges.

- **JAPANESE ENCEPHALITIS:** JE has been reported repeatedly from 13 States/UTs namely Andhra Pradesh, Assam, Bihar, Delhi, Goa, Haryana, Karnataka, Kerala, Maharashtra, Manipur, Tamil Nadu, Uttar Pradesh and West Bengal. In year 2005, 6727 cases and 1682 deaths due to suspected JE were reported from 14 States in the country whereas during 2006 and 2007, 2842 & 4024 cases and 658 & 963 deaths respectively were reported due to suspected viral encephalitis/JE. During the year 2008 (till 18.12.2008) 3598 cases and 644 deaths due to acute encephalitis syndrome (AES) have been reported.

- Apart from vector control measures Govt. of India initiated JE vaccination programme for children between 1 and 15 years of age as an integral component of Universal Immunization Programme (UIP) with single dose live attenuated JE vaccine (SA-14-14-2) in 2006 and since then the identified districts are being covered for immunization in phased manner. The coverage of target population was 75.54% and 77.20% in 2007 and 2008 respectively.

- A sub-office of ROH&FW Lucknow has been established at Gorakhpur to monitor JE situation in UP state from 2nd April 2007.

- A “Vector Borne Diseases Control Surveillance Unit” has been set up at BRD Medical College, Gorakhpur, UP

- Guidelines for reporting Acute Encephalitis Syndrome cases and confirmed JE cases have been circulated to all states.

- **DENGUE FEVER / DENGUE HAEMORRHAGIC FEVER:** Dengue is prevalent in different parts of the country and focal outbreaks are reported mainly in urban areas. However in the recent past, Dengue is reported from rural areas as well, due to increasing urbanization and lifestyle changes. In 1996, the country had experienced an outbreak recording a total number of 16517 cases (suspected) and 545 deaths. During 2003 again, large number of cases and deaths had been reported (12754 and 215, respectively). While in 2005, 11985 cases and 157 deaths were reported. During 2006, 12317 cases and 184 deaths were reported whereas during 2007, 5534 cases and 69 deaths were reported. In 2008 (up to 29.12.08), 12143 cases and 80 deaths have been reported.

- **CHIKUNGUNYA:** During 2006, Chikungunya fever has re-emerged in the country in epidemic form after a quiescence of about three decades. Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Madhya Pradesh, Gujarat, Kerala, A&N Islands, GNCT of Delhi, Rajasthan, Pondicherry, Goa, Orissa, West Bengal, Lakshadweep and Uttar Pradesh were affected. The reported number of suspected Chikungunya fever cases in the country was 1.39 million. 15961

samples were tested out of which 2001 were found positive for Chikungunya. During the year 2008 (up to 29th December), 93934 suspected Chikungunya fever cases have been reported. 7477 samples were tested out of which 2262 were found positive for chikungunya.

- The Government has taken various steps to tackle these vector borne diseases (VBDs) including Dengue and Chikungunya as detailed below:

- Implementation of strategic Action Plan for prevention & control of Chikungunya by the State Govt.

- Identified 13 Apex Referral Laboratories for advanced diagnosis and regular surveillance of Dengue and Chikungunya.

- Identified 137 sentinel surveillance hospitals for proactive surveillance for Dengue and Chikungunya.

- NIV Pune has been entrusted to supply IgM ELISA test kits to these institutes.

- Dissemination of detailed guidelines and advisories.

- Emphasized on intensive IEC/Behaviour Change Communication activities through print, electronic media, Inter-personal communication, outdoor publicity as well as Inter-sectoral collaboration with civil society organizations (NGOs/CBOs/Self-Help Groups), Panchayati Raj Institutions (PRIs), for taking community based measures.

- **CENTRAL ASSISTANCE:** Government of India provides commodity support in the form of anti-malarial drugs, insecticides and larvicides to the states/UTs as per the approved norms. North-eastern states are provided 100 per cent central assistance for programme implementation, since December 1994.

- Additional resources are also being provided to selected high-risk areas in northeastern states, Orissa, Jharkhand and West Bengal through External Aid from GFATM to accelerate anti malaria activities and improve services especially in the remote and inaccessible pockets.

- A new project with World Bank assistance on “Malaria Control and Kala Azar elimination” for a period of 5 years has also been approved which will be implemented in 8 malaria endemic states namely Orissa, Jharkhand, Chattisgarh, Madhya Pradesh, Andhra Pradesh, Maharashtra, Gujarat, Karnataka and three Kala-azar endemic states namely Bihar, Jharkhand and West Bengal,

NATIONAL PROGRAMME FOR PREVENTION & CONTROL OF DEAFNESS(NPPCD)

Hearing impairment / deafness is the second most common cause of disease morbidity in the country.

There has been no national level intervention on one of the most common preventable cause of disability.

MOHFW has therefore launched the new National Programme on Prevention and Control of Deafness (NPPCD). This programme has been approved by the competent authority and approximately 80 districts are being covered in 2008-09.

The key components include early detection and screening; medical and surgical treatment; rehabilitation of children with hearing aids; awareness campaigns.

As part of the strategy two personnel will be deployed in each district – One Audiometric Assistant and one Instructor/lecturer. The shortage of Audiometric Assistant is being met by introduction of new DHLS Program from AIISH, Mysore. This programme introduced in 2007 has already trained more than 75 Audiometric Assistants. The Programme is being upscaled from 5 centres to 11 centres this year, each of which are linked to interactive Audio-visual connectivity, making it possible for the e-education from AIISH, Mysore.

NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)

Tobacco is a single most preventable cause of death in the country. The Government of India is taking steps to ensure effective implementation of the Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003.

The Ministry of Health & FW is also launching the National Tobacco Control Programme in 11th Five Year Plan to build capacity of the States for the effective implementation of the Tobacco Control Act and of the FCTC. The outlay is Rs. 470 cr. approximately and key components include mass media, school health camps; awareness; building lab capacity for product testing; training/sensitization of health & other work force, etc. The Pilot Phase of the National Tobacco Control Programme (NTCP) was launched in 2007 in 9 States and 18 Districts. NTCP also aims at ensuring enforcement of Anti Tobacco Laws and to bring about greater awareness of the harmful and ill effects of tobacco consumption.

The Government has revised the smoke free law with effect from 2nd October, 2008. The new rules prohibit smoking in public places. These rules are meant to empower the non-smokers who constitute two-thirds of India's population. It is hoped that there will be wide spread movement and support for this law, as scientific evidence demonstrates that second hand smoke is as harmful and is therefore a serious public health threat.

National Leprosy Eradication Programme in India

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

Govt. of India launched the National Leprosy Control Programme in 1955 based on dapsone monotherapy. Multi Drug Therapy came into wide use from 1982 following recommendation of WHO study group and National Leprosy Eradication Programme was launched in 1983 with the objective to arrest the disease in all the known cases of leprosy. In 1991, the World Health Assembly resolved to eliminate leprosy at a global level by the year 2000. To strengthen the process of elimination in the country, the first World Bank supported project was introduced in 1993. On completion of this project, the 2nd phase of with World Bank supported project was started in 2001-02 and ended in December 2004. Since then, the programme is being continued with Government of India funds with technical support from WHO and International Federation of Anti Leprosy Association (ILEP) organizations. The programme has been integrated with GHC system in 2002-03, since then leprosy diagnosis and treatment services are available at all PHCs and govt. hospitals.

Following are the components of the programme –

- (i) Decentralized integrated leprosy services through General Health Care System.
- (ii) Capacity building of all General Health Services functionaries.
- (iii) Intensified Information, Education & Communication (IEC).
- (iv) Prevention of Disability and Medical Rehabilitation and
- (v) Intensified monitoring and supervision.

Leprosy Situation in India

After introduction of MDT, spectacular success has been achieved in reducing the disease burden. The goal of leprosy elimination at National level (i.e. PR of less than 1 case/10,000 population) as set by National Health Policy, 2002 had been achieved in December 2005. The prevalence has come down from 57.6 cases per 10,000 population in 1981 to 0.74 in March 2008. By end of March 2008, 0.87 lakh leprosy cases were on record and 1.38 lakh new cases were detected during 2007-08. 29 States/UTs achieved the status of leprosy elimination. 6 states/UTs viz. Bihar, Jharkhand, West Bengal, Chhattisgarh, Chandigarh and Dadra & Nagar Haveli are yet to achieve elimination. These 6 States/UTs with 20.8% of country's population contributed to 35% of new cases detected during 2007-08. 79.7% of districts and 73.6% of blocks had also recorded PR < 1/10,000 population.

State wise Contribution of New Leprosy Cases during 2007-08

Out of 1.38 lakhs new leprosy cases detected during the year, 47% were MB cases, 9.4% child cases, 34.5% female cases and 2.5% were visible deformity cases. Substantial declining trend can be seen in the Leprosy Prevalence and Annual New Case Detection Rate (ANCDR) in the diagram below-

Major Initiatives taken-

- More emphasis is being given on providing Disability Prevention and Medical Rehabilitation (DPMR) services. In addition to 32 ILEP supported NGOs in the country, 20 govt. institutions have been strengthened for providing reconstructive surgery services to disabled persons affected with leprosy for correction of their disability.
- Under the programme, more focus was given to districts and blocks with prevalence rate of more than 2/10,000 population. During 2007-08, special activities in the form of Block & Urban Leprosy Awareness Campaigns aiming at spreading awareness & providing treatment to newly detected leprosy cases were carried out successfully in endemic 275 blocks and 53 urban areas. 5137 new cases were detected and put under treatment.
- More focus has now been given to new case detection rather than prevalence which only give the number of cases on record at a point in time. The New Case Detection Rate is the main indicator for programme monitoring now being calculated on quarterly basis by the state as per the guidelines.
- Treatment Completion Rate (TCR) has been taken as an important indicator to be calculated on regular basis every year all over the country as an inbuilt component of the programme. The guidelines for calculation of TCR by Cohort Analysis had been issued to states and the rates for the reporting year 2006-07 have been received as base line information.
- IEC campaigns with the theme 'Towards Leprosy Free India' was started from 30th January 2008 with focus on further reduction in leprosy burden in the community, early reporting of cases & treatment completion, provision of quality leprosy services and reduction of stigma & discrimination.

New Paradigms-

After elimination of leprosy, the programme has expanded the scope of providing leprosy services to the patients, their families and community at large. To sustain leprosy services for many years to come, there has been a shift from campaign like elimination approach, towards the long term process of sustaining integrated high quality leprosy services.

New paradigms under the programme take into consideration the following-

1. More focus on new case detection and treatment completion.
2. Improvement of quality of leprosy services which are accessible to all and follow the principle of equity & social justice.
3. Strengthening referral services with more focus on long term care of the leprosy affected persons.
4. Support of NRHM for improving delivery of leprosy services by involvement of ASHA, Village Health & Sanitation Committees and Rogi Kalyan Samities.
5. Community Based Rehabilitation of leprosy affected persons.
6. Renewed focus on reduction of stigma & discrimination against leprosy affected persons and their family members.

To streamline the activities and to guide the states/UTs in proper implementation of the "New Paradigms in NLEP", following guidelines were issued during the year-

- i. Guidelines for use of Treatment completion rate as an Indicator under the National Leprosy Eradication Programme.
- ii. Guidelines for use of Treatment completion rate as an Indicator under the National Leprosy Eradication Programme.
- iii. Guidelines on Quarterly assessment of New Case Detection Rate (NCDR) under National Leprosy Eradication Programme.
- iv. NLEP- Monitoring and Evaluation tools for implementation of New Paradigms during 11th Plan period.
- v. NLEP quality service indicators- Significance & actions required.
- vi. Guidelines on “other cases” under NLEP.
- vii. Disability, MB & Child proportion- Epidemiological significance & interpretations.
- viii. Guidelines on Community Based Rehabilitation.
- ix. Guidelines on reduction of Stigma and Discrimination.
- x. Guidelines strategy for Behavioral Change Communication.

Urban Leprosy Control Programme-

To address the complex problem like larger population size, migration, poor health infrastructure and increasing prevalence in urban areas, the Urban Leprosy Programme was initiated in 2005.

Urban Leprosy Control Programme has been implemented since 2005 under which assistance is being provided by Govt. of India to 422 urban areas having population size of more than 1 lakh. For the purpose of providing graded assistance, the urban areas are grouped in four categories i.e. Township I, Medium Cities I, Medium Cities II, Mega Cities.

Involvement of NGOs-

Non Governmental Organizations (NGOs) have been involved for the cause of leprosy elimination for many decades and their contributions have made a positive impact in reducing the prevalence of leprosy. Presently 38 NGOs are getting grant-in-aid from Govt. of India under Survey, Education and Treatment (SET) scheme. Few NGOs have been given recognition for conducting reconstructive surgeries (RCS) where facilities for these services are available.

The NGOs serve in remote, inaccessible, uncovered, urban slums, industrial / labour population and other marginalized population groups. 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 Leprosy Society. Under SET scheme, Rs. 2.63 crores were released to NGOs during 2007-08.

ILEP Agencies –

International Federation of Anti-leprosy Association (ILEP) is actively involved as partner in NLEP. In India, ILEP is constituted by 10 Agencies viz. The Leprosy Mission, Damien Foundation of India Trust, Netherland Leprosy Relief, German Leprosy Relief Association, Lepra India, ALES, AIFO, Fontilles – India, AERF - India and American Leprosy Mission. A MOU was signed with ILEP partners in October 2008 for providing technical support to the programme till March 2012. ILEP is providing support in the form of planning, monitoring & supervision of the programme, capacity building of GHC staff, providing re-constructive surgery services and socio economic rehabilitation of persons affected with leprosy.

WHO Support-

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

- **IEC-**
- Four video spots of IEC of Leprosy were produced with the help of TLM Media Centre, Noida.
- Leprosy free India campaign was launched on 30th January, 2008. Advertisement on 'Leprosy Free India' was published in country wide newspapers.
- Mass Media campaign was done on four channels viz. D.D, Aaj Tak, Zee News and ETV.
- Independent evaluation of IEC activities of the programme were conducted by Centre for Media Studies, New Delhi

Disability Prevention & Medical Rehabilitation (DPMR)-

The main activities carried out during the year 2007-08 are as under –

1. Finalized, printed and distributed 'DPMR-Operational Guidelines' – ILEP agencies prepared the first draft, experts committee examined and improved it, final draft was printed & distributed to states for its use.
2. Implementation of DPMR activities as per guidelines and reporting its outcome – Treatment of 'Leprosy Reaction', ulcers, Physiotherapy, Reconstructive Surgery and providing MCR shoes /protective aids. Outcome of all these activities started reporting through 'Monthly progress Report' from the states to CLD. 3439 persons were operated and benefited by RCS services, 25585 foot wears were given to needy cases having anesthesia sole and 5480 cases of Leprosy reaction were treated by Prednisolone. 15343 cases were given 'self care kits' to prevent & treat recurrent ulcers.
3. Integrating DPMR services – There are provision of services to Persons with Disability' (PWD) by various departments under different ministries. Two meetings under chairmanship of Joint Secretary Health initiated the process. Convergence of NLEP services into NRHM facilitated this integration.
4. Training of GHC staff – Many states have carried out trainings of GHC staff to improve the quality of DPMR services delivered by PHC system. Training of surgeons and surgical team of medical college hospitals in leprosy surgery has enhanced the services of 'Reconstructive Surgery' for persons with disability due to leprosy.
5. Monitoring DPMR activities – Analysis of reports, feedback to states and review meetings remain main activities to monitor the DPMR program. Field visits and review meetings at state level has further strengthened the monitoring of DPMR program.
6. Ministry of Health and Family Welfare is coordinating with other ministries /departments for identifying and striking down the discriminatory provision existing in various Acts, Laws, Rules, Govt. Orders etc. against leprosy affected persons.

Monitoring and Evaluation of NLEP-

NLEP has an inbuilt information system for monitoring and supervision of the programme activities at Central, State, District & Peripheral level.

- ❖ Simplified Information System (SIS) was introduced in 2002 so that GHC service personnel can easily adapt to the system of recording and reporting under the programme. This system has drastically improved recording, reporting and its transmission. The programme is monitored at District, State and Central level through scrutiny of regular monthly reports.
- ❖ Leprosy Elimination Monitoring (LEM) exercise were undertaken with WHO support through the NIH&FW, New Delhi, to assess the programme achievement in identified indicators during the year 2002, 2003 and 2004. Immediate actions were initiated on the deficiencies observed.
- ❖ An independent evaluation of the programme was carried out during 2007-08 through the Indian Institute of Health Management Research, Jaipur. The final report is awaited.
- ❖ Evaluation of IEC activities under the programme was carried out through Centre For Media Studies (CMS) an independent agency.
- ❖ The programme is reviewed at District and PHC level in monthly meetings. Quarterly review meetings were held at State level for the District Leprosy Officers and other partners, which are also attended by officers for the Central Leprosy Division.
- ❖ For the North Eastern and also Northern states, Regional level meetings were organized in the year 2007-08, which were also attended by all the partners' organizations.

Future Strategy-

Although the prevalence has come down at national level, yet large numbers of new leprosy cases are being detected every year. These new cases will continue to occur and will have to be provided quality leprosy services through existing GHC system for ensuring early diagnosis and treatment completion. Further there are few districts & blocks with prevalence rate of more than 2/10,000 population that need extra focus. The future strategy of the programme is to further reduce the leprosy burden, provide quality leprosy services through GHC system, enhance disability prevention and rehabilitation services, reduce stigma and discrimination against persons affected with leprosy & their family members, capacity building of GHC staff and strengthening monitoring and supervision.

National Cancer Control Programme

Cancer is a major public health concern in India and has become one of the ten leading causes of death in the country. It is estimated that there are about 2.5 million cases of cancer at any particular point of time with 8 to 9 lakh new cases being detected every year. About 4 lakh deaths occur annually in the country due to cancer. The burden of cancer is expected to further increase due to increase in life expectancy, demographic transitions and the effects of tobacco and other risk factors. The leading sites of cancer are the oral cavity, lungs, oesophagus and stomach among men and cervix, breast and oral cavity amongst women.

The existing five schemes are the following:

1. Recognition of New Regional Cancer Centers (RCCs): A one-time grant of Rs.5.00 crores is being provided for New RCCs.
2. Strengthening of existing Regional Cancer Centers: A one-time grant of Rs.3.00 crores is provided to the existing Regional Cancer Centers.
3. Development of Oncology Wing: Government Hospitals & Government Medical Colleges are provided with a grant of Rs.3.00 crores for the development of Oncology Wing.
4. District Cancer Control Programme: A grant-in-aid of Rs.90.00 lakhs spread over a period of 5 years is provided for the district Cancer Control Program.
5. Decentralized NGO Scheme: A grant of Rs.8000/- per camp is provided to the NGOs for IEC activities through nodal agency of the State Govt.

Proposed Schemes for NCCP during the 11th Plan Period:

- (i) Upgradation of CHCs: Early Detection & Referral (level O)
- (ii) Basic Cancer Care (Level I & II)
 - Districts with Basic Cancer Care without Radiotherapy (Level I)
 - Districts with Basic Cancer Care with Radiotherapy (Level II)
- (iii) Incentive Scheme for Referral at PHC/CHC
- (iv) Tertiary level Cancer Care (Level III)
 - Revised Oncology Wing Scheme for Medical Colleges
- (v) Tertiary level Cancer Care (Level IV)
 - Revised scheme for New Regional Cancer Centres (IV A)
 - Revised scheme for Existing Regional Cancer Centres (IV B)
- (vi) Miscellaneous:
 - Training
 - IEC
 - Cancer Research including vaccine research
 - National Cancer Institute
 - Chittaranjan National Cancer Institute (including 2nd Campus)
 - National Cancer Fund
 - Monitoring Cells at National & State Level

Achievements during 2008-09

1. *For providing financial assistance to poor and needy BPL cancer patients Health Minister's Cancer Patient Fund is being established after taking approval from competent authority.*
2. *3rd year membership fee paid to International Agency for Research on Cancer (IARC), Lyon, France.*
3. *Grant has been released to two districts in Sikkim to create awareness among the general people about cancer control / early detection. under District Cancer Control Programme .*
4. *For establishment of 2nd Campus of CNCI, Kolkata DPR is being prepared by HSCC (I). Soil testing and preparation for raising the boundary wall are being done by HSCC(I).*
5. *On the occasion of the National Cancer Awareness Day, observed on 7th November every year. This year audio and video spots were relayed in National radio and television network for 1 week from 7th to 14th November 2008. Advertisements were given in National dailies and banners were displayed at different positions for creating awareness among the general masses.*
6. *Onconet India, a project to facilitate telemedicine services and continued medical education through networking of Regional Cancer Centers (RCCs) and their peripheral centers is being done by NIC.*

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS

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

Due to formation of National Rural Health Mission, the structure of the Programme (both the administrative requirements and the Programme inputs) have been implanted vis-à-vis the available resources under NRHM. State Blindness Control Societies and District Blindness Control Societies formed for implementation of the Programme in states under NPCB have been merged with State Health Societies and District Health Societies respectively formed under NRHM.

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

The main objectives of the programme are:

- i. To reduce the backlog of blindness through identification and treatment of blind;
- ii. To develop Comprehensive Eye Care facilities in every district;
- iii. To develop human resources for providing Eye Care Services;
- iv. To improve quality of service delivery;
- v. To secure participation of Voluntary Organizations/Private Practitioners in eye Care;
- vi. To enhance community awareness on eye care.

Major performance indicators of NPCB

i) Cataract Operations:			
Year	Target	Cataract operations performed	% surgery with IOL
2002-03	4000000	3857133	77
2003-04	4000000	4200138	83
2004-05	4200000	4513667	88
2005-06	4513000	4905619	90
2006-07	4500000	5040089	93
2007-08	5000000	5404406	94

ii) School Eye Screening Programme:	
Year	No. of free spectacles provided to school age group children
2002-03	98697
2003-04	184305
2004-05	283070

2005-06	385403
2006-07	456634
2007-08	512020

iii) Eye Donation:

Year	Collection of donated eyes
2002-03	19833
2003-04	23741
2004-05	23553
2005-06	28007
2006-07	30007
2007-08	38546

iv) Training of Eye Surgeons:

Year	No. of eye surgeons trained
2002-03	176
2003-04	229
2004-05	350
2005-06	250
2006-07	250
2007-08	300

Pattern of Assistance during 11th Plan

The following are the main features of Pattern of Assistance during 11th Plan:

- Keeping in view austerity measures and to avoid duplicity of work, State Ophthalmic Cell has been merged with State Blindness Control Society. Due to formation of National Rural Health Mission (NRHM), State Blindness Control Society (SBCS) under NPCB has been further merged with State Health Society under NRHM. District Blindness Control Society (DBCS) under NPCB has also been merged with District Health Society under NRHM.
- Increase in assistance for commodity to various facilities to increase their capacity for treatment of all types of eye ailments;
- Facility for Intra-ocular Lens (IOL) implantation expanded up to Taluka level;
- Marginal increase in grant-in-aid to Eye Banks, Eye Donation Centres and NGOs due to escalation of costs and to improve quality of services;
- In addition to cataract, assistance would also be provided for other eye diseases like glaucoma, diabetic retinopathy, management of laser techniques, corneal transplantation, vitreoretinal surgery, treatment of childhood blindness etc.
- Assistance for construction of dedicated Eye Wards and Eye Operation Theatres in North East States and few other states as per need;
- Assistance for appointment of Ophthalmic manpower – Ophthalmic Surgeons, Ophthalmic Assistants and Eye Donation Counsellors – on contractual basis;
- Assistance for involvement of Private Practitioners in sub-district, block and village levels;
- Assistance for maintenance of Ophthalmic equipments supplied under the programme; Development of Mobile Ophthalmic Units with Tele-ophthalmology Network and some fixed tele-models to cover difficult hilly terrains and difficult areas;

j)

PRADHAN MANTRI SWASTHYA SURAKSHA YOJANA (PMSSY)

SETTING UP OF SIX AIIMS-LIKE INSTITUTIONS UNDER 1ST PHASE

Government of India has approved the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) in March, 2006 with the objective of correcting regional imbalance in the availability of affordable/reliable tertiary healthcare services and also to augment facilities for quality medical education in the country. Under the PMSSY, it has been decided to set up 6 AIIMS-like institutions, one each in the States of Bihar (Patna), Chattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneswar), Rajasthan (Jodhpur) and Uttaranchal (Rishikesh) at an estimated cost of Rs 332 Crores per institution which is likely to be revised. Each institution will have a 960 bedded hospital (500 beds for the medical college hospital; 300 beds for Speciality/Super Speciality; 100 beds for ICU/Accident trauma; 30 beds for Physical Medicine & Rehabilitation and 30 beds for Ayush) intended to provide healthcare facilities in 39 speciality/super-speciality disciplines. Medical College will have 100 UG intake besides facilities for imparting PG/doctoral courses in various disciplines.

Progress of setting up of six AIIMS-like institutions in the 1st phase of PMSSY

Pre-construction survey and Environment Impact Assessment (EIA) study conducted. The proposals for EIA clearances are being examined by Ministry of Environment & Forests.

Construction of medical college and hospital complex:- Design DPR Consultants were selected in October-November, 2007 for preparation of designs and DPR for Medical College & Hospital Complex at each institution. Lay-out/master plans for AIIMS, Bhopal, Rishikesh and Jodhpur were approved by Project Management Committee on 8.1.2008; for Bhubaneswar on 20.2.2008; for Raipur on 12.3.2008; and for Patna on 25.3.2008. The architectural designs were evaluated by the faculty of AIIMS/PGIMER for ensuring functional efficiency; The Energy Resource Institute (TERI) for green building concept; and Bureau of Energy Efficiency (BEE) for ECBC (Energy Conservation Building Codes) compliance. Project Management Committee (PMC) approved preliminary architectural designs for the sites at Bhopal, Jodhpur and Rishikesh on 22.4.2008 and for Patna, Raipur and Bhubaneswar on 28.5.2008.

Insofar as for Jodhpur and Rishikesh, Complete DPRs for Jodhpur and Rishikesh were received and are being evaluated by Technical Committee. DPRs for Raipur and Patna are being reviewed by the concerned Project Consultants. The complete DPRs for Bhubaneswar, Bhopal, Raipur and Patna sites are likely to be made available to the Technical Committee by the end of December, 2008 for evaluation. Based on the DPRs received, the revised cost estimates will be firmed up and taken up in the EFC/CCEA for fresh proposal.

Construction of residential (housing & hostels) complex: Work at Jodhpur site started in November, 2007. The construction agencies have also been selected for remaining sites through open competitive bidding. The work at Patna, Rishikesh, Bhubaneswar and Raipur sites has been awarded in August, 2008 and the contractors have mobilized/started civil construction at all sites. At Bhopal site construction work started in November, 2008.

It is expected that the civil construction work will be completed by 2009-10 for housing complex and by 2010-11 for hospital/medical college complex.

Upgradation of 13 medical college institutions under PMSSY

The medical college institutions being upgraded under the 1st phase of PMSSY are as under:-

1. Govt. Medical College, Jammu (J&K)
2. Govt. Medical College, Srinagar (J&K)
3. Kolkatta Medical College, Kolkatta (W.B.)
4. Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow (U.P)
5. Institute of Medical Sciences, BHU, Varanasi (UP),
6. Nizam Institute of Medical Sciences, Hyderabad(A.P)
7. Sri Venkateshwara Institute of Medical Sciences, Tirupati (A.P) (50% cost of upgradation will be borne by the TTD Trust)
8. Govt. Medical College, Salem (T.N.)
9. B.J. Medical College, Ahmedabad (Gujarat)
10. Bangalore Medical College, Bangalore(Karnataka)
11. Medical College, Thiruvananthapuram, (Kerala)
12. Rajendra Institute of Medical Sciences (RIMS), Ranchi
13. Grants Medical College & Sir J.J. Group Of Hospitals, Mumbai, (Maharashtra)

Upgradation of the above institutions was approved by CCEA on 22.6.2006 except RIMS, Ranchi, for which CCEA approval was obtained on 26.4.2007.

The work relating to Project Consultancy and execution of upgradation of the medical college institutions has been assigned to M/s. Hospital Services Consultancy Corporation (India) Ltd., M/s. Hindustan Latex Ltd. and CPWD.

Upgradation of the medical college institutions broadly envisages strengthening the existing departments, through procurement of equipment. It is also proposed to build a Super Speciality Block, Nursing College, OPD etc. for many of the institutions. Out of the 13 medical college institutions being upgraded, 3 medical colleges have only procurement of equipments for existing facilities and the remaining 10 have both civil work and procurement components. Civil work has started at 9 institutions and for remaining 1 (RIMS, Ranchi) where there is civil work, the tenders are under finalization. Civil construction work in most of the institutions will be completed by the end of 2009.

Progress of civil work:-

- ❖ Thiruvananthapuram Medical College:- Work started for construction of 253 bedded Super Speciality Block in **January, 2008** and is progressing as planned. It is expected to be completed by June, 2009.
- ❖ Mohan Kumaramangalam Government Medical College, Salem:- Work started for 319 bedded Super Speciality Block and 122 bedded Trauma Centre in **January, 2008**. The work is scheduled to be completed by March, 2009. Approximately 30% of work has been completed and there has been some delay in work due to shortage of labour.

- ❖ Kolkata Medical College:- Work started for construction of OPD and Academic Block in **January, 2008**. The work is scheduled to be completed by March, 2009. 24% of work has been completed so far and there is some delay due to services and structures found in the foundation area, heavy rains and non-removal of existing structure in Academic Block. Construction of Super Speciality Block will be started thereafter. HSCC, Project Consultant has been requested to prepare DPR for SSB.
- ❖ SGPGIMS, Lucknow:- Work started for construction of 230 bedded Super Speciality Block in **January, 2008**. The work is scheduled to be completed by April, 2009. 23% of work has been completed so far and there is some delay due to delay in getting clearances for tree cutting and heavy rainfall.
- ❖ Jammu Medical College:- Work started for construction of 200 bedded Super Speciality Block in **February, 2008**. The work is scheduled to be completed by Sept, 2009. 38% of work has been completed. Progress of the work delayed for 2-3 months due to civil disturbance/agitation in the State.
- ❖ Bangalore Medical College:- Work started for construction of 203 bedded Super Speciality Hospital and Nursing College in **January, 2008**. The work is scheduled to be completed by October, 2009. Approximately 20% of the work has been completed. There has been slight delay in progress of work due to delay in shifting of power cables by the BESCO authorities.
- ❖ NIMS, Hyderabad:- Work started for construction of 300 bedded Super Speciality Block and 200 bedded Accident (Trauma) & Emergency Hospital in **March, 2008**. The work is scheduled to be completed by **June, 2009**. 21% of work has been completed. There has been a slight delay due to unforeseen circumstances such as cutting of hard rock, restricted entry of materials and torrential rains.
- ❖ Srinagar Medical College:- Work started for construction of 200 bedded Trauma Care Centre in **March, 2008**. 12% of work has been completed. Shortfall is due to civil disturbance/agitation in J&K and non-availability of labour. The work is expected to be completed by March, 2010.
- ❖ IMS, BHU, Varanasi:- Work started for construction of 334 bedded Trauma Centre in **October, 2008**.
- ❖ RIMS, Ranchi:- **Tenders under finalization** for construction of 172 bedded Super Speciality Block and 68 bedded Oncology block.
- ❖ **Procurement of Equipments**
- ❖ Specification of common and high end equipments for all the departments was finalized by Technical Specification Committee.
- ❖ Strategy for decentralized procurement of equipments for the medical college institutions has been worked out and detailed guidelines to be followed by the institutions/State Governments have been issued in **May, 2008** and also put on MoHFW's website.
- ❖ Procurement of low end and uncommon equipment would be made by the beneficiary institutions/State Governments.

- ❖ However, in the case of procurement of common and high end equipment, MoHFW, through HLL, would carry out central procurement of equipment for obtaining benefits of scale.
- ❖ Integrated Purchase Committee (IPC) approved Centralized procurement of common and high end equipment for Radiology and Trauma departments on **10th November, 2008** and Cardiology department on **5th December, 2008**. Placement of orders on suppliers will be made shortly.

Food Safety and Standards Authority of India

The Food Safety and Standards Authority of India (FSSAI) has been established under Food Safety and Standards Act, 2006, which consolidates various Acts & Orders that have hitherto handled food related issues in various Ministries and Departments. FSSAI has been created for laying down science based standards for articles of food and to regulate their manufacture, storage, distribution, sale and import to ensure availability of safe and wholesome food for human consumption.

Highlights of the Food Safety and Standards Act, 2006

Various Central Acts like Prevention of Food Adulteration Act, 1954, Fruit Products Order, 1955, Meat Food Products Order, 1973, Vegetable Oil Products (Control) Order, 1947, Edible Oils Packaging (Regulation) Order, 1988, Solvent Extracted Oil, De-oiled Meal and Edible Flour (Control) Order, 1967, Milk and Milk Products Order, 1992 etc will be repealed after commencement of the FSS Act, 2006.

The Act also 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. To this effect, the Act establishes an independent statutory authority – the Food Safety and Standards Authority of India with head office at Delhi. Food Safety and Standards Authority of India (FSSAI) and the State Food Safety Authorities shall enforce various provisions of the Act.

Establishment of the Authority

Ministry of Health & Family Welfare, Government of India is the administrative ministry for the implementation of FSSAI. The Chairperson and Chief Executive Officer of Food Safety and Standards Authority of India (FSSAI) have already been appointed by Government of India. The chairperson is in the rank of Secretary to Government of India.

Shri P.I. Suvrathan who was earlier Secretary, Ministry of Food Processing Industries, has been appointed as the first Chairperson of the Food Safety and Standards Authority of India (FSSAI) and he has joined his duties w.e.f. 10.06.2008. Shri. G. Balachandhran has joined as the Chief Executive Officer of the Authority w.e.f. 18.02.2008

The Authority has been notified with Chairperson, Member Secretary and 22 Members.

Duties and functions of the Authority

FSSAI has been mandated by the FSS Act, 2006 for performing the following functions:

- ❖ Framing of Regulations to lay down the Standards and guidelines in relation to articles of food and specifying appropriate system of enforcing various standards thus notified.
- ❖ Laying down mechanisms and guidelines for accreditation of certification bodies engaged in certification of food safety management system for food businesses.
- ❖ Laying down procedure and guidelines for accreditation of laboratories and notification of the accredited laboratories.
- ❖ To provide scientific advice and technical support to the Central Government and State Governments in matters of framing the policy and rules in areas which have a direct or indirect bearing of food safety and nutrition.

- ❖ Collect and collate data regarding food consumption, incidence and prevalence of biological risk, contaminants in food, residues of various contaminants in food products, identification of emerging risks and introduction of rapid alert system.
- ❖ Creating an information network across the country so that the public, consumers, Panchayats etc receive rapid, reliable and objective information about food safety and issues of concern.
- ❖ Provide training programmes for persons who are involved or intend to get involved in food businesses.
- ❖ Contribute to the development of international technical standards for food, sanitary and phyto-sanitary standards.
- ❖ Promote general awareness about food safety and food standards.

Committees & Panels

Central Advisory Committee – The Central Advisory Committee would be notified shortly and once notified, it would advise the Authority on the work programme, prioritization of work, identifying potential risks and pooling of knowledge.

Scientific Committee and Scientific Panels – Scientific Panels would consist of experts in areas such as food additives, pesticides & antibiotics residues, genetically modified organisms & foods, biological hazards, contaminants in the food chains, labeling, methods of sampling etc. The Chairpersons of the Scientific Panels together with independent scientific experts who are not part of the scientific panels would comprise the Scientific Committee which would be the main advisory body within the Authority on matters pertaining to science. Matters not covered by the Scientific Panels or matters that overlap due to multi-sectoral implications would be dealt with by the Scientific Committee. FSSAI has already invited proposals from experts for participation in Scientific Panels and Scientific Committee. The Scientific panels and Scientific Committee would be notified shortly.

Administrative Structure of the Authority

The Authority is headed by a Chief Executive Officer, who is of the rank of Additional Secretary to Government of India. Right now, a Secretariat with minimal staff is in place.

Sec. 90 of the Food Safety and Standards Act, 2006 provides for transfer of personnel from different Ministries/Departments who are handling work that has been entrusted with the Authority. Accordingly, a notification has been issued under this Section transferring all the concerned officials from different Ministries/Departments to FSSAI. These are the personnel who are mainly engaged in licensing of various food processing industries and who are engaged in prevention of food adulteration.

Various States have notified their State Food Commissioners who will be Heads of state level agencies for enforcing the food law and the instructions issued by Authority. Authority would also designate personnel at Airports, Seaports, Borders and other entry points where food items that are brought into the Country would be regulated and monitored.

NATIONAL AIDS CONTROL PROGRAMME

National AIDS Control Organisation has been carved out as a Separate Department under the Ministry of Health & Family Welfare from December 2009

1. Current Epidemiological Situation of HIV/AIDS

HIV situation in the country is assessed and monitored through regular annual sentinel surveillance mechanism established since 1992. The sentinel surveillance started with 180 sentinel sites which later expanded to 1134 sites, covering most of the districts of the country. These sentinel sites have been established in 646 Antenatal clinics representing general population and 488 at High Risk sites, representing High Risk Population. The high risk sites are among Injecting Drug users (52 sites), Female Sex workers (137 sites), Men having Sex with Men (40 sites) and STD Clinic attendees (248 sites).

As per the recent estimates using the internationally comparable Workbook method and using multiple data sources namely expanded sentinel surveillance system, NFHS-III, IBBA and Behavioural Surveillance Survey, there are 1.8 – 2.9 million (2.31 million) people living with HIV/AIDS at the end of 2007. The estimated adult prevalence in the country is 0.34% (0.25% - 0.43%) and it is greater among males (0.44%) than among females (0.23%). The prevalence rate of HIV infection in the country has stabilized over the last few years as shown in the graph below.

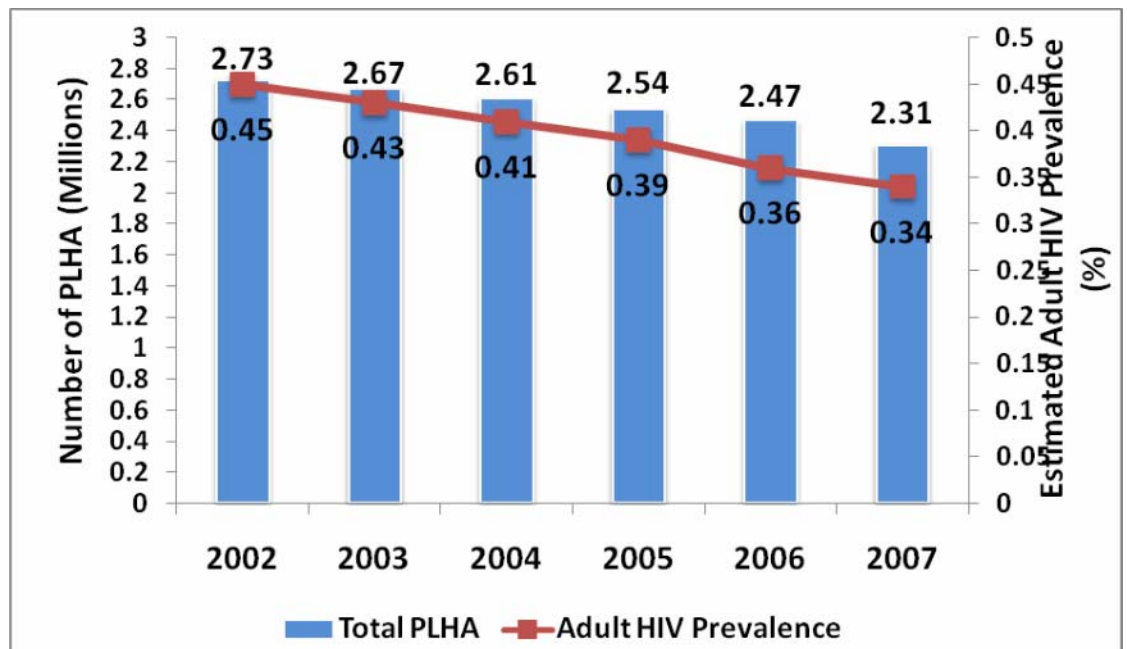


Figure 1: Estimated Adult HIV Prevalence and number of PLHA, India, 2002-07

The overall HIV prevalence among different population groups in 2007 continues to portray the concentrated epidemic in India, with a very high prevalence among High Risk Groups – IDU (7.2%), MSM (7.4%), FSW (5.1%) & STD (3.6%) and low prevalence among ANC clinic attendees (Age adjusted - 0.48%).

Except Andhra Pradesh with HIV Prevalence of 1%, all other states have shown less than 1% Median HIV Prevalence among ANC Clinic attendees. At the district level, a total of 87 districts (117 sites) have shown HIV prevalence $\geq 1\%$ among ANC clinic attendees in 2007. Out of these, 13 districts are in moderate and low prevalence states. 10 districts have shown a very high prevalence of $\geq 3\%$ among ANC clinic attendees. 9 districts have been identified as having ANC HIV prevalence $\geq 1\%$ for the first time in low and moderate prevalence states which includes 3 districts in Bihar, 1 district each in Chhattisgarh, Gujarat, Kerala, Madhya Pradesh, Orissa and West Bengal.

An overall decline in HIV prevalence among ANC clinic attendees is noted at all India level and in high prevalence states in south and northeast. Rising trend among ANC clinic attendees is observed in some low and moderate prevalence states, especially in the four states of Gujarat, Rajasthan, Orissa and West Bengal.

47 districts (48 sites) have shown $>5\%$ HIV Prevalence among FSW, which also include FSW sites in low prevalence states namely West Bengal, Bihar and Gujarat. FSW sites in Pune, Mumbai and Thane have shown $> 30\%$ HIV prevalence among FSW. Among FSW, there is a decline in South Indian States reflecting the impact of interventions, while rising trends are evident in the North East suggesting a dual nature of the epidemic.

Expanded surveillance among MSM has revealed more than 5% HIV prevalence in Karnataka (17.6%), Andhra Pradesh (17%), Manipur (16.4%), Maharashtra (11.8%), Delhi (11.7%), Gujarat (8.4%), Goa (7.9%), Orissa (7.4%), Tamil Nadu (6.6%) and West Bengal (5.6%).

Among IDUs, Maharashtra (24.4%), Manipur (17.9%), Tamil Nadu (16.8%), Punjab (13.8%), Delhi (10.1%), Chandigarh (8.6%), Kerala (7.9%), West Bengal (7.8%), Mizoram (7.5%) & Orissa (7.3%) have shown high prevalence of $\geq 5\%$. New pockets of epidemic among IDU identified during 2006 continue to show high HIV Prevalence in 2007. Trends among IDUs are on a decline in Manipur, Nagaland and Chennai while there is a clear rise in Meghalaya, Mizoram, West Bengal, Mumbai, Kerala and Delhi.

The epidemic is greater in urban areas than rural areas, greater among males than females, decreases with increasing education level, and is found to be highest among women whose spouses work in transport industry.

Based on the sentinel surveillance data for the last three years (2004-2006), all the districts in the country have been classified into four categories. There are 156 A category districts and 39 B category districts. The remaining are in categories C & D.

Thus, HIV epidemic in India is a dual epidemic driven by sexual and IDU routes of transmission, concentrated in nature with high HIV prevalence among high risk groups and heterogeneous in spread with pockets of infection found in various districts of the country.

2. National Response to HIV Epidemic

2.1. National AIDS Control Programme – Phase I & II

The first phase of National AIDS Control Programme was initially from 1992 to 1997 and was later extended to 1999. NACP-II commenced from April 1999 with the twin objectives of reducing the spread of HIV infections and strengthening the capacity of Central and State Governments to

respond to HIV/AIDS on a long term basis. Targeted interventions were initiated for high risk groups and measures to prevent HIV transmission among the general population were taken up. Anti-Retro Viral Therapy was provided to AIDS patients at selected centres.

The Programme implementation has been completely decentralized to states and UTs. Each state and UT has registered a State AIDS Control Society (SACS) responsible for implementing the programme at the State/ UT level. The cities of Mumbai, Chennai and Ahmedabad have formed the Municipal AIDS Control Societies to effectively implement the AIDS control programme in these large cities.

Important Policy initiatives taken during NACP-II include: adoption of National AIDS Prevention and Control Policy (2002); National Blood Policy; a strategy for Greater Involvement of People with HIV/AIDS (GIPA); launching of the National Rural Health Mission; launching of National Adolescent Education Programme; provision of anti-retroviral treatment (ART); formation of an inter-ministerial group for mainstreaming; and setting up of the National Council on AIDS, chaired by the Prime Minister.

Key achievements of NACP-II are summarized in table 1.

<i>S. No</i>	<i>Activity/ Component</i>	<i>Baseline Sept 1999</i>	<i>Achievements June 2007</i>
1.	<i>Establishment of Sentinel Sites for HIV trends</i>	180	1122
2.	<i>Knowledge of HIV/AIDS & at least 2 methods of HIV prevention</i>	50-80% (urban) 13-64% (rural)	43-83% (urban) 25-86% (rural)
3.	<i>Consistent condom use among female sex workers</i>	50.3%	73.4%
4.	<i>Coverage of schools and colleges for AIDS awareness</i>	0	112000 schools
5.	<i>Condom vending machines installed through NACO</i>	0	11,025
6.	<i>Condoms distributed</i>		2.24 billion
7.	<i>Modernisation of blood banks</i>	960	1230
8.	<i>Voluntary Blood donation (% of requirement)</i>	20%	56.4%
9.	<i>Establishment of ICTC</i>	0	4132
10.	<i>HIV tests conducted</i>	0	10 million
11.	<i>Centres providing PPTCT services</i>	0	2418
12.	<i>Centres providing HIV-TB Collaborative services</i>	0	2684
13.	<i>Government STI clinics</i>	504	845
14.	<i>Anti-Retroviral Therapy Centres</i>	0	127
15.	<i>Patients on ART</i>	0	85,915
16.	<i>Children on ART</i>	0	6300
17.	<i>Community Care Centres</i>	0	101
18.	<i>PLHA Networks</i>	0	90
19.	<i>Drop-in Centres</i>	0	84
20.	<i>Coverage of High-Risk Population across the country through targeted intervention projects</i>	300	764

2.2. National AIDS Control Programme – Phase III

Taking stock of the achievements and the gaps to be filled, and incorporating the lessons learnt from NACP-II, the third phase of NACP was launched in June 2007. The overall goal of NACP-III is to halt and reverse the epidemic in India over the next 5 years. Considering that more than 99% of the population in the country is free from infection, NACP-III will place the highest priority on preventive efforts while, at the same time, seeking to integrate prevention with care, support and treatment. This will be achieved through a **four-pronged** strategy:

- through:
1. Prevention of new infections in high risk groups and general population
 - a. Saturation of coverage of high risk groups with targeted interventions (TIs)
 - b. Scaled up interventions in the general population
 2. Providing greater care, support and treatment to larger number of PLHA.
 3. Strengthening the infrastructure, systems and human resources in prevention, care, support and treatment programmes at the district, state and national level.
 4. Strengthening the nationwide Strategic Information Management System.

The specific objective is to reduce new infection as estimated in the first year of the programme by:

- Sixty per cent (60%) in high prevalence states so as to obtain the reversal of the epidemic; and
- Forty per cent (40%) in the vulnerable states so as to stabilize the epidemic.

The unifying credo of Three Ones, i.e., one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System, Respect for the rights of the PLHA, Civil society representation and participation are among the important guiding principles for NACP-III.

Given the spread of HIV infection into rural areas, NACP-III will further decentralize its organizational structure to implement programmes at the district level. The basic unit of implementation will now be the district. Accordingly, priority is given to the Category A and B districts in all the states.

2.2.1. Priority Targeted Interventions for populations at high risk

One of the most important components of the National AIDS Control Programme (NACP)-III is the Targeted Intervention (TI) projects that aim to interrupt HIV transmission among highly vulnerable populations. These populations are at a greater risk of acquiring and transmitting HIV infection due to more frequent exposure to HIV, higher levels of risky behaviour and insufficient capacity or power to decide to protect them-selves. Such population groups include - commercial sex workers, injecting drug users, men who have sex with men, truckers, and migrant workers. Providing peer counseling, condom promotion, treatment of sexually transmitted infections are the major service interventions that are supported by structural interventions such as enhancing community ownership and creating enabling environment. This activity is being delivered through non-government organizations and community based organisations.

Currently, 805 Targeted Intervention projects is operational in the country. 55% of FSW, 53% of IDU and 6% of MSM & Transgender populations are being covered under these TIs.

Experience has demonstrated that addressing issues of empowerment of high risk groups is a successful strategy for obtaining their adherence to safe sex behaviour. During NACP III high risk groups will be supported to organise themselves into Community Based Organisations (CBOs) (i.e. organisations managed by the target beneficiaries themselves) so as to ensure sustainability and reduce their continued dependence on NGOs for accessing critical services.

Saturation of all high risk groups through 2100 TI projects and development of 50% of TIs into CBOs is the target aimed at during NACP-III.

An amount of Rs. 2288 Crores will be spent on this activity during NACP III.

2.2.2. Preventive interventions for the general population

Prevention has always been the main stay of addressing the HIV/AIDS epidemic. Under NACP-III, it is proposed to integrate and scale-up service delivery to sub-district and community levels through existing infrastructure in the public and private sectors. The following is the package of preventive services provided under NACP-III:

- i. Creating awareness about symptoms, spread, prevention and services available through a strong IEC campaign
- ii. Condom promotion
- iii. Promotion of voluntary blood donation and access to safe blood
- iv. Integrated Counseling and Testing (ICT)
- v. Prevention of Parent To Child Transmission
- vi. Management of STI and RTI
- vii. Post Exposure Prophylaxis (PEP)
- viii. Promotion of safe practices and infection control
- ix. Intersectoral coordination and mainstreaming

2.2.2a. Communication Strategy

Information, Education and Communication (IEC) is one of the most important strategies in the fight against HIV/AIDS. The key principle that drives the NACP-III programme is the scaled-up synergy between communication response and service delivery at all levels. Therefore, Communication Strategy and Implementation is a cross-cutting and integral strategic intervention in all components of HIV/AIDS prevention, care and support and treatment programmes under NACP-III.

Working on a communication strategy which has made a paradigm shift from simply awareness generation to bringing about behaviour change, NACO focused on reduction of stigma and discrimination, promotion of services viz., counselling & testing, ART, increasing condom use and blood safety. Intensive IEC among general populations has resulted in increasing awareness of HIV/AIDS among rural populations to about 75% (BSS 2006). Under the adolescent education program, over 1,12,000 high schools have been covered with HIV/AIDS and life skill education programs.

The IEC strategy efforts are operationalised at four levels – National level, State level, District level and Community level. Broadcast of quality audio/video spots on HIV/AIDS prevention, promotion of condoms, stigma & discrimination, Voluntary Blood Donation, Youth, PPTCT and HIV-TB co-infection on AIR, Doordarshan and Cable & Satellite Channels. Time-check messages were also broadcast on AIR. Two serials titled “Jasoos Vijay” and “Haath Se Hath Mila” in the infotainment format were produced in association with Prasar Bharti and BBC World Service Trust. Eight episodes of a 30-minute duration health magazine – Kalyani were sponsored and telecast on regional networks of Doordarshan for nine states. Two weekly radio programs – “Jeewan Hai Anmol” in a form of docu-drama and “Lets Talk AIDS” were broadcast in 24 languages over 174 stations of AIR.

Advertisements were issued in newspapers on important themes like Anti Retroviral Therapy, Condom Promotion, Prevention of Parent to Child Transmission, Voluntary Blood Donation, HIV-TB co-infection, needle safety etc. Information panels on different aspects of HIV/AIDS were installed at strategic locations including PPTCT centres in High Prevalence States and

Ministries/ Deapartments. Updates on HIV/AIDS in India were brought out in booklet and brochure formats.

The major thrust areas of IEC activities include:

- ❖ Promoting safe behaviour through mass media, special programs on radio and TV covering rural and semi-urban population.
- ❖ Moving beyond awareness to behaviour change in the high risk as well as general population.
- ❖ Routinization of condoms, promotion of services viz. ART, ICTC and PPTCT
- ❖ A cadre of village level Link workers to be set up in A and B category districts for focused interventions on BCC.
- ❖ Saturating the mass media channels for disseminating messages on HIV/AIDS.
- ❖ Special programmes on TV and Radio focusing on women and youth
- ❖ Expanding inter-personal communication through units of Directorate of Field Publicity, Song & Drama Division, holding of Advocacy and sensitization workshops.

An amount of Rs. 1018 Crores will be spent on this activity during NACP III.

2.2.2b. Condom Promotion

Given the fact that 87 percent of HIV infection in India is through the sexual route, condom programming is central to HIV/AIDS prevention at the intervention level. The use of condoms is promoted as a protection against STIs and HIV/AIDS in addition to Family Planning. Condom promotion is through free distribution and social marketing. NACO works in collaboration with Family Welfare Department, SACS and NGOs to distribute free condoms countrywide. Adequate supply in STD clinics, ICTCs and obstetrics and gynecology clinics is ensured. Chief beneficiaries are high risk groups and marginalized groups like FSW and MSM. Efforts are made for generating more demand for condoms among people from all sections of society and at the same time, strengthening the supply. In 2007, 1250 million condoms were freely supplied and 604 million were distributed through social marketing. 11025 Condom Vending Machines were installed and another 11025 are in the process. In addition 40000 unconventional condom social marketing outlets have been established, in the last 2 years. 3.5 billion condoms are targeted to be distributed through 3 million outlets during NACP-III.

The overall market growth trend as reported in ORG Retail Audit is as follows.

(Figures in million pcs)

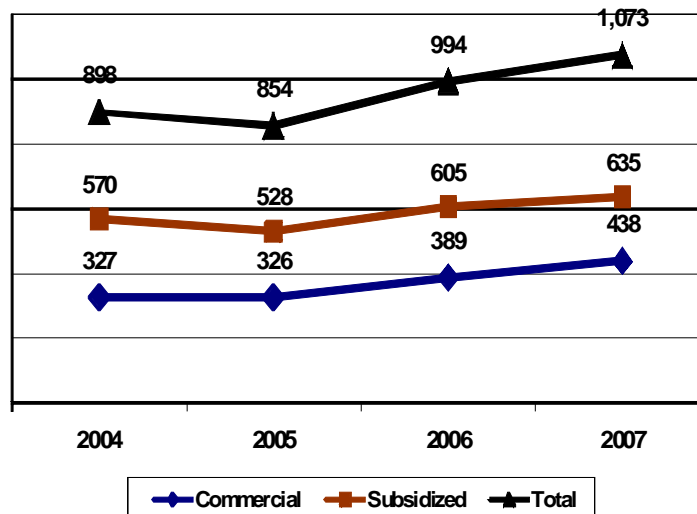


Figure 2: Retail off-take of condoms, India, 2004-07

Key elements of the condom strategy will be:

- Integrating social marketing with the TI programs;
- Building supply chain
- Education for correct and consistent use of condom and negotiation skills for high risk population
- Rural marketing through private sector contracts
- Mainstreaming into other supply chains
- Linkage with NRHM

An amount of Rs. 329 Crores will be spent on this activity during NACP III.

2.2.2c. Blood Safety:

A National Blood Policy formulated by NACO was adopted by Government of India in April 2002. Subsequently, an action plan on blood safety was finalized and adopted by the government. Transmission of HIV through Blood Transfusion is reduced from 6.07% (1999) to 1.96% (2006) and 1.3% (2007).

Blood collected from voluntary (non-remunerated) blood donors all over the country demonstrated a definite rise indicating improvement in voluntary blood donation. Out of the total number of blood units required, the percentage of units collected through voluntary blood donation increased from 20% in 1999 to 59% in 2007. Currently, NACO is supporting 1230 blood banks in the country including 82 blood component separation units and 10 State-of-art Model Blood Banks.

NACP-III has the following vision with regards to blood safety:

- Promote appropriate use of blood, blood components and blood products among clinicians.
- Aim to reduce transfusion associated HIV transmission to less than 0.5%
- Achieve efficient and self-sufficient blood transfusion services.
 - Important targets that NACP-III aims to achieve are:
- Establish blood storage centres in 3222 Community Health Centres
 - Provide blood bank vans in 500 districts to network with blood storage centres
- Setting up of blood banks in 39 districts without blood banks
- Establish one Plasma Fractionation centre
- Establish one Model Blood Bank in each state
- Establish four Centres of Excellence in Metro cities
- Establish additional 80 blood component separation units
- Promotion of voluntary blood donation to more than 90%

In line with Supreme Court judgment in 1992, National and State Blood Transfusion Councils were registered as societies and supported by NACO. At state levels, these councils maintain oversight over the voluntary blood donation and the appropriate clinical use of blood, training and manpower development, and supervision of the blood transfusion services in the state.

An amount of Rs. 955 Crores will be spent on this activity during NACP III.

2.2.2d. Integrated Counseling and Testing Services

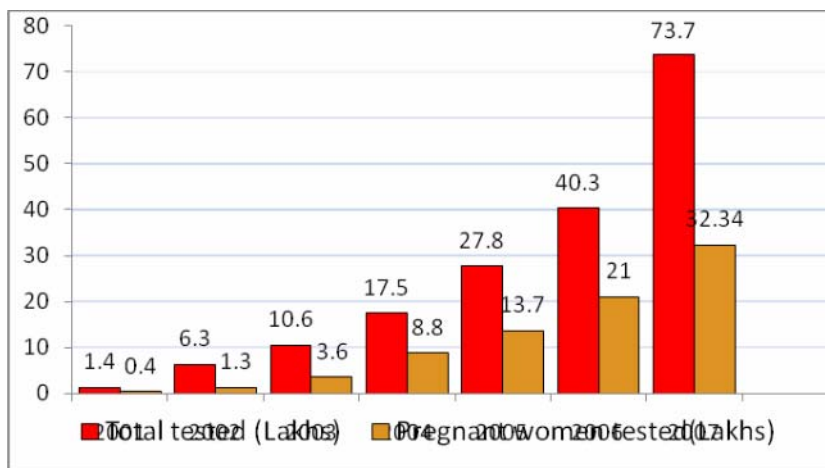
More than 75% of those infected are not aware about their status and there is need to extend access to the counseling and testing facilities and increase demand generation. The Counseling and Testing Centres have been established at medical colleges, district hospitals, sub district level hospitals and community health centres.

Under NACP-III, Voluntary Counseling and Testing Centres (VCTC) & Prevention of Parent to Child Transmission Centres (PPTCT) are remodeled together as ICTC (Integrated Counseling and Testing Centre). The number of integrated counseling and testing centres increased from 982 in 2004, 1476 in 2005, 4027 in 2006, 4132 in 2007 and 4567 till June 2008. The number of persons tested in these centres has increased from 17.5 lakh in 2004 to 27.8 lakh in 2005, 40.3 lakhs in 2006, 73.7 lakhs in 2007. Graph-III below depicts the progress of ICTCs.

The impact of TB and HIV is interlinked and it is difficult to control one of them without managing the other. NACP and RNTCP can share implementation arrangements such as ICTC and sputum microscopy centres. HIV/TB coordination earlier emphasized only on cross referral of clients between the RNTCP microscopy centres and the ICTCs but now it is being extended to also cross referrals between ART Centres, CCCs & RNTCP to ensure confirmation of diagnosis and early treatment of TB and starting on ART at the earliest for identified HIV/TB patients with CD4 counts less than 350 as per the new guideline. In 2007, there were 78,700 cross referrals from ICTCs, 70,245 cross referrals from RNTCP and 18,286 patients were found to be having HIV-TB Co-infection.

ICTCs also provide PPTCT services to pregnant women. The number of pregnant women counseled and tested was 8.8 lakh in 2004, 13.7 lakh in 2005, 21 lakh in 2006 and 32.34 lakh in 2007. In 2007, 19359 pregnant women were found to be HIV positive. Women who are HIV positive are given a single dose of prophylaxis Nevirapine at the time of labor and new born is also given a single dose of Nevirapine within 72 hours of birth. In 2007, a total of 9983 mother-baby pair were given prophylaxis dose of Nevirapine.

Figure 3: Year wise progress in Integrated Counseling Testing Services



NACP-III aims to accomplish the following targets to expand the outreach of ICTC services:

- All Community Health Centres will have ICTC
- 24hr Primary Health Centres and Private hospitals are also involved
- Mobile ICTCs in hard to access areas with NRHM
- Internal and External Quality assurance mechanisms
- Target of 8-10 tests per day per centre

The total budget allocated for this activity is Rs. 836 crores.

2.2.2e. Sexually Transmitted Infections (STI) Services

Sexually Transmitted Infections increase the risk of HIV transmission significantly. STI care has been given high importance in NACP. The number of STI clinics being supported by NACO has increased from 815 in 2005 to 845 in 2006. The reported number of patients treated for STI was over 16.7 lakh in 2005, 20.2 lakh in 2006 and 25.9 lakh in 2007.

During NACP-III, STI services are being expanded through effective integration with the RCH-II programme, and through involvement of private sector. RCH programme will provide training to the medical and paramedical personnel and drugs and equipment at all PHCs and CHCs. During 2006, NACO and RCH division jointly drafted a manual on management of STIs so as to strengthen the services in the government health facilities and also to involve the physicians working in the private sector. Efforts are also being done to improve the completeness of reporting. Routine screening of the HRG population for STD by a designated NGO administering TI and referring them for treatment will be one of the important STD strategies under NACP-III. This will be facilitated through project owned or project linked or referral networks.

Regional centres for monitoring drug resistance to gonococci will be established during the programme period. Cervical smears collected from random sample of HRGs coming for check - ups will be transported for monitoring drug resistance and deciding on syndromic management guidelines. This will be done in collaboration with the ICMR STD network.

The programme will cover 50% of those with the symptoms i.e. about 15 million persons. These persons will be progressively provided access to treatment through the large network of public health facilities as well as an estimated 25,000 accredited private providers who will be trained and assisted to deliver services to key populations.

An amount of Rs. 150 crores will be spent on this activity during NACP-III.

2.2.2f. Inter-sectoral coordination and Mainstreaming

Mainstreaming and partnerships will be the key approach to facilitate multi-sectoral response engaging a wide range of stakeholders. Private sector, civil society organizations, PLHA networks and government departments would all play crucial role in prevention, care, support, treatment and service delivery. Technical and financial resources of the development partners will be leveraged to achieve the objectives of the programme.

Following principles guide Intersectoral coordination for HIV prevention:

- Mainstreaming HIV/AIDS in schemes/ Programmes of different ministries (e.g. Ministry of Social Justice & Empowerment for Injecting Drug Users).
- Strengthening HIV/AIDS interventions in the world of work – workplace policy and Programmes in both formal and informal sectors
- Mainstreaming HIV/AIDS in Civil Society Organizations, religious organizations, and media.

A significant measure taken up to ensure mainstreaming of HIV/AIDS is the constitution of National Council on AIDS under chairmanship of Hon'ble Prime Minister with representation of 33 ministries and departments.

So far, out of 1,44,409 government Secondary and Sr. Secondary schools in the country, an estimated 1,11,243 schools were covered & 2,12,028 teachers were trained under Adolescence Education Programme. Around 20,000 Red Ribbon Clubs were formed and in

majority of the states, Governors convened the meeting with Vice-Chancellors of universities in the respective states.

The first National Convention of Zila Parishad Presidents and Mayors was held at Vigyan Bhawan on August 8, 2006 in association with the Parliamentarians' Forum on HIV/AIDS and UNAIDS to strengthen the local response to fight HIV/AIDS.

An amount of Rs. 125 Crores will be spent on this activity during NACP III.

2.3. Care, Support and Treatment for People Living with HIV/AIDS (PLHA)

Care, support and treatment services will include management of opportunistic infections (OI) including TB, anti-retroviral treatment (ART), safety measures, positive prevention and impact mitigation.

For people living with HIV/AIDS, treatment for opportunistic infections is being made available right from the beginning of NACP. In NACP-II, provision has been made for free ART to those who are HIV positive and eligible to receive this therapy, based on clinical as well as laboratory criteria. Government of India announced a policy cum programme commitment for providing free ART with effect from 1st April, 2004. Antiretroviral treatment (ART) is a combination of at least 3 ARV drugs that is given to HIV infected individuals once they have advanced immuno-suppression. ART suppresses viral replication, slows or halts disease progression, thereby helps restoring the balance within the immune system, prolongs longevity in AIDS cases and improves their quality of life.

Under NACP-III, first line ART drugs will be provided to all those who need it. Public health facilities will ensure that ART is provided to (a) PLHAs referred from targeted interventions; (b) sero-positive women particularly those who have participated in PPTCT programme; (c) infected children; and (d) those below poverty line.

At present, 174 Anti-Retroviral Treatment (ART) centres are functioning. As of June 2008, a total of 1,56,403 patients are receiving free ART in Govt. & intersectoral health sector. In addition nearly 35,000 patients are receiving ART in private and NGO sector.

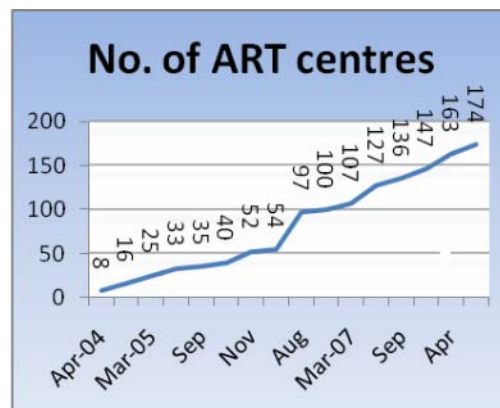


Figure 4: Progress in ART Services, India

National Pediatric ART Initiative was launched on 30th November 2006. Pediatric drugs are provided at all ART centres. Number of children receiving ART increased from 1800 (2006) to 10130 till May 2008.

By 2011, the programme will be able to treat 3.2 lakh OI episodes in a year and provide TB referrals to 28 lakh PLHA. NACP-III aims to achieve a target of 300,000 adults & 40,000 children on ART by 2012.

A total of 159 **Community Care Centres** have also been established in high prevalence states to enable PLHA to get used to ART, to provide Counseling & follow-up on drug adherence, management of opportunistic infections and Nutrition Counseling, to provide pre-ART care for those PLHA who are not yet on ART through out reach and home-based services.

The targets of national ART programme under NACP-III are:

1. To provide free ART to 300,000 adult and 40,000 paediatric PLHAs by 2012 through 250 ART centres and 650 Link ART centres
2. To involve inter-sectoral partners, NGOs and Private partners, so as to have a comprehensive national framework of ART programme.
3. To achieve and maintain a high level of drug adherence and minimise the number of patients lost to follow up, so that drugs are effective for longer period of time.
4. To provide comprehensive care, support and treatment through establishment of 350 CCCs by 2012.

An amount of Rs. 1953 Crores will be spent on this activity during NACP III.

2.4. Institutional Strengthening and Capacity Building

The aim of NACP-III is to build capacity of the programme managers at the national, state and district levels in leadership and strategic management; technical and communication skills of the health professionals and health care providers at all levels of care and health care organizations, CBOs and NGOs; and technical, communications and counselling skills of the grass-roots level workers and functionaries of various government departments.

Strengthening Human Resource Capacity at NACO by enhancing strategic planning skills, disseminating best practices for TIs, establishing and managing a network of technical expertise through Technical Resource Groups (TRGs) in STI/HIV/AIDS, conducting OR and to oversee R&D activities nationwide, are some of the thrust areas for strengthening institutional capacity. NACO has also developed Project's financial management system for effective financial management of the programme.

Regional and state level training were organised as part of capacity building for health care providers under NACP-II. As on March, 2008, a total of 135615 personnel were trained during 2007-08, including specialist doctors of medical colleges, general DMOs, nurses, IEC officers, counselors, NGOs, lab technicians, blood bank officials and district nodal officers. During this period review and printing of training curricula/module/materials was undertaken, guidelines for District Action Plans was laid down, training of national and state level trainers was completed and refresher/induction training of TOTs held.

An amount of Rs. 497 Crores will be spent on this activity during NACP III.

2.5. Strategic Information Management System

India's response to the evolving HIV epidemic is largely influenced by the available surveillance data, implementation capacities and political commitment at state level. The HIV surveillance system in India has been characterized by a growing network of sentinel and facility based HIV sero-prevalence surveys, used for measuring trends in HIV prevalence and developing state and national prevalence estimates. Behavioural surveillance surveys and research studies have also been conducted in a number of states to track HIV related risk behaviours. The

Computerized Management Information System (CMIS), established nation-wide, is another source of strategic information for programme monitoring and evaluation. Similarly, NACP has also successfully established a Computerized Project Financial Management System (CPFMS).

In order to maximize effective use of all available information and implement evidence based planning, NACP-III will establish a Strategic Information Management Unit (SIMU). It will be set up at national and state levels to address strategic planning, monitoring and evaluation, surveillance and research. SIMU will assist NACP-III in tracking the epidemic and the effectiveness of the response and help assess how well NACO, SACS and all partner organizations are fulfilling their commitment to meet agreed objectives.

Key activities aimed to be undertaken are

- Establishing a Research Wing/ Division at NACO with strong linkages developed with research/academic institutions at regional/ state level;
- Strengthening operations research and evaluation studies on the design, strategies, implementation and testing of HIV intervention programmes and measure their impact related to risk/vulnerability reduction, behaviour change, stigma reduction, HIV prevalence rate etc.;
- Building capacity for monitoring and evaluating community based interventions, school based adolescent education programmes and support groups of positive people;
- Conducting two types of Behavioural Surveillance Survey, namely, a) annual risk assessment at the district level and b) methodologically rigorous BSS at state level, at least once in three years;

A total amount of Rs. 360 crore will be spent under this component including Rs. 195 crore for nation-wide M & E system, Rs. 80 crore for expanded Surveillance system and Rs. 85 crore for research related activities.

3. Financial allocation:

The details regarding allocation of funds and utilization during NACP-II is as follows:

Year	Revised Estimate	Expenditure Incurred	Percent spending
2002-2003	242.00	240.00	99.2 %
2003-2004	233.40	231.88	99.4 %
2004-2005	426.00	422.25	99.1%
2005-2006	533.50	532.69	99.9%
2006-2007	705.67	682.63	96.7%
2007-2008	943.34	917.56	97.3%

During NACP III, in order to implement the wide range of interventions indicated above, a financial resource plan has been worked out. Overall, the plan needs an investment of Rs. 11,585 crore. Of this an amount of Rs. 8023 crore is provided in the budget, the rest being extra budgetary funding largely from private donations, direct funding from bilaterals and UN organisations. A summary of the component-wise financial requirements are given below:

Programme Component	Total Estimated Amount (Rs. in Crore)	Percentage to total	Amount Required to be provided in the Budget (Rs. in Crore)	Percentage to spending under budget
Prevention	7,786	7.2	5886	3.4
Care, Support and Treatment	1,953	6.9	1584	9.7
Programme Management	910	.9	450	.6
Monitoring, Surveillance and Research	360	.0	103	.3
Others Including Contingency	576	.0	*	
Total	11,585		8023	

* Contingency included

**Table 3: Sources of Funding for NACP III
Details of Donor Support**

No.	Sl.	Source	Amount (Rs. in crores)
I		Govt. of India (DBS) NRHM and Direct support	2861
II		EAC (External Aid Comp)	
	i	World Bank	1125
	ii	DFID	808
	iii	GFATM(II, III, IV&VI)	1787
	iv	UNDP	71
	v	USAID	225
		Sub Total	4016
III		Outside Government (Direct funding from other donors) Committed	
	i	UN	252
	ii	DFID	54
	iii	Gates Foundation	1425
	iv	USAID	450
	v	Clinton Foundation	113
	vi	Other Bilaterals	63
	vii	Other Foundations	155
	viii	EU	77
	ix	Other sources (Recipients from Global Fund such as Population Foudation of India & Alliance International & Other International Donors)	523
		Sub- Total	3112
IV		Private (projected and includes funds to be spent by private industry on preventive services to their employees)	450
V		Future Mobilization	

	Global Fund Future Rounds	450
	World Bank IDA 15 supplementary fund	696
	Sub Total	1146
	Grand Total (I+II+III+IV+V)	11,585

4. Conclusion

In 2007, the country is estimated to have 1.8 – 2.9 million HIV positive persons, with an estimated adult HIV prevalence of 0.34% (0.25% – 0.43%). Trends of HIV infection indicate a mixed response in the country, with increase in some areas and decrease in other. As the HIV Prevalence among high risk groups is around six to eight times that among general population, India continues to be in the category of concentrated epidemic. Sexual mode continues to be the major mode of transmission, though transmission through injecting drug use and MSM is on rise in many new pockets.

Though the expected outcomes of NACP-II have been broadly accomplished and there has been a systematic improvement in the response, there are areas that still require greater attention and stronger focus. Complexities of the epidemic and its exact dimensions are yet to be understood especially in the Northern and North Eastern states of the country. Decentralisation and devolution of decision-making powers to the SACS was a right step, but it has to be complemented with capacity development and technical support. Focused attention on the HRGs through TIs proved to be an effective strategy for preventing the spread of infection. However, saturation of coverage of HRGs nationwide is yet to be accomplished.

NACP-III seeks to learn from the lessons of the previous two phases of programme implementation and build on the strengths thereof. The present programme is based on sound public health principles and NACP-III will place the highest priority on preventive efforts while, at the same time, seeking to integrate prevention with care, support and treatment.

Moving over from awareness to behaviour change is the main focus of communication strategy. Sub-populations that have the highest risk of exposure to HIV will receive the highest priority for intervention. Those in the general population who have greater need for accessing prevention services such as treatment of STIs, voluntary counselling and testing and condoms will be next in the line of priority. NACP-III will ensure that all persons who need treatment would have access to prophylaxis and management of opportunistic infections. Persons who need access to ART will also be assured first line ARV drugs. Mainstreaming and partnerships will be the key approach to facilitate multi-sectoral response engaging a wide range of stakeholders. Building up of a strong Strategic Information Management System and strengthening the Surveillance and Research components to provide evidence for planning and implementation will be given major thrust during NACP-III. National AIDS Control Programme is currently focusing on up-scaling of services to improve coverage and to improve the quality of services provided.

FAMILY WELFARE

FAMILY PLANNING

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

QUALITY ASSURANCE in FAMILY PLANNING

Quality assurance in family planning services is a major decisive factor in the acceptance of the service. The guidelines to be followed on Quality care and Standards in FP services in the implementation of the national program are provided by the division. The Quality Assurance Committees set up at the State and District level monitor the sterilisation services and conduct medical audits and at the central level these activities are monitored through reports and field visits.

The acceptance of spacing methods in the country is still very low in spite of the large unmet need and one of the main reasons is lack of skilled manpower. To address this problem an alternative methodology of training in IUD services using pelvic models has been developed and the pilot phase of this intervention has been launched in 12 states in 2007..

MALE PARTICIPATION IN PLANNED PARENTHOOD INCLUDING NO SCALPEL VASECTOMY (NSV)

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

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

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

Government of India has been providing compensation to the acceptors of sterilization for their loss of wages and giving infra structural support to the state for providing quality services in contraception.

NATIONAL FAMILY PLANNING INSURANCE SCHEME

Government Of India launched the National Family Planning Insurance Scheme on Nov 11th 2005 for compensation to the acceptors of sterilization or his/her nominee in the unlikely event of his/ her death, failure or complications following a sterilization operation. The scheme also provides for Indemnity insurance cover to the Medical officers and the facilities for up to four cases of litigation per year he/she or the facility may face as a consequence of performing sterilisation operations.

ASSISTED REPRODUCTIVE TECHNIQUES (ART) for INFERTILITY

As per WHO data the incidence of infertility in various countries including India is around 10-15%. There has been an increased demand for assisted reproduction from these infertile couples. This has led to mushrooming of infertility clinics in India and in many of these centres the quality of services is in question. The National Guidelines on ART has been developed by ICMR and National Academy of Medical Sciences for Government of India for regulating and supervising the functioning of ART clinics and this would help the ART clinics in providing safe and ethical services.

PRE-CONCEPTION AND PRE-NATAL DIAGNOSTIC TECHNIQUES (PROHIBITION OF SEX SELECTION) ACT (PC&PNDT ACT)

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

Inclusion of the issue under NRHM

Sensitization on sex ratio issue has been made a part of curriculum for ANM. For tracking the delivery of a pregnant woman, it is proposed to provide ASHA a remuneration of a fixed amount at the village level.

A National Monitoring and Inspection Committee has been constituted at the Centre to take stock of the ground realities by field visits to the problem States. During 2006-07, the Committee has visited the State of Delhi, Haryana, Maharashtra, UP, Rajasthan, Orissa, Karnataka and Kerala.

Constitution of National Support and Monitoring Cell (NSMC)

A ‘National Support and Monitoring Cell’ with external assistance has been set up for effective implementation of the Act. The Cell consists of a Social Scientist and a Leader. The Cell would help in putting a mechanism in place so that actual wrong doers who are committing female foeticide/abetting female foeticide are apprehended by the Appropriate Authorities.

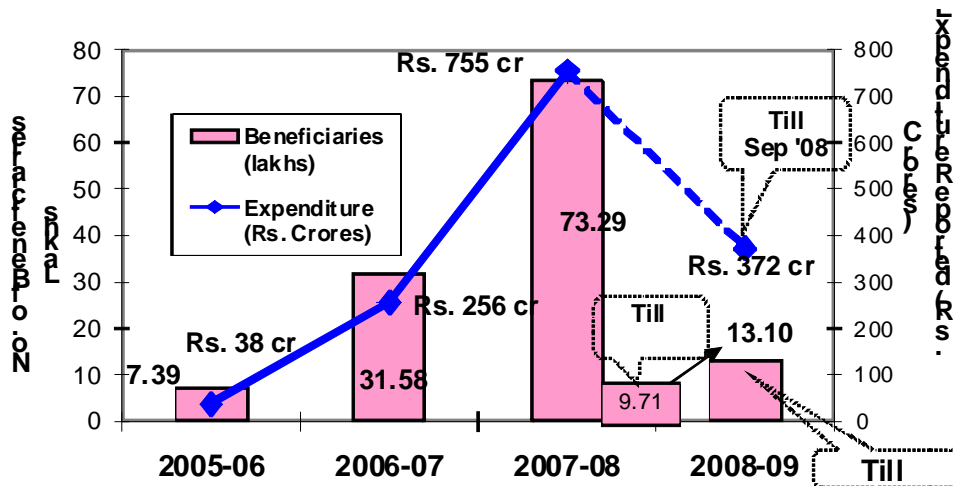
Awareness Generation

It is, nevertheless, recognized that mere legislation is not enough to deal with this problem that has roots in social behavior and prejudices. Various activities have been undertaken to create awareness against the practice of pre-natal determination of sex and female foeticide through Radio, Television, and print media units. Workshops and seminars are also organized through Voluntary Organizations at State/regional/ district/block levels to create awareness against this social evil. Cooperation has also been sought from religious / spiritual leaders, as well as medical fraternity to curb this practice. The Government of India has launched 'Save the Girl Child Campaign' with a view to lessen son preference by highlighting achievements of young girls.

JANNANI SURAKSHA YOJANA (JSY)

The Jannani Suraksha Yojana (JSY) is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post delivery care. The scheme was launched with focus on demand promotion for institutional deliveries in states and regions where these are low. It targeted lowering of MMR by ensuring that deliveries were conducted by Skilled Birth Attendants at every birth. The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women in 10 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other eligible states and UTs, wherever, AWW and TBAs or ASHA like activist has been engaged in this purpose, she can be associated with this Yojana for providing the services.

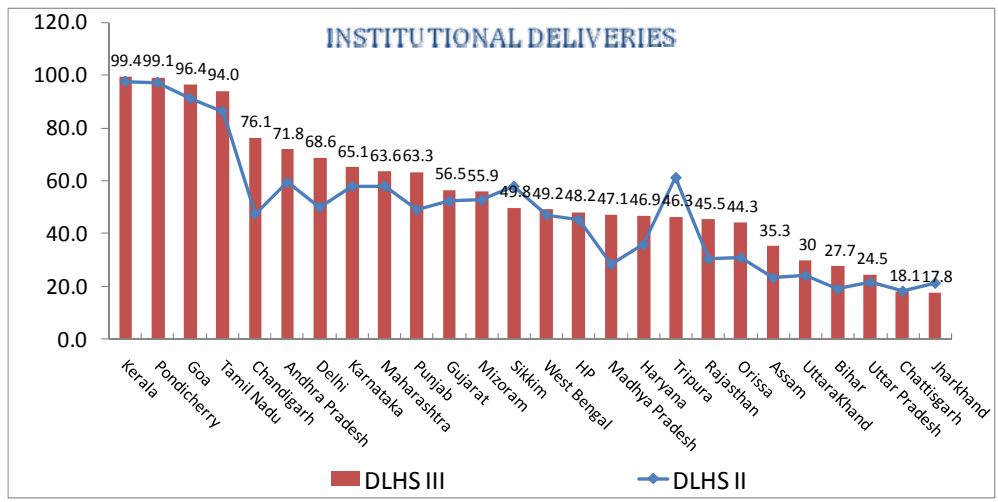
The JSY scheme has shown phenomenal growth in the last three years. Starting with a modest number of 7.39 Lakhs beneficiaries in 2006-07, the total number reached 73.29 Lakhs in the year 2007-08 – a Ten Fold growth. The expenditure also rose from Rs. 38 Crores in the year 2006-07 to 755 Crores in the year 2007-08.



T

he
rapi
d

increase in the institutional deliveries, coupled with improvement in infrastructure, manpower and training has resulted in improvement in the figures of Institutional deliveries in all major states except Jharkhand in the DLHS III data as compared with DLHS II. The growth in the institutional delivery figures is substantial in the five major states of U.P. Rajasthan, M.P., Orissa and Bihar



In 1951, India was the first country in the world to launch a family planning programme. Since then approaches aimed at reducing population growth have taken a variety of forms. The passive, clinic-based approach of the 1950s gave way to a more proactive, extension approach in the early 1960s. The late 1960s saw the emergence of a "time-bound", "target-oriented" approach with a massive effort to promote the use of IUDs and condoms. This was followed by an even more forceful "camp approach" to promote male sterilization in the 1970s. The excesses of these campaigns lead to a backlash from which it took years for the programme to recover. The 1980s saw the rebuilding of the programme with an emphasis on female sterilization, and maternal and child health. In the 1990s the International Conference on Population and Development, Cairo and the International Conference on Women prompted a paradigm shift, with the advocacy of a client-centred, need based, quality-oriented reproductive health approach. . The National Population Policy of 2000 and the National Health Policy 2002 took cognisance of this and accordingly broadened the perspective of the National Family Welfare programme and renamed it the Reproductive and Child Health programme and set 2010 as the target date to achieve replacement-level fertility.

Method-specific targets were removed, and the programme focused on the unmet needs of clients. RCH II continues with this approach Technologically the programme has attempted to keep pace with the technological advances in the world of medicine by incorporating them in the programme as and when the planners felt that these advances fulfilled the felt needs of the community. Hence over the years methods like the lippes loop (incorporated into the programme during the third Five Year Plan) and the **National Health Policy 1983 envisioned significant reduction in IMR, NMR & CMR by 2000. All the child health programmes are directed towards achieving these goals.**

India is a signatory to the Millenium Development Goals(MDGs).The fourth Millenium Development Goal is reduction of child mortality and the target for this is to reduce by two thirds, between 1990-2015 the mortality rate of children under five. This is reflected in the Tenth Five Year Plan (2002-07), which states that Infant Mortality Rate is to be reduced to 45/1000 by 2007 and 28/1000 live births by 2012.

INFANT MORTALITY RATE

Status

Infant mortality, currently at 58 per 1000 live births(2005), has declined substantially(by 35%) over the past 15 years. Manipur has the lowest IMR (13 /1000 live births) and Madhya Pradesh is the highest at 76 per 1000 live births. Infant mortality rates have declined in both urban(40/1000 live births) and rural areas(64/1000 live births). Higher rates of antenatal, delivery and post natal care are usually associated with lower infant mortality. Such an inverse relationship is observed with higher education status of mothers and a higher standard of living index.



Infant mortality rates across India, 2000

The rate of decline was rapid in the decade of the eighties and has slowed down in the nineties to only two points per year. The pace of decline of Infant Mortality Rate needs to be accelerated for the country to be able to achieve the MDG Goal of 30 per thousand live births by 2015.

Causes

The principal causes of infant mortality in India are

- low birth weight (30%)
- birth injury
- acute respiratory infections
- sepsis
- diarrhoeal diseases

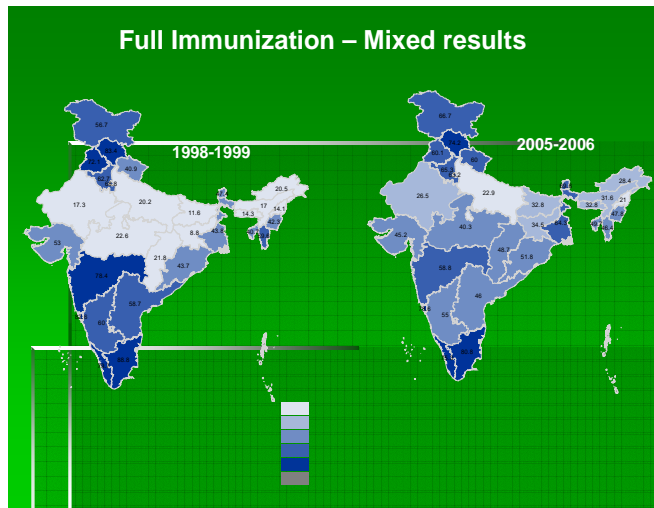
Malnutrition among Indian children is very prevalent and is the underlying factor towards mortality from many causes.

Analysis of Infant Mortality rate (IMR)

- ❖ As result of general improvement in health and sanitation and as a result of interventions under the Family Welfare Programme, the Infant Mortality Rate has declined from 71 during 1997 to 58 in 2005, a decline of 18.3%. Urban IMR , at 40 per thousand live births is much lower as compared to the rural IMR, which stands at 64 per thousand live births .The better availability and accessibility of health care services in urban areas could well be the reason for this, aided by higher levels of literacy and greater media exposure to information. The bias inherent in our culture against females is reflected in

the female infant mortality being higher than the male, not only in the rural (female IMR 66 vs male IMR 62), but also in the urban areas (female IMR 43 vs male IMR 37).

- ❖ 20 States and Union Territories have achieved the national goal for IMR of 45 by the year 2007. West Bengal (38), Tamilnadu (37), Punjab(44), Maharashtra (36), Kerala (14), Delhi (35), Arunachal Pradesh (37), Goa (16), Manipur (13), Mizoram (20), Nagaland (18), Sikkim (30), Tripura (31), Uttrakhand (42), A&N Islands (27), Chandigarh (19), Dadra & Nagar Haveli (42) Daman & Diu (28), Lakshadweep (22), Pondicherry (28) have achieved IMR below 45.
- ❖ There are, however, wide inter-state variations with a range of 14 in Kerala to 76 in Madhya Pradesh.
- ❖ Ten states and UTs have already achieved an IMR of 30 per thousand live births, which is the national goal for the RCH-II. These are Kerala(14), Goa(16), Manipur (13), Mizoram (20), Nagaland (18), Chandigarh (19) , Daman & Diu (28), Lakshadweep (22), Pondicherry (28).
- ❖ Kerala had an IMR of 10 per thousand live births for the years 2002 and 2003. Subsequently the IMR has been 12 & 14 per thousand live births for the years 2004 and 2005 respectively. This could perhaps be due to the fact that Kerala now needs to invest heavily in providing sophisticated newborn care which is capital and skilled manpower resource intensive. As per the results of NFHS III, although Kerala has an institutional delivery rate of 97 per cent , only 85% of the mothers and newborns receive postnatal and newborn care respectively.
- ❖ Andaman & Nicobar Islands have experienced an increase in infant mortality from 19 to 27 per thousand live births for the years 2004 and 2005 respectively. This could be due to the long term deleterious effects of the Tsunami
- ❖ As per the National Family Health Survey results of the second and third rounds, there are mixed results for immunization. Immunization of children has a very little role in reduction of infant mortality but has a significant role to play in reduction of child mortality. Sikkim (47 to 70), West Bengal(44 to 64), Chattisgarh(22 to 49), Bihar(12 to 33) and Jharkhand (9 to 33) are the states which show marked improvements in immunization. It is unfortunate that well performing states like Tamil Nadu(89 to 81), Himachal Pradesh(83 to 74), Maharashtra(78 to 59), Punjab(72 to 60), Mizoram(60 to 46),Gujarat (59 to 45) and Andhra Pradesh(53 to 45) are the states which show declines in immunization thus losing gained ground. Laying stress on immunization is one of the priorities of the second phase of RCH II.



- As per the results of the National Family Health Survey III, anaemia levels are at an alarming level of 79 % among children and on comparison with the results of the second round, it is even more painful to note that all India levels of anaemia have actually increased from 74% to 79%. However, this has been countered by incorporating a policy change whereby all children from six months of age up to adolescence are now part of the RCH II programme and to improve compliance, iron preparations in the form of syrup will be provided for children six months to five years of age.

- Also, it is with these factors in mind that holistic interventions like Integrated Management of Neonatal and Childhood Illnesses(IMNCI) have been initiated and policy decisions like introduction of Zinc as an adjunct to ORS in the management of diarrhea and Vitamin A reintroduced for all children from 9 months of age to five years of age (as is the norm all over the world) and not up to only three years as was being done earlier. Mass awareness about the female child's rights and the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, is being implemented to correct the male female ratio.

INTEGRATED MANAGEMENT OF NEONATAL AND CHILD HOOD ILLNESSES

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

The major components of this strategy are:

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

The first two components are the facility based IMNCI and the third is the community based IMNCI. The list of districts which have initiated IMNCI implementation is placed at Annexure 1.

Goals

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

*Estimated

HOME BASED NEW BORN CARE

The Government of India has recently approved the implementation of Home Based Newborn Care (HBNC) based on the Gadchiroli model, where appreciable decline in Infant Mortality Rates has been documented on the basis of work done by SEARCH, a NGO. ASHAs will be trained in identified aspects of newborn care during the second year of their training. The modules have been finalized. State sensitization workshops have been held. In the five high focus states to be covered under the Indo Norway Initiative (NIPI), the HBNC shall be implemented by SEARCH with support from ICMR. Permission has been accorded in 2 districts in each of these five states (- MP, UP, Orissa, Rajasthan and Bihar) for ASHAs to use injectable antibiotics for neonatal sepsis and childhood pneumonia.

FACILITY BASED NEW BORN CARE

The facility based newborn care programme implanted by the Government in 140 districts with technical assistance from the National Neonatology Forum (NNF) has been evaluated and based on this feedback, a facility based newborn care programme is being set up.

Level II sick newborn units have been proposed by the states in their RCH II PIPs and are being set up throughout the country in a phased manner, initially at district hospitals. Facilities have been established at Purulia, Birbhum, Cooch behar, Uttar Dinajpur and Bankura, Udaipur, Jaipur, Bhiwada, Tonk, Guna, Vaishali, Lalitpur, Guwahati, Nadia, Burdwan, Malda, North 24 Parganas (Barasat) and Darjeeling (Siliguri).

VITAMIN- A

With the objective of decreasing the prevalence of Vitamin A deficiency to levels below 0.5%, the strategy being implemented is:

Infancy

- Health and nutrition education is being taken up to encourage colostrums feeding, exclusive breastfeeding for the first six months and the introduction of complementary feeding thereafter.
- 1,00,000 IU dose of Vitamin A is being given at nine months

Childhood

- Health education efforts to ensure adequate intake of Vitamin A rich food throughout childhood
- Early detection and prompt treatment of infections
- **Vitamin A dose of 1,00,000 IU at 9 months and 2,00,000 I.U thereafter at six monthly intervals up to five years of age**

Sick children

- All children with xerophthalmia to be treated at health facilities
- All children suffering from measles to be given one dose of Vitamin A if they have not received it in the previous one month
- All cases of severe malnutrition to be given one additional dose of Vitamin A.

Achievements:

<i>Latest available status of Vitamin A</i>			
	<i>Vitamin A</i>	<i>Achievement</i>	<i>%</i>
<i>coverage</i>			<i>achievement</i>
<i>1st dose</i>		24,976,653	107.5
<i>2nd - 5th dose</i>		45,645,858	58.9

ANAEMIA AMONG CHILDREN

To manage the widespread prevalence of anaemia in the country, the policy has recently been revised. Infant from the age of 6 months onwards up to the age of five years shall receive iron supplements in liquid formulation in doses of 20mg elemental iron and 100mcg folic acid per day for 100 days in a year. Children 6-10 years of age shall receive iron in the dosage of 30 mg elemental iron and 250mcg folic acid for 100 days in a year and adolescents 11-18 years shall receive supplements at the same dosage and duration as adults.

PROMOTION OF INFANT AND YOUNG CHILD NUTRITION (IYCN)

A Breastfeeding Partnership involving all the key partners has been formed under the auspices of the Hon’ble MOS . Revival of the Breastfeeding Hospital initiative(BFHI) has been approved and implementation shall be initiated.

CHILD NUTRITION IN THE RCH PROGRAMME

Breastfeeding

(i) Objectives

Breastfeeding: “Exclusive breastfeeding of the first six months of life” to be propagated as it would have the following benefits:

- It is the ideal method of infant feeding,
- Is the single most cost effective intervention for reduction of infant mortality.
- Delays return to fertility in the mother and hence acts as a natural contraceptive (Lactational Amennorrhoea Method, LAM)

(i) Strategy A breastfeeding partnership of the government with all major professional bodies and various NGOs has been formed. The Infant Milk Substitute (IMS) Act is being implemented

- a. Baby Friendly Hospital Initiative
- b. Lactation Clinics

c. Peer Counselling

Iron and folic acid supplementation

(i) **Objectives**

- Screening of children for anaemia wherever required and appropriate treatment of those found anaemic

(ii) **Strategy**

- ❖ Iron supplementation for at least hundred days in a year for all age groups, infants above six months of age up to adolescence and beyond, for all diagnosed as anaemic, with iron
- ❖ Children from six months of age to five years to be supplemented with liquid iron.
- ❖ Improve dietary intake to meet RDA for all macro and micronutrients;
- ❖ Dietary diversification-inclusion of iron folate rich foods as well as food items that promote iron absorption;
- ❖ Food fortification, including introduction of iron and iodine-fortified salt and other iron-fortified items(e.g. atta in specific areas);
- ❖ Health and nutrition education to improve over all dietary intakes and promote consumption of iron and folate-rich foodstuffs

(iii) **Infants:**

- ❖ Exclusive breast feeding for six months, and introduction of green leafy vegetables along with cereal/pulse/oilseed mix in the seventh month for the prevention of anaemia;
- ❖ Screening for anaemia in pre-term, low birth weight infants and those with growth faltering and repeated episodes of infection; and
- ❖ Appropriate treatment for anaemic infants.

(iv) ***Preschool Children***

- ❖ advocacy with regard to dietary diversification for the prevention of anaemia;
- ❖ all growth retarded children and those with repeated infections have to have HB estimation carried out and
- ❖ those found to be anaemic are provided with appropriate treatment.

- ❖ In hookworm endemic areas, it is necessary to improve:
 - ❖ sanitation and educate people not to walk barefoot;
 - ❖ treat children with a history of passing worms with broad spectrum antihelminthics;
 - ❖ screen all anaemic children for hookworm infestation and treat them

The co-operation of the PRIs and women's self help groups, where ever existent, may be sought to promote and monitor intake of IFA tablets in their community.

(v) **Coverage**

- As per a survey carried out in 2002 by the National Nutrition Monitoring Bureau, under the ICMR, 67% of the preschool children were anaemic.
- 2,84,729 kits are distributed throughout the country each year under the RCH programme, each kit containing 13,000 tablets of paediatric IFA tablets.

(vi) Implementation

Through the health institutions under the government sector

Vitamin A supplementation strategy

(i) Objectives

- Decrease prevalence of Vitamin A deficiency from the current 0.7% to 0.3%

(ii) Strategy

Infancy

- Health and nutrition education is being taken up to encourage colostrums feeding, exclusive breastfeeding for the first six months and the introduction of complementary feeding thereafter.

- 1,00,000 IU dose of Vitamin A is being given at nine months

Childhood

- Health education efforts to ensure adequate intake of Vitamin A rich food throughout childhood

- Early detection and prompt treatment of infections
- Vitamin A dose of 2,00,000 I.U at six monthly intervals up to five years of age

age

Sick children

- All children with xerophthalmia to be treated at health facilities
- All children suffering from measles to be given one dose of Vitamin A if they have not received it in the previous one month

- All cases of severe malnutrition to be given one additional dose of Vitamin A.

(iii) Coverage Vitamin A supplementation coverage rate (6-59 months)

	2004-05	2005-06*
1 st dose	112.9%	107.5%
2nd to 5th dose	55.4%	58.9%

(iv) Implementaion

Through the health institutions and anganwadis under the government sector

PROGRESS IN CHILD HEALTH OVER THE PAST TWO YEARS

Integrated Management of Neonatal and Child Hood Illnesses(IMNCI)

- IMNCI was approved as the centre piece of the child health strategy in the early phases of 2005 and has since then expanded to 154 districts across the country which are at various stages of implementation. The list of these districts is placed at Annexure 1.
- To be able to scientifically evaluate the implementation of IMNCI, simultaneous evaluation has been started through a 16 district study which is being conducted by the India program Evaluation Network, a part of the International Clinical Epidemiology Network(INCLEN).The evaluation is being funded by UNICEF and USAID.
 - **Home Based New Born Care**
- The Government of India has recently approved the implementation of Home Based Newborn Care(HBNC) based on the Gadchirolli model , where appreciable decline in Infant Mortality Rates has been documented on the basis of work done by SEARCH, a NGO. The modules have been finalized. and state sensitization workshops have been held in UP, MP, Bihar, Orissa and Rajasthan.
- In the five high focus states to be covered under the Indo Norway Initiative (NIPI), the HBNC shall be implemented by SEARCH with support from ICMR. Permission has been accorded in 2 districts in each of these five states(- MP, UP, Orissa, Rajasthan and Bihar) for ASHAs to use injectable antibiotics for neonatal sepsis and childhood pneumonia.
- Under the chairperson ship of Dr Abhay Bang, a committee of experts was approved by the former AS, and the modules for the Home Based Newborn Care have been finalized at ICMR. Orientation meetings have been held at each of the five states of Bihar, orissa, UP,MP and Rajasthan for this activity.

Facility Based Newborn Care

- ❖ The facility based newborn care programme implanted by the Government in 140 districts with technical assistance from the National Neonatology Forum(NNF) has been evaluated and the findings were presented to Mrs S Jalaja, Additional Secretary in the last week of February 2007.
- ❖ Based on this feedback, a facility based newborn care programme was formulated by experts on 4-5 June 2007 and a review meeting was held on 10th August 2007.The decision will be taken shortly.

Home Based Newborn Care(HBNBC)

- ❖ The modules for HBNBC based on the Gadchirolli model of Dr Bang have been finalized.
- ❖ Orientation meetings have been held in all the five NIPI states(UP, MP, Orissa, Rajasthan and Bihar) for HBNBC.
- ❖ Permission has been obtained from the DCG(I) for trying out Injection Gentamycin in two districts in each of these five states.

Vitamin – A

The policy has been revised in the latter half of 2006 - All children between the ages of 9 months to five years (and not up to three years only as was the practice earlier)will now receive Vitamin A supplementation bi annually. In this context it is submitted that India was the only country in the world to supplement Vitamin A up to three years of age.

Anaemia among children

To manage the widespread prevalence of anaemia in the country, the policy has recently been revised in the last quarter of 2007. Infants from the age of 6 months onwards up to the age of five years shall receive iron supplements in liquid formulation in doses of 20mg elemental iron and 100mcg folic acid per day for 100 days in a year. Children 6-10 years of age shall receive iron in the dosage of 30 mg elemental iron and 250mcg folic acid for 100 days in a year and adolescents 11-18 years shall receive supplements at the same dosage and duration as adults.

Modification of the treatment of diarrhea

India was the first country in the world to introduce the low osmolarity Oral Rehydration Solution (ORS), as recommended by WHO, for the management of diarrhea exactly two years ago.

In the last quarter of 2006, Zinc has been approved as an adjunct to ORS for the management of diarrhea.

Promotion of Infant and Young Child Nutrition (IYCN)

A Breastfeeding Partnership involving all the key partners has been formed under the auspices of the Hon'ble MOS . Revival of the Breastfeeding Hospital initiative(BFHI) has been approved and implementation shall be initiated.

Infant and Young Child Feeding guidelines produced by the MWCD have been endorsed by an expert group and included for implementation in RCH II.

An action plan for revitalizing Baby Friendly Hospital Initiative(BFHI) has been approved by the Secretary (H&FW). Talks were on with the Indian Academy of Paediatrics to implement it but now the Indian Medical Association(IMA) has agreed(informally)to implement it. The formal approval is in process.

An action plan for promoting early initiation of breastfeeding and exclusive breastfeeding has been approved by AS(J). A budget head for this activity needs to be found.

Co-ordination with Ministry of Women and Child Development (MWCD)

In the Action Plan for the Child produced by MWCD, it has agreed to train all anganwadi workers in IMNCI. This has been a landmark achievement.

ROUTINE IMMUNIZATION PROGRAMME

Immunization programme is one of the key interventions for protection of children from life threatening conditions, which are preventable. Immunization Programme in India was introduced in 1978 as Expanded Programme 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.

Under the Immunization Programme Government of India is providing vaccination to prevent six vaccine preventable diseases i.e. Tuberculosis, Diphtheria, Pertussis, Tetanus, Polio, and Measles. The vaccination schedule is as under:

- BCG (Bacillus Calmetter-Guèrin)– Birth
- DPT (Diphtheria, Pertussis and Tetanus Toxoid)– 6,10,14 weeks and at 16-24 months of age
- OPV (Polio)- 6,10,14 weeks & 16-24 months of age and birth dose for institutional delivery
- Measles – 9-12 months of age
- DT (Diphtheria and Tetanus Toxoid) – 5 years of age
- ***TT (Tetanus Toxoid) – 10 years and 16 years of age***
- TT - for pregnant woman two doses or one dose if previously vaccinated within 3 years

The Immunization coverage of vaccines under Routine Immunization as per NFHS-II and NFHS-III data is enclosed. To improve the coverage in low performing NE States, Special Immunization weeks are being observed in the NE States along with EAG States from the year 2005-06 every year.

To further strengthen the Routine Immunization, with the aim to improve the coverage, Government of India has taken the following initiatives as part of NRHM:

- Introduction of AD syringes for all immunization replacing the existing glass syringe and needles.
- Downsizing the BCG vial from 20 dose to 10 dose.
- Plans for alternate vaccine delivery from PHC to Sub centre and outreach sessions.
- Outsourcing immunization activities in urban slums and under served areas.
- Strengthening supervision and monitoring.
- Mobility support to District Immunization officer for supportive supervision and monitoring.
- Review meeting at the State level with the districts on 6 monthly basis.
- Mobilization of children to immunization session sites by Accredited Social Health Activist. (ASHA), Link workers, Women Self Help Groups etc.

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

Status of Routine Immunization

To strengthen Routine Immunization Government of India under NRHM has launched newer initiatives as part of the State Programme Implementation Plan (PIP), some initiatives are:

- To ensure injection safety, Auto Disable (AD) Syringe introduced throughout country.
- Support for alternate vaccine delivery from PHC to Sub-Centres and Outreach Sessions.
- Provision for deploying additional manpower to carryout Immunization activities in urban slums and underserved areas where services are deficient.
- Mobility support to State Immunization Officer, District Immunization Officer and other Officer as per State Plan for monitoring and supportive supervision.
- Review meeting at the State level with the districts on 6 monthly intervals.
- Training of ANM, Cold Chain Handlers, Mid Level Managers, Refrigerator Mechanics etc.
- Support for mobilization of children to immunization session sites by Accredited Social Health Activist (ASHA), Women Self Help Groups etc.
- One Computer Assistant to State Head Quarter and each District.
- Printing of Immunization Cards and other tools like tickler bag, tally sheet, monitoring chart, Cold Chain temperature monitoring chart, vaccine inventory charts etc.
- Implementation of Routine Immunization Monitoring System (RIMS) software.
- Support for other specific issues.
- In addition the central support of the following will continue under Immunization as supplies to States –
 - Strengthening of cold chain system in the State
 - Cold Chain Maintenance
 - Supply of vaccines
 - Supply of vaccine van at the rate of one per district

INTRODUCTION OF HEPATITIS – B VACCINE

A pilot project for the introduction of Hepatitis-B vaccine in the National Immunization Programme was approved by the Government and launched by Hon'ble Prime Minister on 10th June 2002. Under the pilot project 33 districts and 15 metropolitan cities implemented Hepatitis B vaccination. The current schedule includes birth dose along with earlier 3 doses.

Vaccine and syringes are being made available by Global Alliance for Vaccine and Immunization (GAVI) for the expansion programme. Expenditure for IEC, training and monitoring budget is being incurred through the domestic funds.

The progress of Hepatitis-B project

After the success of pilot project, the Hepatitis B programme has been expanded to 10 states viz. Andhra Pradesh, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Punjab, Tamil Nadu and West Bengal in phased manner. As on 2008, the overall coverage of infants in 11 districts and 6 cities, which have been continuing Hep-B vaccination since the pilot project, is 56.7%. The overall coverage of infants in the 10 states is 39.0 %.

Introduction of Japanese Encephalitis (JE) Vaccine

JE Vaccination was started 2006 in 11 districts and 4 states using SA-14-14-2, with 88% of the targeted 10.5 million children in the 12 month to 15 years age immunized. In 2007, 27

districts in 10 states were covered with 75% of the targeted 22.0 million children in the 12 month to 15 years age immunized. In 2008, 24 more endemic districts have been added.

The JE vaccine is being integrated into routine immunization in the districts where campaign had already been conducted to immunize the unimmunized cohort of children by vaccinating with single dose at 16-18 months

PULSE POLIO IMMUNIZATION

In pursuance to the World Health Assembly resolution No. 1988/41.28 pulse Polio Immunization (PPI) Programme was started in India from 1995 to eradicate Polio from India. Following the successful pilot undertaking in Delhi in 1994, Nation-wide PPI rounds was undertaken in 1995 covering children in the age group of 0-3 years from 1996-97 the age cohort for vaccination was started to cover 0-5 years children. Till 1998-99 two rounds used to be organized in the month of December and January each year. From 1999-2000 house to house vaccination of missed children was also introduced to vaccinate children missed during the fixed booth based vaccination of children. This resulted in increasing coverage of 2-3 crore additional children.

The annual strategy for polio eradication is decided on the basis of the recommendations of the India Expert and International Experts from World Health Organization (WHO), United Nation's Children Fund (UNICEF), and Centre for Disease Control (CDC) Atlanta. The IEAG reviews the Polio epidemiological situation two times a day and recommend the suitable strategies for the country. The National Polio Surveillance Project (NPSP) of WHO provides technical support for high quality Acute Flaccid Paralysis (AFP) surveillance and assists the government in micro planning, training and monitoring of polio immunization campaign.

Since the initiative to eradicate polio from India started in 1995, significant success has been achieved in reducing number of polio cases in the country and total cases decline gradually to only 66 cases in 2005. Out of 35 States & UTs, 33 States & UTs were free from indigenous transmission of polio virus since last three years. It is taking more times in UP and Bihar to achieve zero transmission due to factors like high population density and poor sanitation.

In order to achieve the goal of zero transmission at the earliest, the strategy in UP and Bihar has been modified to have increased number of polio immunization campaign with Monovalent vaccine type I (mOPV 1) as per the recommendation of India Expert Advisory Group on polio to target the Polio virus type 1 and polio virus type 3 sequentially.

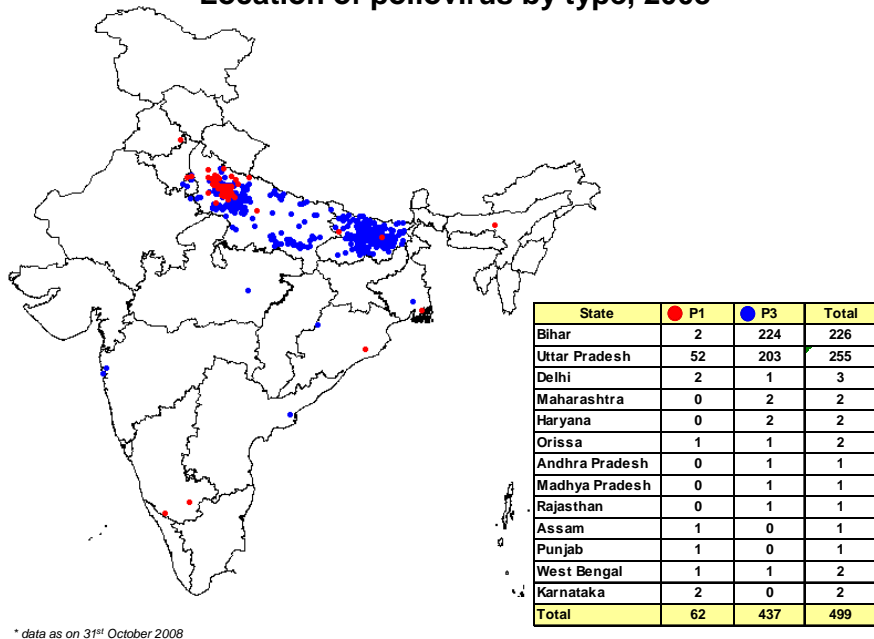
As a result of this strategy, there has been a significant decline in the number of cases caused by the most virulent strain of polio virus type 1 (P1). Only 62 type 1 polio cases (till 31st October 2008) have been reported this year as against 83 Type 1 last year and 648 cases during 2006. The reported cases of P1 in endemic region of Western Uttar Pradesh are an importation from Bihar.

P1 circulation in Bihar is restricted to a small proportion of Blocks that have operational difficulties that got worse during the recent floods. Only 2 cases of P1 type has been reported till 31st October 2008. Efforts are being made to overcome these operational barriers and it is feasible to stop type 1 circulation in Bihar during the low season of 2008.

Out of 437 Poliovirus Type 3 reported so far, Bihar has reported 224 and UP 203 and rest cases have been reported from Delhi, Maharashtra, Haryana, Orissa, Andhra Pradesh, Madhya Pradesh, Rajasthan & West Bengal. This is consistent with the immunization strategy recommended by the IEAG focusing on curtailing transmission of Polio type 1 virus and keeping

Type 3 virus in check because P1 circulates more widely has been responsible for International spread and has the propensity to cause large outbreaks.

Location of poliovirus by type, 2008*



Activities Undertaken

- So far in 2008, two country wide National Immunization Days (NIDs) in January and February and five Sub National Immunization Days (SNIDs) in March, April, June, July and September have been conducted.
- One SNID would be held in November 2008
- During each NID 172 million children less than 5 years are given polio drops and during each SNID around 70 million children are vaccinated. The SNIDs are usually cover the endemic states of UP and Bihar and other areas at risk of poliovirus such as Delhi and surrounding areas and Mumbai and neighboring areas
- In each NID nearly 2.3 million vaccinators under the direction of 1,55,000 Supervisors visit 209 million houses. To reach people on the move, mobile and transit vaccination teams immunize the children at Railway stations, inside running trains, at bus stands, market areas brick kilns, construction sites etc.
- In addition to planned NIDs/SNIDs, mop-up rounds have been conducted in response to polio cases detected in the country
- In order to achieve the goal at the earliest the implementation strategy has been further strengthened like:
- Vaccinating children at fixed booth and house to house visit, efforts in vaccinating children in transit at railway stations, insides long distance trains, major bus stops, market places, religious congregations, major road crossing etc. through out the country have been intensified. Through these efforts 5 million children in transit have been effectively administered polio drops during each immunization rounds.

- Migratory population (children) from UP and Bihar in Haryana, Punjab, Gujarat and West Bengal are being immunized during the SNIDS in UP and Bihar.
- ASHA have been involved as team member for mobilization and vaccination of children'
- The missed children during SNIDs are being mobilized by ASHA//AWW and vaccinated during the monthly Health days.
- Strategy to involve the leaders and opinion makers of the underserved committee is being adopted in Western U.P. districts to involved the community better in the programme

COLD CHAIN SYSTEM VACCINE STORAGE AT PHC/CHC LEVEL

The National Cold Chain Assessment has been conducted in the country with support of UNICEF and WHO to assess the gaps and take necessary actions to strengthen the cold chain. The cold chain system consists of a series of transportation & storage facilities for vaccines from the manufacturers to the beneficiaries at a recommended temperature. More than 72000 units consisting of the following equipments have been supplied to the States for storing the vaccines:

- a) Walk-in-Coolers and Walk-in-Freezers Rooms: These are supplied at State/Regional Level to maintain a vaccine stock required for 3 months in its catchment area. There are at present 161 walk in coolers and 36 walk in freezers installed at various locations of the States in the country.
- b) Ice Lined Refrigerators (Large) and Deep Freezers (Large) at the District Level: 6300 numbers ILRs (L) and Deep Freezers (L) have been supplied. At the district stores Deep Freezers can be used for storing Polio vaccine at below (-)15°Centigrade.
- c) A Twin set of ILR/Deep Freezer: These have been supplied in pairs to all PHCs, where a stock of one month's requirement of vaccines is maintained. 65700 such units have been supplied to different health institutions.

REPRODUCTIVE & CHILD HEALTH- II (RCH II)

In order to effectively improve the health status of women and children and fulfill the unmet need for Family Welfare services in the country, especially the poor and under served by reducing infant child and maternal mortality and morbidity, Government of India during 1997-98 launched the RCH Programme for implementation during the 9th plan period by integrating Child Survival and Safe Motherhood (CSSM) Programme with other reproductive and child health (RCH) services. In addition, a new component for management of Reproductive Tract Infection (RTI) and Sexually Transmitted Infection (STI) has also been incorporated. The RCH Programme is partly funded by World Bank, UNICEF, UNFPA and European Commission etc. Reproductive and Child Health Program is in 5th year of its operation and is currently operational in entire country. The program follows a differential strategy with inputs under the program linked to the needs of the area coupled with the capacity for implementation. The program was reviewed extensively not only in context of achievements during mid-term stage, but also in context of National Population Policy.

Efforts were made to strengthen the routine immunization as well as PPI by launching a project for Immunization Strengthening with the World Bank assistance. The ongoing activities were accelerated and new schemes on Financial Envelop, Dais' Training, RCH Camps and RCH out reach services were started to address felt gaps. The implementation of EC assisted Sector Investment Programme has geared up, especially State/District level activities and urban RCH component.

Under the Reproductive and Child Health Programme (RCH) being implemented in all States of the country various interventions for reduction of infant mortality rate are being implemented. These include immunization against fixed vaccine communicable diseases, control of death during diarrhea, control of deaths due to acute respiratory infections; prophylaxis against vitamin A deficiency and iron deficiency anemia. Essential newborn care and promotion of exclusive breastfeeding and appropriate complementary feeding practices. Unequal access of pregnant women in rural areas and those in the lower socio economic bracket is recognized as an important issue. Provision has been kept under the National Rural Health Mission to strengthen the services at village and sub-center level and also for provision of transport facilities to pregnant women needing emergency treatment.

Integrated Management of Neonatal and Childhood Illnesses(IMNCI) package will be implemented in a phased manner throughout the country in the second phase of the RCH programme. It offers a comprehensive package for the management of the most common causes of childhood illnesses i.e sepsis, measles, malaria, diarrhoea, pneumonia and malnutrition. It is supported by appropriate strengthening of the health care system and promotion of positive health care practices of the community

Integrated Management of Childhood Illness (IMCI) strategy, which has already been implemented in more than 100 countries all over the globe, encompasses a range of interventions to prevent and manage five major childhood illnesses i.e. Acute Respiratory Infections, Diarrhoea, Measles, Malaria and Malnutrition. It focuses on preventive, promotive and curative aspects, i.e it gives a holistic outlook to the programme.

Govt. of India recognized the need to strengthen child health activities in the country. In order to strengthen Child Health activities and introduce IMCI in the country, a Core Group was constituted which included representatives from Indian Academy of Pediatrics (IAP), National Neonatology Forum of India (NNF), National Anti Malaria Program (NAMP), Department of Women and Child Development (DWCD), Child-in-Need Institute (CINI), WHO, UNICEF, eminent Pediatricians and Neonatologists, and the representatives from Ministry of Health and Family Welfare Government of India. The Adaptation Group developed Indian version of IMCI guidelines and renamed it as **Integrated Management of Neonatal and Childhood Illness (IMNCI)**.

The major components of this strategy are:

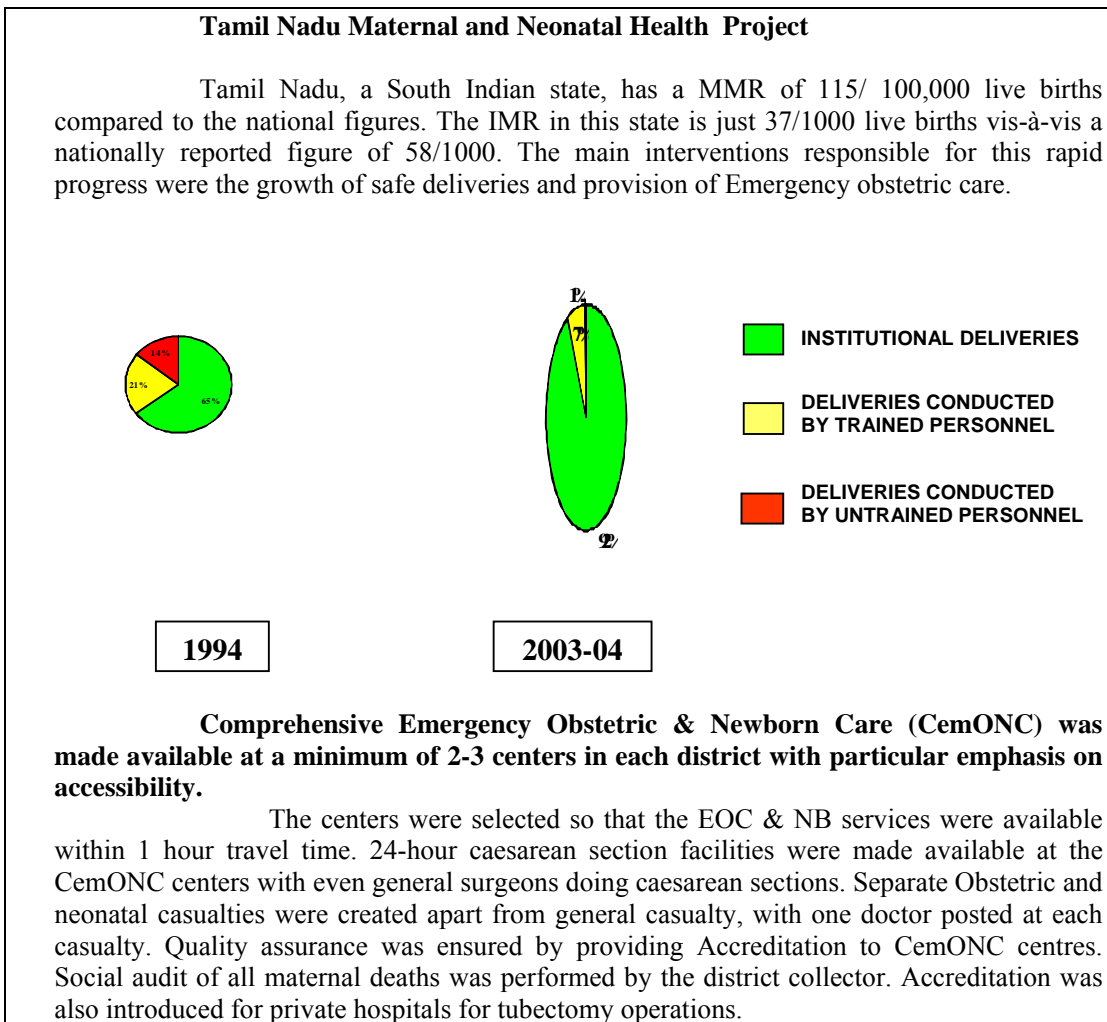
- Strengthening the skills of the health care workers
- Strengthening the health care infrastructure
- Involvement of the community

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

The major highlights of Indian adaptation are:

- Incorporation of neonatal care as it now constitutes two thirds of infant mortality
- Inclusion of 0-7 days
- Incorporating National guidelines on Malaria, Anemia, Vitamin A supplementation and Immunization schedule
- Training schedule reduced from 11 to 8 days
- Training begins with sick young infant upto 2 months
- Proportion of training time devoted to sick young infant and sick child is almost equal

The Government has initiated implementation of the IMNCI strategy in four districts each in nine selected states of Orissa, Rajasthan, Madhya Pradesh, Haryana, Delhi, Gujarat, Uttaranchal, Tamil Nadu and Rajasthan.



MAJOR MILESTONES IN CHILD HEALTH

Till 1977 the major health activity was family planning which was changed into Family welfare programme with Maternal and Child Health becoming integral part of family planning programme with the vision that reduction in birth rate has a direct relationship with reduction in infant and child mortality.

The diarrhoeal disease control programme was started in the country in 1978. The main objective of the programme was to prevent death due to dehydration caused by diarrheal diseases among children under 5 years of age due to dehydration. Health education aimed at rapid recognition and appropriate management of diarrhea has been a major component of the CSSM. Under the RCH programme ORS is supplied in the kits to all sub-centres in the country every year.

Universal Immunization Programme against six preventable diseases, namely, diphtheria, pertussis, childhood tuberculosis, poliomyelitis, measles and neonatal tetanus was introduced in the country in a phased manner in 1985, which covered the whole of India by 1990.

Significant progress was made under the Programme in the initial period when more than 90% coverage for all the six antigens was achieved.

The UIP was taken up in 1986 as National Technology Mission and became operational in all districts in the country during 1989-90. UIP became a part of the Child Survival and Safe Motherhood (CSSM) Programme in 1992 and Reproductive and Child Health (RCH) Programme in 1997. Under the Immunization Programme, infants are immunized against tuberculosis, diphtheria, pertussis, poliomyelitis, measles and tetanus. Universal immunisation against 6 vaccine preventable diseases (VPD) by 2000 was one of the goals set in the National Health Policy (1983).

The ARI Control Programme was started in India in 1990. It sought to introduce scientific protocols for case management of pneumonia with co-trimoxazole. Initially 14 pilot districts were selected and later on new districts were included. A review of the health facility done in 1992 revealed that although 87% of personnel were trained and the drug supply was regular yet there were problems in correct case classification and treatment. Since 1992 the Programme was implemented as part of CSSM and later with RCH. Cotrimoxazole tablets are supplied as part of drug kit for use by different category of workers for managing cases of Pneumonia. Under RCH-II activities are proposed to be implemented in an integrated way with other child health interventions.

The Child Survival and Safe Motherhood Programme jointly funded by World Bank and UNICEF were started in 1992-93 for implementation up to 1997-98. The Child Survival and Safe Motherhood Programme were implemented in a phased manner covering all the districts of the country by the year 1996-97. The objectives of the programmes were to improve the health status of infants, child and maternal morbidity and mortality. The programmes seek to sustain high coverage levels achieved under the Universal Immunisation Programme (UIP) in good performance areas and strengthen the immunisation services of poor performing areas. The programme also provides for augmenting various activities under the Oral Rehydration Therapy (ORT) Programme, universalising prophylaxis schemes for control of anemia in pregnant women & control of blindness in children and initiating a programme for control of acute respiratory infection (ARI) in children. Under the safe motherhood component, training of traditional birth attendants (TBA), provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken up. The approved outlay for the CSSM Programme was Rs. 1125.58 crores for the entire IDA credit facility of SDR period. The Programme yielded notable success in improving the health status of pregnant women, infants and children & also making a dent in IMR, MMR and incidence of vaccine preventable diseases.

INFANT MORTALITY RATE(IMR)

Sl. No.	States	2003	2004	2005	2006	2007
	ALL INDIA	60	58	58	57	55
1	Andhra Pr.	59	59	57	56	54
2	Assam	67	66	68	67	66
3	Bihar	60	61	61	60	58
4	Chhatisgarh	70	60	63	61	59
5	Gujarat	57	53	54	53	52
6	Haryana	59	61	60	57	55
7	Jharkhand	51	49	50	49	48
8	Karnataka	52	49	50	48	47
9	Kerala	11	12	14	15	13
10	Madhya Pr.	82	79	76	74	72
11	Maharashtra	42	36	36	35	34
12	Orissa	83	77	75	73	71
13	Punjab	49	45	44	44	43
14	Rajasthan	75	67	68	67	65
15	Tamil Nadu	43	41	37	37	35
16	Uttar Pr.	76	72	73	71	69
17	W. Bengal	46	40	38	38	37
18	Arunachal Pr	34	38	37	40	37
19	Delhi	28	32	35	37	36
20	Goa	16	17	16	15	13
21	Himachal Pr .	49	51	49	50	47
22	J & K	44	49	50	52	51
23	Manipur	16	14	13	11	12
24	Meghalaya	57	54	49	53	56
25	Mizoram	16	19	20	25	23
26	Nagaland	NA	17	18	20	21
27	Sikkim	33	32	30	33	34
28	Tripura	32	32	31	36	39
29	Uttaranchal	41	42	42	43	48
30	A&N Islands	18	19	27	31	34
31	Chandigarh	19	21	19	23	27
32	D&N Haveli	54	48	42	35	34

33	Daman & Diu	39	37	28	28	27
34	Lakshadweep	26	30	22	25	24
35	Pondicherry	24	24	28	28	25

Annexure - I

**MATERNAL MORTALITY RATIO
(per 1,00,000 live births)**

	1997-98	1999-01	2001-03
India	398	327	301
Andhra Pradesh	197	220	195
Assam	568	398	490
Bihar	531	400	371
Gujarat	46	202	172
Haryana	136	176	162
Karnataka	245	266	228
Kerala	150	149	110
Madhya Pradesh	441	407	379
Maharashtra	166	169	149
Orissa	346	424	358
Punjab	280	177	178
Rajasthan	508	501	445
Tamil Nadu	131	167	134
Uttar Pradesh	606	539	517
West Bengal	303	218	194

**Ninth Editors' Conference on Social Sector Issues
4-2-2009**

ERRATA

The following table may be substituted in the place of table appearing on page 7

An overall trend in the expenditure vis-a-viz the Budget Estimates during the 10th Plan and Eleventh Plan for Health and Family Welfare is given below:

Plan Period	Budget Estimates (BE)			Expenditure		
	Health	FW/NRHM	Total	Health	FW/NRHM	Total
10TH PLAN OUTLAY						
Original Outlay	9253.00	27125.00	36378.00			
Revised Outlay	10252.00	26126.00	36378.00			
Existing Status	10521.00	31064.00	41585.00	8694.15	26345.58	35039.73
2002-03	1550.00	4930.00	6480.00	1359.00	3916.63	5276.45
2003-04	1550.00	4930.00	6480.00	1325.81	4409.27	5735.08
2004-05	2208.00	5780.00	7988.00	1772.36	4862.09	6634.45
2005-06	2908.00	6424.00	9332.00	2253.72	5672.53	7926.25
2006-07\$	2305.00	9000.00	11305.00	1982.44	7485.06	9467.50
11TH PLAN (2007-12)	46669.00#	89478.00	136147.00			
2007-08	2985.00	10890.00	13875.00	2100.15	10380.25	12480.40
2008-09	4070.00**	11930.00	16000.00	1686.29*	7848.83*	9535.12*

\$ figures shown as Health and NRHM from 2006-07

which includes Rs.4496.08 crores for Department of Health

**Expenditure upto 15th January 2009*

***includes Rs.420.00 crores for Department of Health Research*