Chapter 30

Health and Family Welfare

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

30.2 As per **World Health Statistics 2015**, life expectancy at birth has increased 6 years for both men and women since 1990 . The median age of people living in low-income countries is 20 years, while it is 40 years in high-income countries. Over one-third of adult men smoke tobacco and about one quarter of men suffer from high blood pressure whereas 15% of women worldwide are obese. Two-thirds of deaths worldwide are due to non communicable diseases. In low- and middle-income countries, only two-thirds of pregnant women with HIV receive anti retrovirals to prevent transmission to their baby and only 1 in 3 African children with suspected pneumonia receives antibiotics. In some countries, total government expenditure on health is less than 5% of total public expenditure.

30.3 However, MDGs (Millennium Development Goals) have been good for public health even though health-related goals in each of the 194 countries for which data are available , show mixed results. By the end of 2015, if current trends continue, the world will have met global targets for turning around the epidemics of HIV, malaria and tuberculosis and increasing access to safe drinking water. It will also have made substantial progress in reducing child under nutrition, maternal and child deaths, and increasing access to basic sanitation. However, there are still wide gaps between and within countries

Global and regional progress towards the achievement of the health-related MDGs

	Target	Global	AFR	AMR	SEAR	EUR	EMR	WPR
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger								
Percent reduction in proportion of underweight children under five years of age, 1990–2013	50	40	27	60	43	86	36	79
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate								
Percent reduction in under-five mortality rate, 1990–2013	67	49	49	64	60	63	46	71
Measles immunization coverage among 1-year-olds[a] (%), 2013	90	84	74	92	78	95	78	97
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio								
Percent reduction in maternal mortality ratio, 1990–2013	75	45	49	37	64	59	50	60
Births attended by skilled health personnel[b] (%), 2007–2014	90	74	51	96	68	98	67	96
Target 5.B: Achieve, by 2015, universal access to reproductive health								
Antenatal care coverage (%): at least one visit, 2007–2014	100	83	77	96	77	...	78	95
Unmet need for family planning (%), 2012	0	12	24	9	13	10	18	6
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS								
Percent reduction in HIV incidence, 2001–2013	>0	46	59	24	45	20	< -50	21
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases								
Percent reduction in incidence of malaria[a], 2000–2013	75	30	34	76	49	100	39	69
Percent reduction in mortality rate of tuberculosis (among HIV-negative people)[a], 1990–2013	50	45	40	69	54	11	15	74
Target 7.C: Halve, by 2015, the proportion of the population without sustainable access to safe drinking-water and basic sanitation								
Percent reduction in proportion of population without access to improved drinking-water sources, 1990–2012	50	54	32	60	70	60	13	76
Percent reduction in proportion of population without access to improved sanitation, 1990–2012	50	32	8	40	27	22	32	53

[a] Target established via resolutions of the World Health Assembly or agreed upon by WHO multilateral partnerships.
[b] Target set by the International Conference on Population and Development.

Met or on track | Substantial progress | No or limited progress | ... Data not available or not applicable

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

Source : World Health Statistics 2015

Comparison – some key Indicators

	Density of health infrastructure and technologies		Children aged < 5 years[d] (%)					Prevalence of raised blood pressure among adults aged ≥ 18 years[g] (%)		Adults aged ≥18 years who are obese[h] (%)		General government expenditure on health as % of total expenditure on health[b]	
	Hospitals[f] (per 100 000 population)	Psychiatric beds[e] (per 100 000 population)	Wasted	Stunted	MDG 1 Underweight 1990–1995	MDG 1 Underweight 2007–2014	Overweight	Male	Female	Male	Female	2000	2012
	2013	2014	2007–2014					2014		2014			
Ranges of country values													
Minimum	0.0	0.0										3.1	6.9
Median	1.1	5.9										54.9	60.6
Maximum	56.4	343.3	0.0	1.8	0.6	0.2	0.0	13.2	8.4	0.7	3.1	100	99.9
			5.1	24.0	16.1	11.5	6.3	26.4	23.1	17.2	22.9		
			22.7	57.7	61.5	45.3	23.4	38.3	35.9	46.6	55.1		
WHO region													
African Region	0.8	3.4										44.2	50.8
Region of the Americas	…	22.4	10.3	39.4	34.1	24.9	6.2	29.7	29.5	5.5	15.2	44.9	49.0
South-East Asia Region	…	2.4	1.0	7.4	4.7	1.9	7.4	20.8	15.6	24.0	29.6	32.3	37.9
European Region	…	57.4	14.5	34.2	46.7	26.4	4.3	25.3	24.2	3.2	6.8	74.0	72.9
Eastern Mediterranean Region	0.9	7.0	1.2	7.2	9.8	1.4	12.4	27.1	19.7	21.5	24.5	49.1	50.7
Western Pacific Region	…	42.0	8.6	26.4	22.2	14.1	7.3	27.5	26.4	14.6	23.6	62.1	63.5
			2.7	9.3	17.4	3.7	5.4	20.6	16.7	5.9	7.9		
Income group													
Low income	0.8	2.1	8.8	36.8	39.9	21.4	4.7	27.7	28.2	2.2	7.3	37.6	38.8
Lower middle income	…	3.6	12.5	35.2	38.3	24.4	4.8	26.2	24.7	5.1	10.4	34.0	36.4
Upper middle income	…	15.2	2.2	8.0	12.5	2.7	6.7	22.4	18.7	10.5	15.8	46.7	56.2
High income	…	90.9	…	…	…	…	…	22.3	15.1	22.6	24.3	59.3	60.6
Global	…	22.9	7.7	24.5	24.8	15.0	6.3	24.0	20.5	10.7	15.2	55.5	57.6

Source : World Health Statistics 2015.

History of Health Planning in India:

30.4 Pre Independence : Probably the first document of 'public health policy' in British India was the 1863 report of the Royal Commission on the sanitary state of the British Army in India (Harrison, 1994). Concern about threats to the health of the Indian Army, particularly after the rebellion of 1857, motivated a wide-ranging inquiry into health conditions in the country. If India did not experience the massive decimation of indigenous populations through disease and warfare that the 'New World' witnessed, there were nevertheless many episodes of sharp rises in mortality, associated with the violence and social disruption of conquest and conflict, most notably the Bengal Famine of 1770. A century later, the great famines of the 1870s and 1890s caused both mass mortality and mass migration; it was fear of unrest and social disruption that caused the colonial state, belatedly, to take some interest in famine relief and public health (Dreze, 1988; Hodges, 2004). It was for a long time a commonplace that one of the 'benefits' of colonial rule in Asia and Africa was the advent of modern medicine. Institutions of public health—hospitals, health centres, medical research laboratories, pharmaceutical production facilities—were amongst the new colonial institutions that appeared in South Asia, along with the railways, the telegraph and new forms of land tenure and law. As an 'extractive' colonial state, public health and social welfare were never near the top of the Raj's priorities as it focused on keeping epidemics at bay, responding to crises and not much more. A crucial institutional innovation came in the 1880s (Jeffery, 1988), when much of the responsibility for local health and sanitation was devolved to partly elected local government bodies, a responsibility shared by the 1920s with provincial governments- an arrangement that continues more or less till present day. Nonetheless, it was at the level of local sanitation that the most tangible improvements in public health were found in early 20th-century India. Cholera, the great scourge of India in the 19th century, saw a significant decline, as a result of the provision of clean drinking water at major sites of pilgrimage (Arnold, 1993).However due to weakness of infrastructure, 'local authorities at best could only select the most pressing cases for relief; at worst, the slender local funds were dissipated in tiny sporadic ventures from which no permanent benefit was derived' (Tinker, 1954: 287). The nature of the colonial state's engagement with questions of public health can best be described as ambivalent. This left much scope for 'civil society' or voluntary initiatives in health. Devolving responsibility to charities and voluntary bodies suited the colonial state, In the view of Dr Nil Ratan Sircar, a prominent nationalist and member of the Indian Medical Association, 'medical backwardness' was a consequence of imperialism.

Post Independence :

30.5 The serious crises of the 1940s, with the massive influx of refugees during and after Partition, revealed the fragility and weakness of India's

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

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

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

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

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

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

30.11 Even presently, as revealed by WHO database, per capita health expenditure in India is quite low both in terms of government expenditure & total expenditure on health. Besides being significantly lower than the global average, it falls much short even compared to the average for Africa. The low per capita expenditure can't be attributed to India's higher population only (China has more population but it performs far better) since the indicators pointing to relative importance of health (expenditure on health as per cent of GDP and government expenditure on health as per cent of total government expenditure) also do not compare well with the global average or even that of the Africas.

Recent Govt Initiatives & Achievements :

30.12 Health Policy : The policy directions of the Health for All declaration became stated policy of Government of India with the adoption of the National Health Policy Statement of 1983. Driven by this declaration, there was some expansion of primary health care in the eighties. Further, the National Health Policy of 2002 and the Report of the Macro-Economic Commission on Health and Development (2005) were to emphasize a) the need to increase the total public health expenditure from 2 to 3% of the GDP, b) the need to strengthen the role of public

sector in social protection against the rising costs of health care and the need to provide a comprehensive package of services without reducing the prioritization given to women and children's health. **The National Population Policy** (2000) not only focused on the unmet needs of contraception, but also stressed the need for an integrated service delivery for basic reproductive and child health care. It was in this context that the **National Rural Health Mission** was launched and this was the main programme of the 11th Plan period.

30.13 National Health Mission (NHM) : The **National Health Mission (NHM)** encompasses its two Sub-Missions, the **National Rural Health Mission (NRHM)** and the newly launched **National Urban Health Mission (NUHM)**. The main programmatic components include Health System Strengthening in rural and urban areas- Reproductive-Maternal-Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases.

30.14 The National Rural Health Mission (NRHM) was launched by Government of India in 2005. It places considerable emphasis on strengthening rural health infrastructure including physical infrastructure, manpower and other facilities and consists of following components:

(i) Health System Strengthening: Mobile **Medical Units (MMUs)** are being operated to provide outreach services in rural and remote areas. Support has been provided in 369 out of 672 districts for 1685 MMUs under NHM in the country. **National Ambulance Services:** Emergency Medical Transport System - A fleet of EMRI vehicles to provide basic and advanced life support to the beneficiaries, have also been given to states. They are popularly also known as the '108' type ambulance. In addition, there are Dial '102' services, that essentially consist of basic patient transport aimed to cater to the needs of pregnant women and children . Presently, 7058 Dial-108, 400 Dial-104 and 5713 Dial-102 Emergency Response Service Vehicles are operational under NRHM, besides 5778 empanelled vehicles for transportation of patients, particularly pregnant women and sick infants from home to public health facilities and back .Support is being provided to the States for new construction/ up-gradation/renovation of healthcare facilities. Strengthening First Referral Units and Operationalisation of more 24x7 Facilities is also being carried out . Upto 33% of NHM funds in High Focus States can be used for infrastructure development. As per Annual Report of 2014-15, M/o Health & Family Welfare, 28,147 new constructions have been sanctioned and 15,488 completed under NHM whereas 32,024 renovation /Up gradation works have been undertaken out of which 24,018 have been completed.

Facility	New Construction		Renovation/ Up-gradation	
	Sanctioned	Completed	Sanctioned	Completed
SC	24,701	13,881	17,395	12,480
PHC	1,932	1051	9,028	7,610
CHC	619	285	3,231	2,072
SDH	88	41	611	541
DH	98	58	908	656
Other*	709	172	851	659
Total	**28,147**	**15,488**	**32,024**	**24,018**

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

DH : District Hospital, SDH: Sub Diistrict Hospital ,CHC Community Health Centre, PHC : Primary Health Centre, SC : Sub Centres

(ii) Reproductive, Maternal, Newborn, Child and Adolescent Health: The targets under this component of NRHM includes reducing Maternal Mortality Rate , providing essential obstetric care, quality ante and post natal care for mother and new born and skilled attendance at birth . As regards Family Planning , India launched the world's first national program in 1952, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy". Since then, the family planning program has evolved and is currently being repositioned to not only achieve **population stabilization** but also to promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity.** The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NRHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others). Both spacing (IUCD, Oral Comntraceptive Pills, Condoms) and limiting methods (Minilap, laproscopic sterilization, no scalpel Vasectomy) , are being promoted . Strengthening community based distribution of contraceptives by involving ASHAs and Focussed IEC/ BCC efforts for enhancing demand and creating awareness on family planning. *Contraceptives like oral contraceptive pills OCPs, Condoms are also provided through Social Marketing Organizations.*

- **Family Planning Indemnity Scheme (FPIS) : National Family Planning Insurance Scheme** for treatment of post operative Complications, or Death attributable to the procedure of sterilization was introduced w.e.f 25th November, 2005. The same has now been modified into Family Planning Indemnity Scheme wef 1st April 2013. Compensation scheme for acceptors of sterilization for the loss of wages for the day on

which he/she attended the medical facility for undergoing sterilization has also been revised.

- **The Rastriya Swasthya Bima Yojana** (RSBY) being administered by Ministry of Labour & Employment provides for smart card based cashless health insurance cover up to Rs. 30000 for most of the diseass that require hospitalization, to BPL families (a unit of five) in the unorganized sector. The scheme is presently being implemented in 29 States/UTs and there are 37,191,843 active smart cards as per National Health Profile 2015.
- **Child Health & Immunization: Facility Based Newborn & Child care:** Setting up of facilities for care of Sick Newborn such as Special New Born Care Units (SNCUs), New Born Stabilization Units (NBSUs) and New Born Baby Corners (NBCCs) at different levels is a thrust area under NRHM. As on September 2014, a total of 14135 NBCCs, 1810 NBSUs and 548 SNCUs have been made operational across the country.
- **Janani Shishu Suraksha Karyakram** (JSSK) was launched on 1st June 2011 and has provision for both pregnant women and sick new born till 30 days after birth The provisions are (1) Free and zero expense treatment, (2) Free drugs and consumables, (3) Free diagnostics & Diet, (4) Free provision of blood, (5) Free transport from home to health institutions, (6) Free transport between facilities in case of referral, (7) Drop back from institutions to home, (8) Exemption from all kinds of user charges. All the 35 States and Union Territories are implementing this scheme. As per Annual Report 2014-15,M/o H&FW, based on latest reports received from the States/UTs, 84% pregnant women availed free drugs, 77% free diagnostics, 69% free diet, 47% free 'home to facility' transport and 39% free drop back home. For sick infants, 73% sick infants availed free drugs, 40% free diagnostics, 10% sick infants free home to facility transport and 28% free drop back home.
- Services of community health volunteers called **Accredited Social Health Activists (ASHAs)** have been engaged under the mission to work as a link between the community and the public health system. **ASHAs** were useful in Intense monitoring of Polio Progress .As per Annual Report 2014-15 , M/o H&FW, more than 8.96 lakh Accredited Social Health Activists (ASHAs) are in place across the country and serve as facilitators, mobilizers and providers of community level care. Since 2013, when the National Urban Health Mission was launched, ASHAs are being selected in urban areas as well. NRHM/NHM has attempted to fill the gaps in human resources by providing nearly 1.81 lakh additional health human resources to states including 7,974 GDMOs, 2,882 Specialists, 72,505 ANMs, 37,966 Staff Nurses etc. A total of 21,361 AYUSH doctors have been deployed in the states with NRHM funding support.
- **Institutional Delivery: Janani Suraksha Yojana** (JSY) aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a

government health facility. Since the inception of NRHM, 7.33 crore women have benefited under this scheme.

- **Mother and Child Tracking System:** MCTS is designed to capture information on and track all pregnant women and children (0-5 Years) so that they receive 'full' maternal and child health services and thereby contributes to the reduction in maternal, infant and child morbidity and mortality which is one of the goals of National Health Mission. A total of 1,12,84,510 pregnant women were registered in MCTS during 2014-15 (till October), which indicates a registration of 65.81% as against estimated number of pregnant women in 2014-15 (till October). Similarly, a total of 84,33,911 children were registered in MCTS during 2014-15 (till October) which indicates a registration of 54.10% as against estimated number of infants till October).

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

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

30.15 New Initiatives taken under NRHM during recent past are as under :

- **India Newborn Action Plan (INAP):** The India Newborn Action Plan (INAP) was launched on 18th September, 2014. It outlines a targeted strategy for accelerating the reduction of preventable newborn deaths and still births in the country.
- **Rashtriya Bal Swasthya Karyakram (RBSK):** This initiative was launched in February 2013 and provides for Child Health Screening and Early Intervention Services through early detection and management of 4 Ds i.e. Defects at birth, Diseases, Deficiencies, Development delays including disability. In 2014-15, 12922 RBSK Mobile Health Teams and

266 Districts Early Intervention Centre have been approved. In the first quarter of 2014-15 (March to June, 2014), about 1.33 crore children have been screened and 8.44 lakhs children have been referred to health facilities for the treatment. About 4.36 lakhs children have received secondary, tertiary care.

- **Rashtriya Kishor Swasthya Karyakram (RKSK):** This is a new initiative, launched in January 2014 to reach out to 253 million adolescents in the country in their own spaces and introduces peer-led interventions at the community level, supported by augmentation of facility based services
- **Free Drugs Service :**Extremely high out of pocket expenditure on health care due to high cost of drugs and diagnostics have proved to be a deterrent in provision of accessible and affordable healthcare for all. To address this, Ministry introduced an incentive last year to the extent of 5 % of the State's Resource Envelope if the state implemented free essential drugs scheme for all patients coming to public health facilities. In 2013-14, about Rs. 2000 crore to support free drugs and about Rs. 292.00 crore (including JSSK) to support free diagnostics were provided under NHM.
- **Mother and Child Tracking Facilitation Centre (MCTFC):** MCTFC has been operationalized from National Institute of Health and Family Welfare (NIHFW). It is being operated by 80 Helpdesk Agents (HAs). It will validate the data entered in MCTS in addition to guiding and helping both the beneficiaries and service providers with up to date information on Mother and Child care services through phone calls and Interactive Voice Response System (IVRS) on a regular basis.
- **National Iron+ Initiative** is another new initiative to prevent and control iron deficiency Anaemia, a grave public health challenge in India. The operational guidelines for the same were unveiled in February 2013. WIFS (10-19 years) has already been rolled out in 32 States and UTs under the National Iron Plus Initiative. WIFS covered around 3.76 crore beneficiaries by March 2014.
- **Reproductive, Maternal, Newborn, Child and Adolescent Health services (RMNCH + A) :** A continuum of care approach has now been adopted under NHM with the articulation of strategic approach to Reproductive Maternal, Newborn, Child and Adolescent health (RMNCH + A) in India.

30.16 National Urban Health Mission: The National Urban Health Mission (NUHM) as a submission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013. NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation,

school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

30.17 NUHM would cover all cities/towns with a population of more than 50,000. Towns below 50,000 population will be covered under NRHM. The Centre-State funding pattern is 75:25 for all the states except North-Eastern States including Sikkim and other special category States of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the Centre-State funding pattern is 90:10 It would cover urban population including slum dwellers; other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers, who may be in slums or on sites. The existing Urban Health Posts and Urban Family Welfare Centres would be taken as existing infrastructure under NUHM and will be considered for up gradation. All the existing human resources will then be suitably reorganized and rationalized.

30.18 New **Urban–Primary Health Centre (**U-PHCs) will be established as per gap analysis, as per norm of one U-PHC for approximately 50,000 urban population. **Urban-Community Health Centre (U-CHC) and Referral Hospitals:** 30-50 bedded UHCs will be established for providing in-patient care. U-CHCs will be set up in cities with a population of above 5 lakhs. **Outreach services:** NUHM will also support engagement of ANMs for conducting outreach services for targeted groups

30.19 In the 12th Plan, an allocation of Rs.15,143 crores has been made for NUHM. Rs. 1000 crore were provided in the Revised Estimate of 2013-14 for NUHM out of which an amount of Rs.662.23 crore was released to 29 States/UTs. An outlay of Rs.1924.43 crore has been allocated for the Financial Year 2014-15.

Performance of India on various indicators related to health & family welfare :

30.20 The demographic and health status indicators have shown significant improvements. The following table captures data on mortality, fertility & other vital statistics.

Sl. No.	Parameters	1951	1981	1991	2001	Current Levels
1	Crude Birth Rate (per 1000 population	40.8	33.9	29.5	25.4	21.4 (2013)
2	Crude Death Rate (per 1000 population)	25.1	12.5	9.8	8.4	7.0 (2013)
3	Total Fertility Rate	6.0	4.5	3.6	3.1	2.3 (2013)

4	Maternal Mortality Ratio (per 100,000 live births)	NA	NA	398 SRS (1997-98)	301 (2001-03)	167 (2011-13)
5	Infant Mortality Rate (per 1000 live births)	146 (1951-61)	110	80	66	40(2013)
7	Couple Protection Rate (%)	10.4 (1971)	22.8	44.1	45.6	40.4(2011)
8	Expectation of life at birth (in years) -Male -Female	37.1 36.1 (1951)	54.1 54.7	60.6 61.7 (1991-96)	61.8 63.5 (1999-03)	67.3 69.6(2011-15)

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

30.21 Estimated birth rate, death rate and natural growth rate are showing a declining trend. The population, however, still continues to grow, though at a slower pace. Amongst bigger states, in 2013, Bihar recorded highest birth rate (27.6) followed by U.P (27.2) whereas Kerala recorded lowest birth rate of 14.7. MP & Odisha recorded highest death rate of 8.0 and 8.4 respectively, much higher than the national average of 7.0 As per the latest data , maternal mortality ratio was highest for Assam (300 per lakh live births) and lowest for Kerala(61 per lakh live births) during 2011-13. Infant Mortality rate has declined considerably by 2013 ; however there is a huge gap between IMR of rural (44 per thousand live births) and urban (27 per thousand live births).

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

EXPECTATION OF LIFE AT BIRTH

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

Source:

(a)Office of the Registrar General, India.

(b)Occational Paper SRS No. 3 of 1995

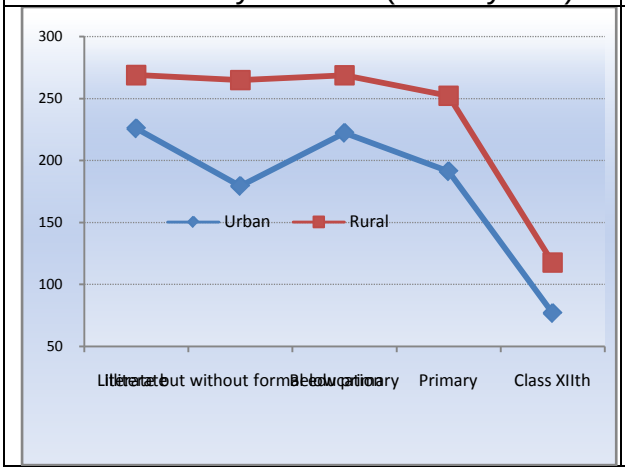
(c)Report of the Technical Group on Population Projections, 1996-2016(Registrar General,

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

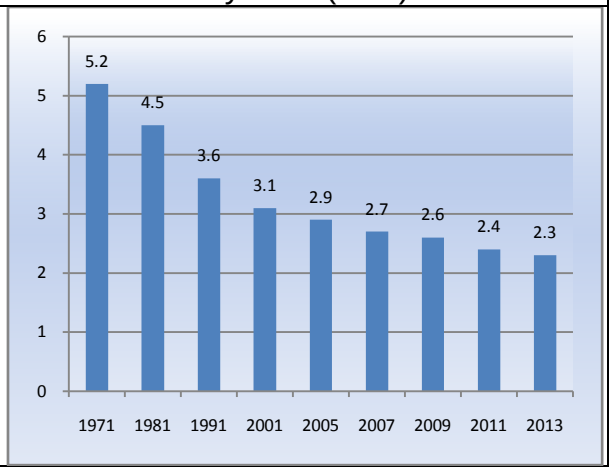
30.23 Fertility Indicators : Age Specific Fertility Rates (ASFR) & Total Fertility Rates(TFR) (2013) : As per Estimates of Fertility Indicators, SRS Statistical Report 2013 , fertility in all the age groups is higher in rural areas than in urban areas. The fertility reaches the peak in the age group 20-24 and usually declines thereafter, irrespective of the place of residence. ASFR curve for urban areas falls under the ASFR curve of rural areas. Rural ASFR curve has declined very steeply after attaining peak for age 20-24 where as urban ASFR curve has gradually declined up to the age 25-29 after attaining peak at age group 20-24. During the last decade, decline in fertility rates is more in urban areas compared to rural areas except in the age groups 25-29, 30-34 and 35-39. The decline is perceptible for the higher age groups 40-49 in urban areas. Except for Jammu & Kashmir & Kerala, where fertility reached its peak in the age group 25-29, the highest fertility in all the other bigger States has been attained in the age group 20-24.

30.24 As per SRS 2013, TFR in eight states has fallen below two children per woman . Just nine states , all of them in the north and east , except Gujrat – haven't yet reached replacement levels of 2.1 , below which the population begins to decline. West Bengal now has India's lowest fertility rate along with the southern sates, J&K, Punjab and Himanchal Pradesh. The TFR for India in the year 2013 was 2.3 per woman and varied from 2.5 in rural areas to 1.8 in urban areas. Among the bigger States, it varies from 1.6 in West Bengal to 3.4 in Bihar.

Level of Literacy & ASFR (20-24 years)



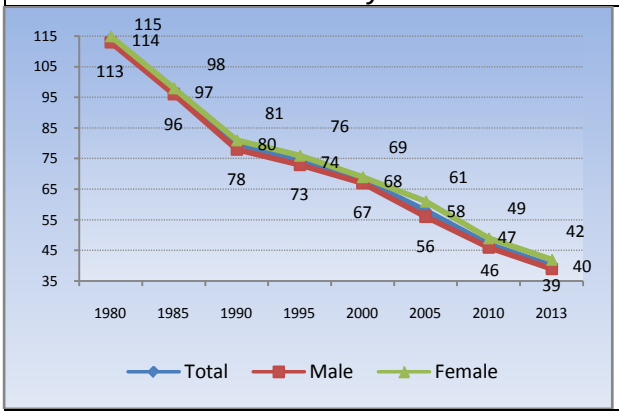
Total Fertility Rate (TFR)



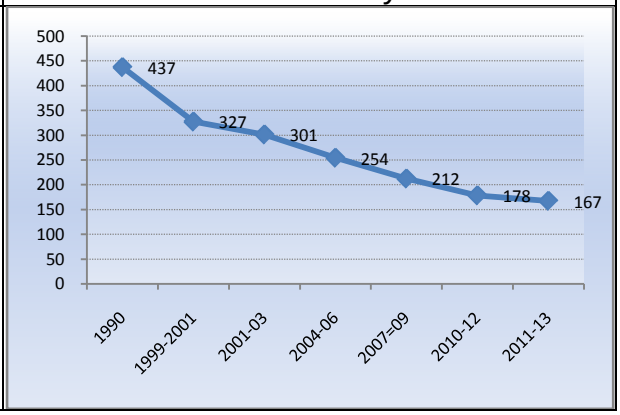
30.25 Maternal & Child Health : India had accepted targets for reduction in **child & maternal mortality** under MDGs & considerable progress has been made though it is likely to miss both the targets as per historical trend. Infant mortality rate has declined significantly (40 per

1000 live births in 2013), however urban (27) – rural (44) differentials and those between male(39) & female (42)infants death are still high .

Infant Mortality Rate



Maternal Mortality Rate



30.26 As per HMIS portal (8.10.2015), during 2014-15, 28.4 million women got registered for ante natal care (ANC) check up compared to 29.0 million in the previous year registering decrease of 1.9 %. The number of women who needed ANC during 2014 -15 , was assessed to be 29.7 million. Accordingly the achievement in terms of registration for ANC to total was 95.6 % . Out of those registered for ANC during 2014-15, 22.1 million (77.7 %) received 3 ANC check ups. The institutional deliveries to total deliveries (Institutional + home) increased from 56.7 % in 2006-07 to 85.5% in 2013-14 and further to 86.9% in 2014-15 as the number of institutional deliveries increased by more than 80,000 during 2014-15 to reach 17.6 million compared to 17.5 million in the year before. Even with the increase in deliveries attended by skilled personnel, the targeted universal coverage might still be elusive.

Performance of Indicators related to maternal health

	MATERNAL HEALTH	All India (2013-14)	All India (2014-15)
1	Annual Estimated Pregnant Women *	29,339,000	29,718,200
2	Annual Estimated Deliveries *	26,671,000	27,016,300
	ANC	**HMIS (Apr 13-Mar 14)**	**HMIS (Apr 14-Mar 15)**
3	Total number of Pregnant women registered for ANC	28,958,717	28,544,539
4	Of Which Registered in First Trimester (to total ANC regd.) %	57.9	60.6
5	Mothers who had at least 3 ANC check ups (to total ANC regd.) %	75.3	77.4
6	Mothers who got TT1 injection (to total ANC regd.) %	76.4	76.4
7	Mothers who received 100 IFA tablets (to total ANC regd.)%	80.1	83.6
8	Total reported Institutional deliveries (to total annual estimated deliveries) %	65.6	64.5
9	Total reported Institutional deliveries (to total reported deliveries) %	85.5	86.8

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

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

30.27 Immunization: In India, under **Universal Immunization Programme (UIP**) vaccines for six vaccine-preventable diseases (TB, diphtheria, pertussis, tetanus, poliomyelitis and measles) are provided free of cost to all. Government of India declared **2012 as "Year of Intensification of Routine Immunization" (IRI).**

30.28 Progress in Immunization (as per HMIS portal:8.10.2015) during 2014-15 vis a vis the year before is tabulated below:

New born care	HMIS (Apr 13-Mar 14)	HMIS (Apr 14-Mar 15)
	All India	All India
Immunisation coverage		
Infants fully immunized to reported live births (BCG,3 dose each of DPT and Polio and Measles) %	107.1	108.3
Infants received BCG to fully Immunisation %	105.5	107.2
Infants received 3 doses of Polio to fully Immunisation %	101.6	101.2
Infants received 3 doses of DPT to fully Immunisation %	84.5	79.9
Infants received Measles to fully Immunisation %	100.5	101.3

High % of immunization may be due to reporting of immunization of a beneficiary by more than one facility.

Performance Related to Immunisation

	Need Assessed (2014-15)	Achievement during April to March			% Achievement of
		(2014-15)	(2013-14)	% Change	need assessed (2014-15)
	(A)	(B)	(C)	(D=((B-C)/C)*100)	(E=(B/A)*100)
Diphtheria, Pertussis and Tetanus (DPT3)	2,59,28,000	1,78,49,618	2,06,62,605	-13.6	68.8
Bacillus Calmette Guerin (BCG)	2,59,28,000	2,40,16,628	2,53,97,080	-5.4	92.6
DT (2nd Dose) or DPT5	2,38,10,000	1,24,51,043	1,20,36,239	3.4	52.3
Tetanus Toxoid (TT10)	2,47,16,000	1,41,90,773	1,56,15,199	-9.1	57.4
Tetanus Toxoid (TT16)	2,59,04,000	1,39,65,581	1,49,94,299	-6.9	53.9

30.29 On 27th March 2014, India along with South-East Asia Region of WHO has been certified **polio free** by Regional Certification Commission for polio eradication.

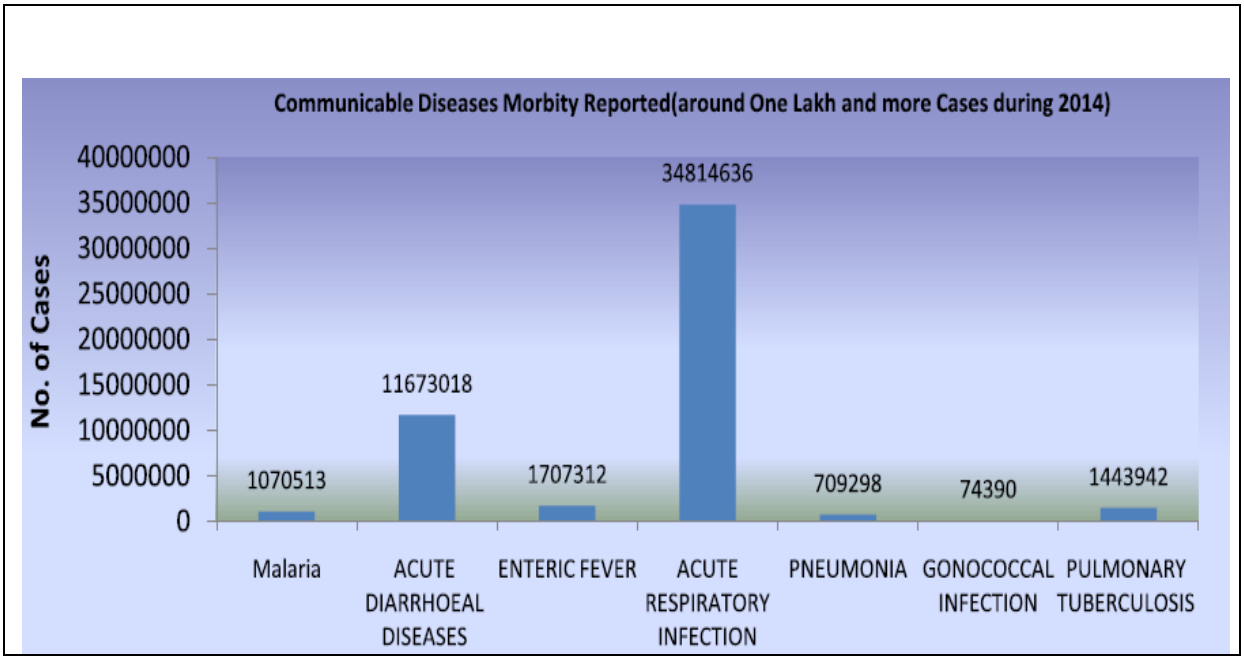
Disease burden indicators: Communicable, non communicable diseases

30.30 Although non communicable diseases like cancer, diabetes, cardio vascular diseases , chronic obstructive pulmonary diseases etc are on the rise due to urbanization and change in life style , communicable diseases like tubercluosis, malaria, dengue fever and other vector borne diseases , and water borne diseases like cholera, diarrhoeal diseases etc continue to be a major public health problem in India. In fact diarrhoeal diseases, respiratory infections, tuberculosis and malaria cause about one quarter of all deaths in the country. Acute respiratory infections are showing an increasing trend. Overall prevalence of malaria diminished in 2012 and 2013 but there was slight increase in the year 2014 all over the country.

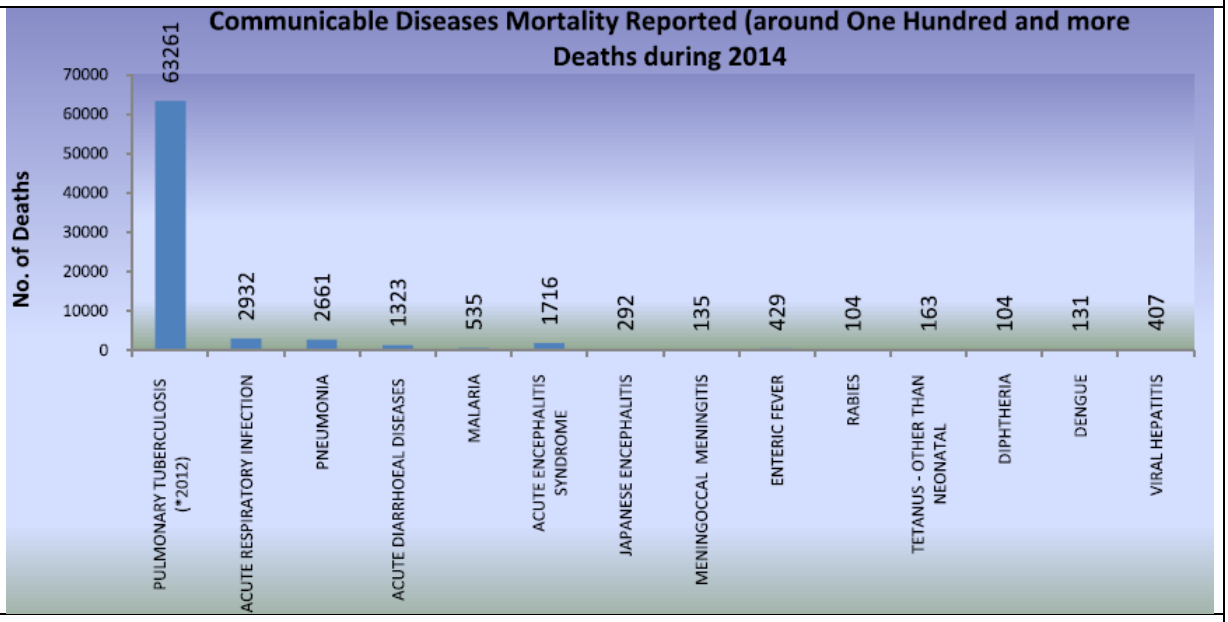
30.31 Among the various **communicable diseases** reported by the States/UTs during the year 2014, while taking a cut off of one lakh or more cases; the communicable diseases which accounted for the maximum number of cases & fatalities reported have been talked about in the graphs given below.

Morbidity & Mortality due to communicable diseases 2014

Morbidity due to communicable Diseases
(around 1 lakh or more cases – 2014)



Mortality due to communicable Diseases
(around 100 or more deaths – 2014)



Diseases with High Case Fatality Rate (About 1% and above) during 2014, as reported by the States/UTs.

No.	Disease	Cases	Deaths	Case Fatality Rate (%)
	RABIES	104	104	100
	ACUTE ENCEPHALITIS SYNDROME	10834	1716	15.84
	TETANUS - OTHER THAN NEONATAL	5513	163	2.96
	MENINGOCCAL MENINGITIS	4210	135	3.21
	PULMONARY TUBERCULOSIS (2012)	1467585	63261	4.31
	H1N1 (SWINE FLU)	937	218	23.27
	TETANUS - NEONATAL	572	17	2.97
	DIPHTHERIA	4071	104	2.55

Source: National Health Profile 2015

30.32 According to National AIDS control organization, 8,38,796 patients from 467 ART Centres have ever started anti retroviral therapy (ART) in the country till December, 2014. As per Department of AIDS control, total number of people living with HIV /AIDS (PLHA) in India was estimated to be around 17.2 lakh- 25.3 lakh during 2011 with around 1.16 lakh newly infected during the year.

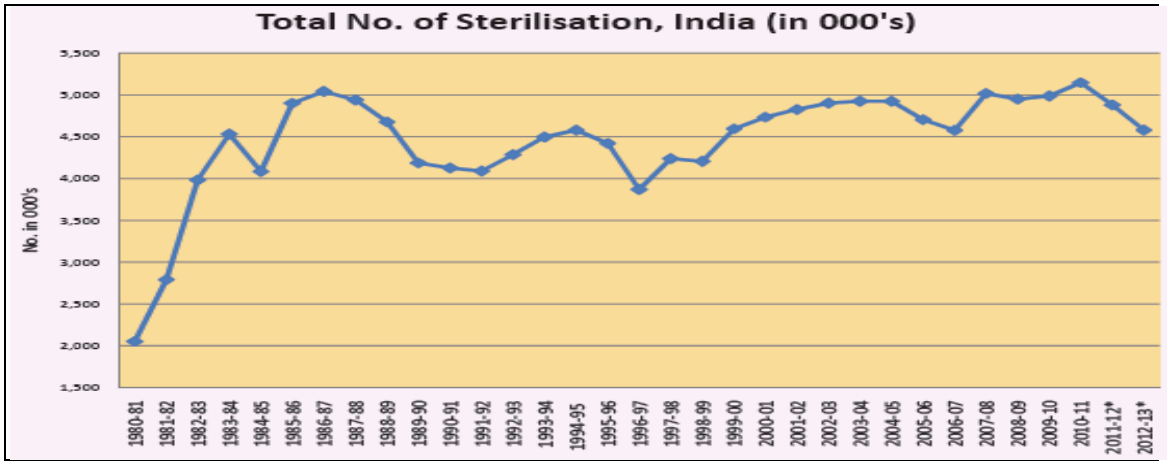
30.33 As per National Health Profile 2015, based on available evidence, cardio vascular diseases (24%), chronic respiratory diseases (11%), Cancer (6%) and diabetes(2%) among the **non communicable** diseases are the leading cause of mortality in India.

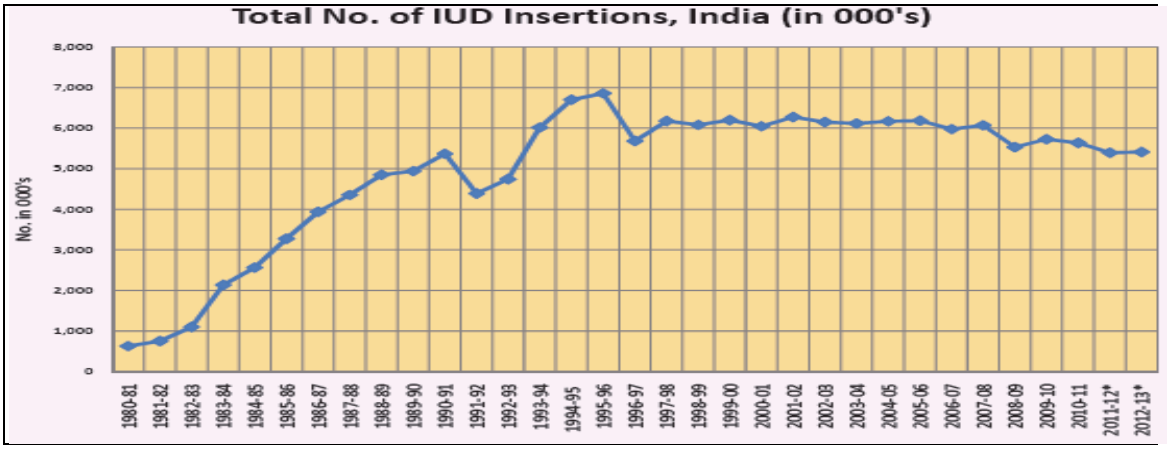
30.34 Data from National Programme for Prevention and Control of Cancer, Diabetes, Cardio Vacsular Diseases and Stroke (NPCDCS) reveals that as on 31st March 2015 , out of 5.8 million patients who attended , 5.6 lakh were diagnosed with diabetes, 7.2 lakh with hypertension, about

61 thousand with CVDs and about 11 thousand with common cancer. As per National Cancer Registry Programme, ICMR about 5.5 lakh males and 6.0 lakh females were projected to have cancer during 2015.

30.35 Family Planning: As per HMIS(8.10.2015), out of the estimated 130.1 million estimated number of unsterilized eligible couples during 2014-15 , 4.0 million were sterilized during the year, a decrease of 14.4 per cent from 4.7 million sterilizations during 2013-14 . Decrease in oral pill users during 2014-15 was more drastic as the number decreased from 6.1 million (3.2 million free distribution, 2.8 million social marketing distribution) from the previous year to 3.2 million (3.1 million free distribution, 0.1 million social marketing distribution) during 2014-15, a decrease of about 47 per cent. Sharp decline of about 65 per cent was also observed in case of condom users as their number decreased from 12.8 million (4.8 million free distribution, 8.0 million social marketing distribution) during 2013-14 to 4.5 million (4.3 million free distribution, 0.1 million social marketing distribution) during 2014-15. However, the decline in number of IUCD insertions was less pronounced (from 5.4 million during 2013-14, to 5.3 million during 2014-15).

30.36 Progress made in last few decades in the adoption of measures of family planning is indicated in the following charts.





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

30.38 The outlays have been substantially enhanced from Rs. 1,40,135.00 crores in the 11th Five Year Plan to Rs. 3,00,018.00 crores for the 12th Five Year Plan, which is 2.14 times the 11th Plan outlay.

30.39 As per National Health Profile 2015, the total public expenditure on health for the year 2012-13 stood at Rs 1.08 lakh crore. Share of Ministry of Health & FW was 26% of the total health expenditure of the government whereas the share of other Central Ministries was 7% and the share of State and UTs was 67%. There hasn't been any significant change in public expenditure on health in terms of percentage of GDP since 2009-10. It stood at 1.08 % of GDP in 2012-13.The share of Centre in total public expenditure on health has been declining steadily over the years and was 33 per cent in 2012-13.North Eastern States (including Assam) had the highest and EAG States the lowest average per capita public expenditure on health in 2012-13 (excluding UTs). Out of pocket (OOP) medical expenditure incurred during 2011-12 was Rs 146 per capita per month for urban and Rs 95 for rural India and over 60 per cent of the total OOP health expenditure was on medicines, both in rural and urban India.

Plan Period	Approved Plan Outlay (BE) (Rs. In crores)						Plan Expenditure (Rs. In crores)		
Year	Health	NRHM/ NHM	Health Research	AIDS Control	AYUSH	Total	Health	NRHM	Total
12th Plan (2012-17)	75145.29	193405.71	10029.00	11394.00	10044.00	300018.00	...	...	...
2012-13	6585.00	20542.00	660.00	1700.00	990.00	30477.00	8111.21	16970.50	25081.51
2013-14	8166.00	20999.00	726.00	1785.00	1069.00	32745.00	8609.72	18295.17	26904.89
2014-15	8733.00	21912.00	726.00	1785.00	1069.00	34225.00	3357.50	15103.71	18461.21 *

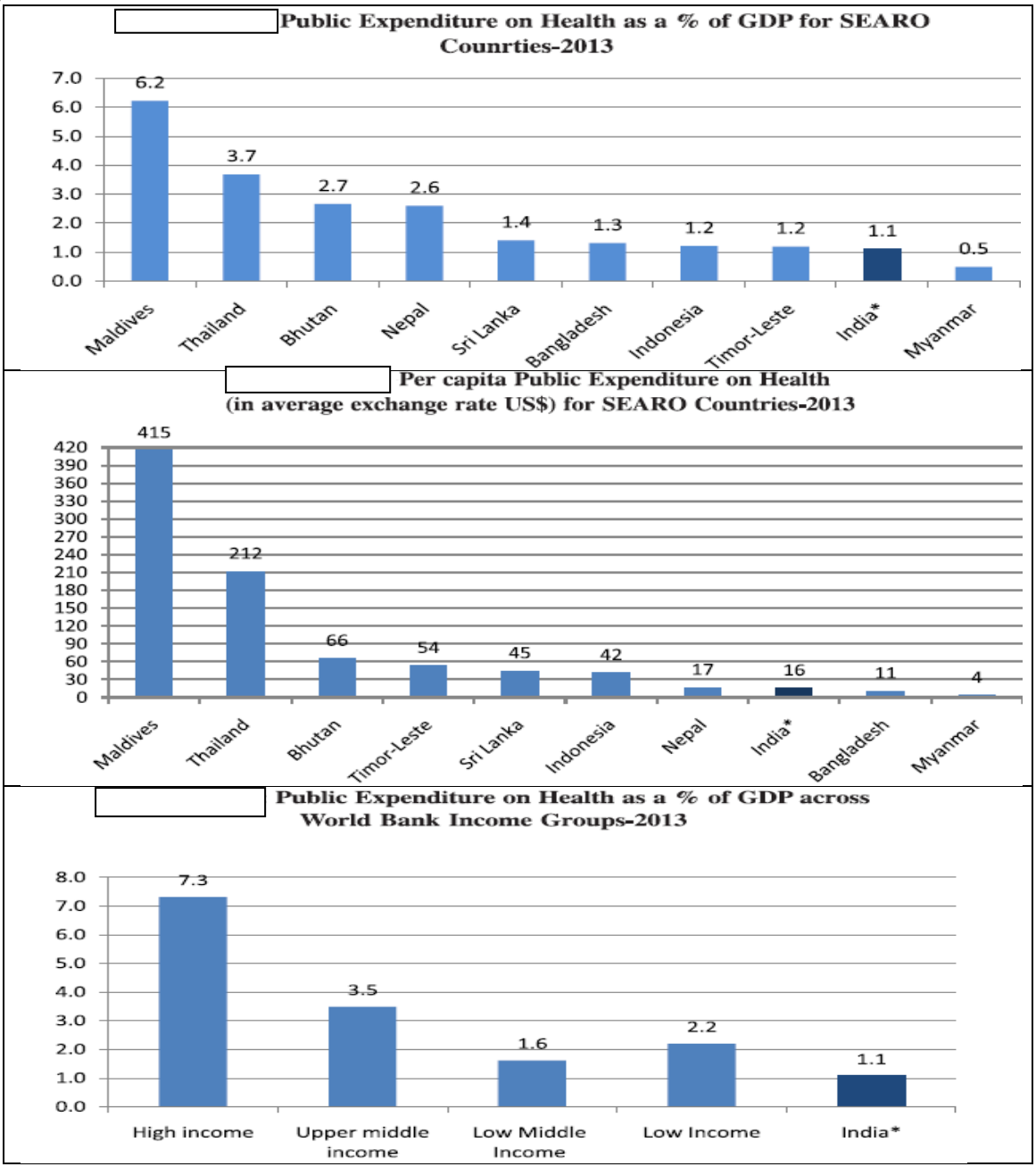
(upto 31.12.2014)

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

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

Figures in brackets indicate percent to total plan investment outlay

30.40 As per Global Health Observatory, World Health Organization database, public health expenditure in India is low, both in terms of percent to GDP and per capita expenditure. In fact, India's public spending on health as per cent of GDP is one of the lowest among SEARO countries. It is also lowest among BRICS countries. The per capita public spending is quite low in comparison to countries that have universal health coverage or are moving towards it. Cross country comparison during 2013 is given below:



30.41 Human Resource & Infrastructure Indicators: As per National Health Profile 2015, the achievements in health infrastructure in terms of educational & service infrastructure are as follows:

30.42 Human Resource : Number of registered allopathic doctors possessing recognized medical qualifications and registered with state medical councils for year 2013 and 2014 were 32,461 and 15,976 respectively. At present, average population served per Govt allopathic doctor is 11,528 . There has been marked improvement in the dentist to population ratio . Number of dental surgeons registered with Central/ State Dental Councils of India up to 31.12 2014 were 1,54,436. Total number of registered AYUSH doctors in India has also increased from 6,68,319 in 2013 to 7,36,538 in 2014 with 54 % dealing with Ayurveda and 38% with Homeopathy. There were total of 7,86,061 Auxiliary Nurse Midwife (ANM) serving in India.

S.No.	National Councils Registered (Latest)	Population Served per Doctor/Dental surgeon/ AYUSH/ Nurse/Phamacist*
1	Per Doctor both Allopathic and AYUSH	1472.73
1.1	Allopathic Doctor	1319.57
1.2	AYUSH Doctor	1682.04
2	Dental Surgeon	8022.00
3	Nurse	482.79
4	Pharmacist	1865.29

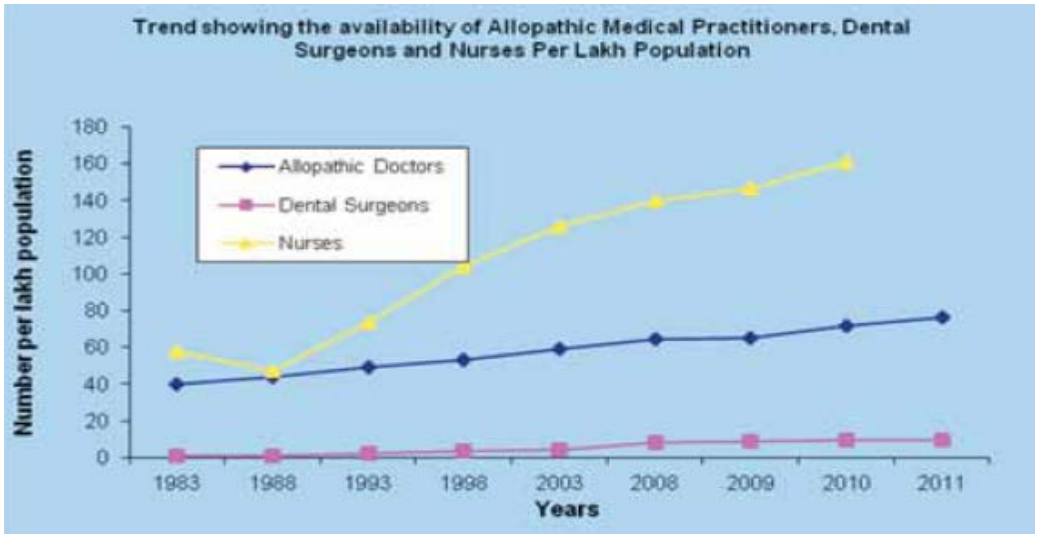
Note-

(i) Provisional Population of India as on 1st March 2014.

(ii) Total No. of registered Nurses/ Pharmacists (Latest) as provided by respective National Councils 2014 (Chapter-5)

(iii) Total No. of registered doctors as provided by Medical Council of India

Source: Medical Council of India , Dental Council of India , Ministry of AYUSH , Indian Nursing Council , Pharmacy Council of India

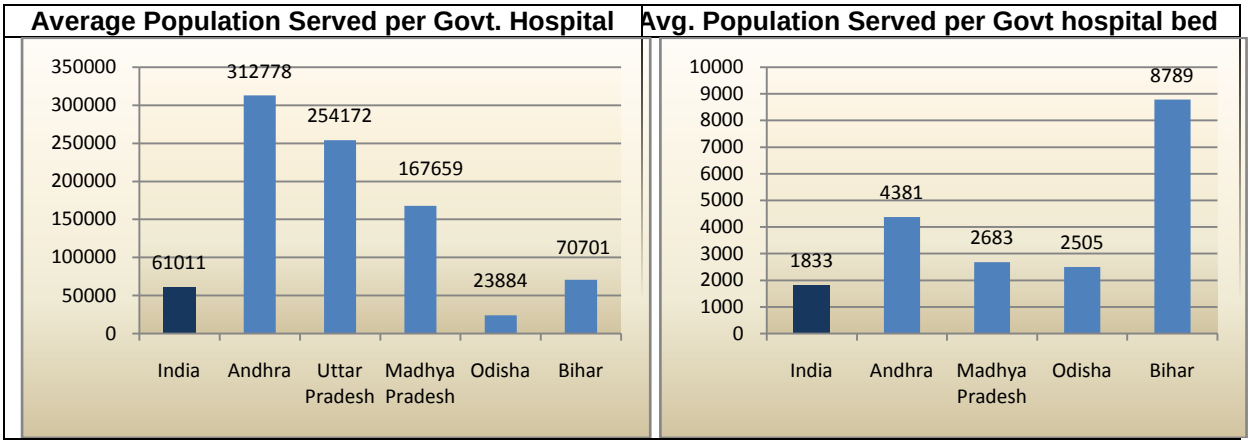


30.43 Educational Infrastructure: Medical education infrastructures in the country have shown rapid growth during the last 20 years. The country has 398 allopathic medical colleges and 305 dental colleges. Total admission of 46,456 in 381 medical colleges (excluding 41 colleges that did not report) & 26,240 in BDS colleges was reported during 2014-15 . There were 2865 Institutions for General Nurse Midwives with admission capacity of 1,15,844, about 1,853 institutions for ANMs with admission capacity of 52,479 and 723 colleges for pharmacy (diploma) with an intake capacity of 43,300 as on 31st Dec 2014.

30.44 Services Infrastructure: As per National Health Profile 2015, there were 20,306 Govt. hospitals having 6,75,779 beds in the country . Out of them, 16,816

hospitals were in rural area with 1,83,602 beds and 3,490 hospitals in urban area with 4,92,177 beds. There were 1,52,326 Sub Centers, 25,020 Primary Health Centres and 5,363 Community Health Centres in India as on 31st March 2014. As on 1.4.2014 26,102 dispensaries and 3,631 hospitals(including CGHS) were providing medical care facilities under AYUSH and the total number of licensed blood banks in the country till February 2015 was 2,760 whereas the number of functional eye banks as on 9th January 2015 was 249.

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



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

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

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

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

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

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

(f) Finance: GNP, Government Revenue and Expenditure, allocation for health, budget estimates, sources of health finance, expenditure on health by voluntary agencies and other NGOs, private expenditure on health, etc.

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

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

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

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

30.50 The **Department of Health & Family Welfare** is responsible for implementing programmes for population control and maternal and child health now renamed as Reproductive and Child Health. The Family Welfare programme is a Centrally-sponsored programme implemented by the respective States and UTs. The information flow starts from the peripheral level where the service delivery takes place. In the sub-centers, ANMs are responsible for the maintenance of records in

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

30.51 Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homeopathy (AYUSH) maintains information on infrastructure, manpower**,** College / Institutions, expenditure etc related with these systems of medicine as an ancillary activity of promoting them & monitoring the progress of various schemes.

30.52 The license registers for various categories of doctors, dentists, pharmacists, nurses, health visitors, etc provide data about **manpower** and are consolidated by **statutory councils** such as the **Medical Council of India, Dental Council of India and Nursing Council** etc.

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

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

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

- **International Institute for Population Sciences (IIPS)** has been declared as the nodal agency (for coordinating & providing technical guidance for the survey) by

Ministry of Health & Family welfare for two important health surveys viz. **National Family Health Survey (NFHS) & District Level Household & Facility Survey (DLHS).**

- The **National Family Health Survey (NFHS)** is a large-scale, multi-round survey conducted in a representative sample of households throughout India. Three rounds of the survey have been conducted since the first survey in 1992-93 and $NFHS_4$ is under progress. The survey provides state and national information for India on fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services. The funding for different rounds of NFHS has been provided by USAID, DFID, the Bill and Melinda Gates Foundation, UNICEF, UNFPA, and MOHFW, GOI. The first survey **($NFHS_1$)** was conducted in 1992-93, second **($NFHS_2$)** in 1998-88, third **($NFHS_3$)** in 2005-06 and the fourth one **($NFHS_4$)** was to be implemented in 2014-15.

- **District Level Household & Facility Survey (DLHS)** was initiated in 1997 with a view to assess the utilization of services provided by government health care facilities and people's perception about quality of services. $DLHS_3$ (2007-08) is the third in the series of district surveys, preceded by **$DLHS_1$** in 1998-99 and **$DLHS_2$** in 2002-04. Like earlier rounds $DLHS_3$ provides estimates on important indicators on maternal & child health, family planning & other reproductive health services . In addition, it provides information on important interventions of National Rural Health Mission (NRHM) . It interviewed ever married women (age 15-49) and never married women (age 15-24) besides currently married women(age 15-44), the only category of women interviewed in earlier rounds. **$DLHS_4$** (2012-13) was also planned in 26 states where Annual Health Survey (AHS) is not being done.

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

- The **National Sample Survey Office, Ministry of Statistics & PI** also conducts demographic surveys, which have been providing information on some aspects of mortality and morbidity and **household expenditure on health services** and facilities.
- Occasional surveys like **Coverage Evaluation Survey 2009 (CES-2009)** conducted by **UNICEF** also provide valuable insights. CES 2009 was a nationwide survey covering all States and Union Territories of India, conducted during November 2009 to January 2010. It was funded by IKEA Social Initiative and ORG – Centre for Social Research carried out the survey in the field. UNICEF had conducted the survey, at the request of Government of India, to assess the impact of NRHM strategies on coverage levels of maternal, newborn and child-health services including immunization among women and children.
- **Office of Registrar General of India, Ministry of Home Affairs** provides much information on vital statistics through its system of **Civil Registration** (mandatory registration of births & deaths) **(CRS)** & **Sample Registration (SRS)-** dual record household panel survey with sampling units retained for about ten years . These provide information on fertility, mortality (infant & maternal mortality) , sex

ratio at birth etc. However, only **state level estimates** are provided by **SRS** which constrained decentralized district based health Planning in view of the large inter district variations . Consequently, **Annual Health Survey** was conceived in 2005 with an aim to have “Survey of all districts which could be published/ monitored and compared against benchmarks” . The objective was to monitor the performance and outcome (at **district level**) of various health interventions of the Government including those under National Rural Health Mission (NRHM), Ministry of Health & Family Welfare at closer intervals through these benchmark indicators. AHS has been designed to yield benchmarks of core vital and health indicators at the district level on fertility and mortality; prevalence of disabilities, injuries, acute and chronic illness and access to health care for these morbidities; and access to maternal, child health and family planning services. AHS has been implemented by the Office of Registrar General, India in all the 284 districts (as per 2001 Census) in 8 Empowered Action Group States (Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Orissa and Rajasthan) and Assam for a three year period during XI Five Year Plan period. The fieldwork for Baseline Survey was carried out during July, 2010 to March, 2011. Three rounds of the survey have been completed in the years 2010-11, 2011-12 and 2012-13 and the results of all the rounds containing 161 vital and health indicators have been published in the form of district level bulletins and factsheets. To supplement the information provided by Annual Health Survey (AHS), a biomarker component has been introduced in AHS to collect data on nutritional status, life style diseases like diabetes & hypertension and anemia in Empowered Action Group (EAG) States & Assam. This component, namely **Clinical, Anthropometric and Bio-chemical (CAB) survey**, was conducted in 2014 on a sub-sample of AHS in all EAG States namely Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand & Uttar Pradesh and Assam. Report on **Medical Certification of Cause of death** based on Civil Registration System is also brought out by O/o Registrar General of India.

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