5.4.1 HEALTH

India was one of the pioneers in the planning of health service with a focus on primary health care. Improvement in the health status of the population has been one of the major thrust areas of the social development programmes of the country. This was to be achieved through improving the access to and utilisation of Health, Family Welfare and Nutrition Services with special focus on under-served and under-privileged segments of population. The main responsibility for infrastructure and manpower building rests with the State Governments with funds from State Non-Plan and Plan supplemented by funds from the Central Government and external assistance. Over the last five decades a massive infrastructure has been created to provide Primary, Secondary and Tertiary level health care services to the urban and rural populations. Major disease control programmes and the Family Welfare Programmes are funded by the Centre (some with assistance from external agencies) and are implemented through the infrastructure of the State governments. The food supplementation programmes for mothers and children are funded by the State and implemented through the ICDS infrastructure funded by the Central Government. Safe drinking water and environmental sanitation are essential pre-requisites for health. Initially these two activities were funded by the Health Department, but subsequently the Department of Urban and Rural Development and the Department of Environment fund these activities both in the State and Centre. Technological improvement and increased access to health care have resulted in a steep fall in mortality but disease burden due to communicable diseases, non-communicable diseases and nutritional problems continue to be high. In spite of the fact that norms for creation of infrastructure and manpower are similar throughout the country, there are substantial differences between the States and districts in the same state in availability and utilisation of health care services and health indices of the population.

2. The Special Action Plan for Health envisages expansion and improvement of the health services to meet the increasing health care needs of the population; no specific targets have been set. Utilisation of health care facilities created at the primary, secondary and tertiary care level have resulted in a decline in overall mortality, but morbidity continues to be high. However, the Special Action Plan envisages improvement of the health services to meet the increasing health care needs of the population.

PRIMARY HEALTH CARE SERVICES

3. The primary health care infrastructure provides the first level of contact between the population and healthcare providers. Realising the importance of the primary health care infrastructure in delivery of health services, the States, the Centre and several agencies simultaneously started creating primary health care infrastructure and manpower. This has resulted in substantial amount of duplication of infrastructure and manpower; inspite of this there are under-served areas where the need for the health services are very great. The problem is mainly one of inequitable distribution of existing institutions and manpower as well as poor functional status due to:

(i) mismatch between personnel and infrastructure;

(ii) need for orientation and skill upgradation of personnel; and

(iii)lack of appropriate functional referral system.

4. The primary health care infrastructure created by the states in rural areas under the modern system of medicine include:

- Sub-centres 137271.
- Primary Health centres 22975.
- Community Health centres 2935.
- In addition in all states there are sub-divisional/Taluk hospitals.
- The Department of Family Welfare supports personnel in 5435 rural family welfare centres, and has created 871 urban health posts, 1083 urban family welfare centres, 550 district postpartum centres and 1012 sub-district postpartum centres.
- Under the Department of ISM&H there are 22,104 dispensaries, 2862 hospitals, 300 medical colleges.
- Municipalities provide urban health services.
- CGHS provides health care for Central Govt employees.
- Railways, defence and similar large Departments have their own hospitals and dispensaries for providing for the health care needs of their staff.
- PSUs and large industries have their own medical infrastructure.
- ESI provides hospital and dispensary based health care to employees.
- All hospitals - primary, secondary or tertiary care also provide primary health care services to rural and urban population.

5. The available data on health care infrastructure is given in Annexure 5.4.1.1. Over and above all these there are the voluntary organisations and the private sector providing heath care.

6. It is important to take into account all these before estimating the gaps in infrastructure and manpower. It is possible to achieve substantial improvement in coverage and quality of health services by appropriately restructuring the existing infrastructure making them responsible for health care for the population in a defined geographic area. Similarly a substantial proportion of the manpower problems can be sorted out by appropriate reorientation and re-deployment of existing manpower.

Rural Primary Health Care Services

7. During the Ninth Plan there is an absolute and total commitment to improve access to and enhance quality of primary health care in urban and rural areas through an optimally functioning primary health care system. The Ninth Plan and Special Action Plan have given high priority for improving the functional status and efficiency of operation of the primary health care infrastructure by:

- Streamlining existing urban and rural primary health care institutions by appropriate reorganisation.
- Ensuring that all these institutions are made fully operational.
- Filling the gaps in Community Health Centres (CHCs) through re-structuring and strengthening existing block level PHC and Taluk, Sub-divisional hospitals.
- Providing need based manpower on the basis of distances, difficulties and work load.

- Providing essential equipment, consumables and drugs.
- Establishing functional referral linkages.

8. At the national level the total number of functional Sub centres and the PHCs nearly meets the set norms (one sub-centre for 3000-5000 population, one Primary Health Centre for 20,000-30,000 population) for the population in 1991. The requirement of primary health care infrastructure (as of 1991 population) and the current status of primary health care infrastructure is given in Table 5.4.1.1.

TABLE 5.4.1.1
Rural Primary Health Care Infrastructure/Manpower

Category of Centre	Requirement for 1991	Functioning as on 30.6.99	Gap/(Surplus)
Sub-Centre	134108	137271	(3163)
PHCs	22349	22975	(626)
CHCs	5587	2935	2652
ANMs At SC	134108	134086	22
Doctors At PHCs	22349	25506	(3158)
Specialists At CHCs	22348	3741	18724

Source: Ministry of Health and Family Welfare.

9. Even though a vast infrastructure has been created, it is functioning sub-optimally. The factors responsible for the sub-optimal functioning of rural Primary Health Care Institutions are:

- Multiple tiers of institutions which had been created at various times and are not organised to take care of health needs of defined population.
- Inappropriate location, poor access and poor maintenance;
- Gaps in critical manpower;
- Mismatch between personnel and equipment;
- Lack of essential drugs/diagnostics and poor referral linkages.

10. In spite of the fact that the norms for creation of infrastructure and manpower are similar throughout the country, there are substantial differences between states and between districts in the same state in the availability and utilisation of health care services and health indices of the population. Attempts are being made to minimise these gaps. It is a matter of concern that many of the districts with poor health indices do not have adequate health infrastructure.

11. In addition to the classical PHC, the States have a large number of rural hospitals and dispensaries in modern system of medicine and ISM&H. In addition to CHCs there are block level PHCs, Taluk Hospitals, Sub Divisional Hospitals & Sub District Postpartum Centres. The Ninth Plan envisages that all the states will restructure the existing rural hospitals/dispensaries as PHCs and existing sub-district taluk hospitals to CHCs so that gaps in infrastructure are minimised. Earmarked funds under BMS could be utilised for completing the restructuring and strengthening of these hospitals/dispensaries. Several states

have initiated action to improve access to primary health care services. Some of the ongoing initiatives to improve access to Primary Health Care include:

- Strengthening/appropriately relocating Sub-centres/PHCs.
- Merger, restructuring, re-locating of hospitals/dispensaries in rural areas and integrating them with existing infrastructure.
- Restructuring existing block level PHC level PHC, Taluk, Sub-divisional hospitals-states such as Himachal Pradesh have already undertaken this.
- Utilising funds from BMS, ACA for BMS and EAP to fill critical gaps in manpower and facilities.
- District level walk-in interviews for appointment of doctors of required qualifications for filling the gaps in PHC - States like Madhya Pradesh and Gujarat have reported limited success.
- Use of mobile health clinics - Orissa, Delhi.

12. Currently, in addition to funding through the earmarked basic minimum services in the State Plan Budget, funding from Additional Central Assistance under PMGY externally assisted projects for strengthening health infrastructure and centrally sponsored programmes in Health and Family Welfare provide funding for strengthening infrastructure, covering critical gaps in manpower, equipment, consumables and drugs. Under PMGY, an allocation of Rs.2500 crore has been provided to the states for five sectors comprising primary health, primary education, shelter, drinking water and nutrition. A minimum of 15 per cent of this allocation is to be spent by the states on each of the five sectors. However, the states do have the flexibility to determine the utilisation of the remaining 25 per cent of funds. Funds from PMGY under primary health care may be utilised for strengthening of existing and functioning primary health care institutions (50 per cent) by procurement of drugs and essential consumables and contingency for travel costs for ANMs, repair of essential equipment, repair/replacement of furniture and 50 per cent for strengthening, repair and maintenance of infrastructure in sub-centres, PHCs and CHCs (priority will be given to ensure portable water supply, adequate toilet facilities and waste management).

13. Poor maintenance and consequent deterioration of the buildings and equipment has been a major factor responsible for sub-optimal functioning. Many states are unable to provide funds for these critical activities from Non Plan funds. Under the Reproductive and Child Health Care Programme, Rs.10 lakh per district has been released to the states for minor repair and maintenance of buildings, especially for operation theatres, labour rooms and for improvements in water and electric supply. Rs.10 lakh per CHC/district hospital is also released to all states for major civil works to improve facilities for essential obstetric services through construction/repair of operation theatre, labour room/or to provide/improve facilities for water/electric supply in PHCs, CHCs & district hospitals. A total of Rs.49 crore for minor civil works and Rs.21 crore has been released in the Ninth Plan upto 1998-99.

14. In order to improve the primary health care services, it is important that:

- Construction activity is to be taken up only when it is absolutely necessary.
- High priority to be accorded to filling the reported large gap in the vital CHC/FRU by re-designation and strengthening, providing appropriate equipment, consumables and drugs required.

- Retraining and skill upgradation of male workers in vertical programmes and their redeployment as male multi-purpose workers.
- Mismatches be corrected between infrastructure/equipment and manpower to make institutions fully functional.

15. Planning Commission and Ministry of Health and Family Welfare have developed a proforma for monitoring this process and its impact on utilisation of services. States have been given the proforma and have been requested to send the Annual Progress report.

Health Manpower In Rural Primary Health Care Institutions

16. The number of doctors in PHCs at the national level exceeds the requirement as per the norms. However, there are marked differences in their distribution. The PHCs without doctors and paraprofessionals are mostly located in remote areas where health care facilities provided by the voluntary or private sector are also limited. Some of the innovative approaches to fill the vacancies in under-served areas currently being tried in some States include local recruitment of doctors, if necessary on part-time basis; adoption of a village/PHC/district by industrial establishments, cooperatives, self-help groups and charitable institutions; permitting local practitioners to pay a rental and practice in the PHCs after OPD hours. The usefulness of these approaches is being assessed. As a substantial proportion of specialist posts even in functional CHCs are vacant, these CHCs are unable to function as First Referral Units (FRUs). It is necessary to ensure that specialists are available in the CHCs so that referral patients and those requiring emergency care receive the treatment they need. There are gaps in some of the critical paraprofessional personnel such as lab technicians and male multi-purpose workers. Efforts are under way to provide the required posts of lab technicians under various CSS to fill the gap within this plan period. The number of sanctioned posts of male multi-purpose workers is only half the number required. This has been cited as one of the major factors responsible for the sub-optimal performance in health sector programmes. There are large numbers of male workers employed in the malaria, leprosy and TB Control programmes. They have to be given appropriate retraining and skill upgradation, redeployment as male multi-purpose workers and given the responsibility of looking after all health and family welfare programmes in the area covered by their sub-centres. Funds for these activities are available under States Annual Plan Health Sector Basic Minimum Services (BMS) Outlays, for BMS and Externally Aided Projects; some of the states have state specific Externally Assisted Projects to improve primary health care infrastructure/manpower.

Urban Primary Health Care Services

17. Nearly 30 per cent of India's population lives in urban areas. There is either non-availability or substantial under utilisation of available primary care facilities along with over-crowding at secondary and tertiary care centres. There is a plethora of personnel and beds in public, private, voluntary agencies but these are not geographically linked with clear assignment of responsibilities or referral linkages. The innate difficulty in restructuring of infrastructure is that there are multiple funding agencies.

18. Nagar Palikas, State Governments, Central Ministries and EAPs provide funding for building, upgradation and re-structuring urban primary health care infrastructure and establishing effective linkages. Earmarked funds under BMS and the ACA for BMS, funds from the urban RCH project and from urban component of IPP project can be utilised for the

development of urban primary health care. Planning Commission has provided an ACA of Rs.1.5 crore for strengthening of urban health care services in Municipal Council, Malgaon, Nasik district, Maharashtra in Annual Plan 1999-2000. Though there are several small success stories, the progress in the overall task of restructuring, reorganising the urban primary health care linked to secondary and tertiary care and appropriate retraining and redeployment of personnel has been very slow.

Tribal Areas

19. The population coverage norms for primary health care institutions is 1 PHC per 20,000 population, 1 SC for 3000 population in hilly/tribal areas as against 1 PHC per 30,000 population and 1 SC for 5000 population for the general rural population, in view of distances and sparse population. There are at present 20,799 SCs, 3,306 PHCs and 469 CHCs in tribal areas; in addition there are 1122 Allopathic dispensaries, 120 Allopathic hospitals, 78 Allopathic mobile clinics, 1106 Ayurvedic dispensaries, 24 Ayurvedic hospitals, 251 Homeopathic dispensaries, 28 Homeopathic hospitals, 42 Unani dispensaries, 7 Siddha dispensaries functioning in tribal areas. Similarly, 16,845 SCs, 5987 PHCs & 373 CHCs have been established in Scheduled Caste Basties/Villages having 20 per cent or more SC population; another 980 Allopathic dispensaries, 1042 Ayurvedic dispensaries, 480 Homeopathic dispensaries and 68 Unani/Siddha dispensaries are functioning in schedule caste concentrated areas.

20. Most of the Centrally Sponsored Disease Control Programmes have a focus on tribal areas. Under the NAMP 100 identified districts which are predominantly tribal in Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Orissa and Rajasthan are covered. Several States have had successful experiments in improving primary health care to Tribals:

- Andhra Pradesh - Committed, Government persons running health facilities in tribal areas.
- Orissa - ACA for mobile health units with fixed tour schedule. Problem Expensive, difficult to replicate.
- Karnataka, Maharashtra - NGO `adopting' and running PHCs in Tribal areas.
- Success is mainly due to commitment of individuals and credibility of NGOs.

21. The problems with such experiments are that the initiatives and commitment of key individuals are responsible for success and they are difficult to replicate in a vast system. A new scheme titled Medical Care for Remote and Marginalised Tribal and Nomadic Communities has been initiated in the Ninth Plan. Under this scheme, a research project on `Intervention Programme for Nutritional Anaemia and Haemoglobinopathies amongst some primitive tribal population of India' has been initiated by ICMR.

SECONDARY HEALTH CARE

22. The secondary health care infrastructure at the district hospitals and urban hospitals are currently taking care of the primary health care needs of the population in the city/town in which it is located and also act as secondary care centres; this inevitably leads to overcrowding and under utilisation of the specialised services.

23. Strengthening secondary health care services is an identified priority in the Ninth Plan. In addition to the provision of funds from State Plan, several States have been seeking External Assistance to build up FRU/District Hospitals. So far six States have initiated such projects with external assistance from the World Bank. The States have initiated construction works, procurement of equipments, ambulances and drugs; improvement in services following training to improve skills in clinical management, attitudes and behaviour of health care providers, reduction in vacancies and mismatches in health personnel/infrastructure and improvement in Hospital Waste Management, disease surveillance and response system have been reported. All the six States have attempted introduction of user charges for diagnostics and therapeutics from people above the poverty line. Initial problems have been sorted out. Some States are still unable to ensure retention of collected charges in the same institute. This problem need be speedily resolved.

TERTIARY HEALTH CARE

24. Majority of the tertiary care institutions in the governmental sector lack adequate manpower and facilities to meet the rapidly growing demand for increasingly complex diagnostic and therapeutic modalities. On the other hand, there is overcrowding in tertiary care hospitals due to a lack of a referral system from primary and secondary care levels. There is a need to optimise facilities in the tertiary care centres. The Ninth Plan priorities for tertiary care centres includes provision of funds for capacity building, levying user changes to people above poverty line and exploring alternative modalities to meet the growing cost of care. Several States (e.g. Rajasthan, Uttar Pradesh) are trying out innovative schemes to give greater autonomy to these institutions, allowing them to generate resources and utilise them effectively. Some States e.g. Rajasthan and Kerala have been levying user charges and attempting to utilise the funds to improve hospital services.

DEVELOPMENT OF HUMAN RESOURCES FOR HEALTH

Health Manpower Production

25. India produces over 17,000 medical graduates annually; two-thirds of them go in for postgraduate training. The existing facilities for training of medical graduates have outstripped the needs. In view of this the Medical Council Act was amended in 1993 to ensure that "no person shall establish a medical college and no medical college shall open a new or a higher course of study or training including a post graduate course of study or training or increase in its admission capacity in any course of study or training without the prior permission of the Central Government". After the enactment of the Amendment Act, 1993, the Central Government have permitted establishment of 18 medical colleges, 13 in the private sector and five in the Government sector.

26. It is well recognised that there is a dearth of paraprofessional personnel. Paraprofessionals are trained in three categories of training institutions: existing Government institutions, private institutions and as a part of 10+2 vocational training. There is an urgent need to ensure uniformity in the training curriculum and improvement in quality of paraprofessional training. In view of the substantial differences between districts in terms of paraprofessional manpower required there is a need to assess paraprofessionals required in each district and take steps for training them, preferably through the 10+2 vocational stream. This would ensure that the needs of the district are taken care of and that the posts do not lie vacant as the persons recruited are from the same area.

27. Unlike health service planning, health manpower planning in India has not received adequate attention. There has been very little attempt to assess the requirement in manpower and to match health manpower production with requirement. At the moment only infrastructure and manpower at the primary health care institutions are monitored and information periodically updated. There is no mechanism for obtaining and analysing information on health care infrastructure and manpower in the private and voluntary sectors in the district. Unless this information is available it will not be possible to undertake any effective area-specific microplanning so that the health manpower required to meet the local health needs of the population is provided. As a first step, in order to create such a data base a Standing Technical Advisory Committee has been set up under the Chairmanship of Director General of Health Services; the Central Bureau of Health Intelligence (CBHI) has been entrusted with the task of compiling the data on rural and urban primary, secondary and tertiary health care infrastructure and manpower in the private, voluntary, industrial, governmental and other sectors. The progress in this effort is very slow.

Continuing Education For Health Professionals

28. Continuing education to update the knowledge and skills of all health professionals is important in the context of evolving technology, demographic transition, changing lifestyles and disease patterns. Currently Continuing Medical Education (CME) to physicians is provided through in-service training programmes in various institutions including National Academy of Medical Sciences, National Board of Examinations and various professional bodies and associations. In addition, major disease control and family welfare programme undertake skill upgradation and programme orientation training of physicians and paraprofessionals.

29. During 1999-2000, 15 CME programmes have been held and 24 programmes have been finalised by the Medical Council of India; financial assistance has been provided by National Academy of Medical Sciences (NAMS) for 30 Seminars/Workshops. Two national workshops on Development of Standards in Nursing practice and performance appraisal in clinical practice were conducted by the Department of Continuing Education of the Raj Kumari Amrit Kaur College of Nursing during 1999-2000.

CONTROL OF COMMUNICABLE DISEASES

30. Even though health is a State subject, the Central Government has over the last forty years provided additional funds through Centrally Sponsored Schemes (CSS) for control of some of the major communicable diseases. These disease control programmes are continuing in the Ninth Plan period. External assistance has been obtained to augment available national funds for implementing these programmes.

National Anti Malaria Programme (NAMP)

31. The National Malaria Control Programme, the first of the Health Sector Centrally Sponsored Scheme aimed at reduction of morbidity and mortality due to malaria was launched in 1953. Spectacular success was achieved under the National Malaria Eradication Programme (NMEP) which brought down the incidence of malaria to 0.1 million cases with no deaths by 1965. However, after 1965, there was a resurgence of malaria and the NMEP initiated a modified plan of operation. The incidence of malaria came down to 2.18 million

in 1984. Since then, the number of cases has remained at over 2 million over the last two decades.

32. In the Ninth Plan period, the National Anti-malaria programme has intensified malaria control activities and overcome the deficiencies that have been identified in the programme. The programme aims at intensive and effective implementation of the modified plan of operation in the seven North Eastern States, 100 districts spread over the States of Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh, Maharashtra, Orissa and Rajasthan and in 19 cities/towns which have a rising slide positivity rate and in areas where there have been focal outbreaks of malaria during the previous year. Funds have been obtained from the World Bank for augmenting the national funds available for implementation of the programme. The programme was operationalised in 1998. The components of the Modified plan of Operation includes early diagnosis and prompt treatment; selective vector control and personal protection; prediction, early detection and effective response to outbreaks and IEC.

33. The performance of NAMP is given in Table 5.4.1.2.

TABLE 5.4.1.2
National Anti Malaria Programme

Year	B.S.E. (In Million)	Positive Cases	P.F. Cases	A.P.I (In 1000)	Aber Per cent	S.P.R Per cent	S.F.R Per cent	No. of Deaths
1996	91.54	3.04	1.18	3.48	10.49	3.32	1.29	1010@
1997	89.45	2.66	1.01	3.01	10.11	2.97	1.13	879
1998 *	86.26	2.15	0.93	2.37	9.51	2.49	1.08	658
1998 **	49.83	0.91	0.38			1.84	0.76	221
1999 **	47.95	0.88	0.39			1.84	0.81	373

Provisional

** Comparative data for 1999 with corresponding period of 1998, as per reports received from States upto 25th October 1999.

@ Out of 1010 deaths, 926 are confirmed and 84 suspected deaths. This does not include 1794 fever related deaths from Haryana.

Financial Scenario

(Rs. lakh)

Year	Outlay	Expenditure (RE)
Eighth Plan	42500.00	59106.55
1996-97	14500.00	14366.76
Ninth Plan	100000.00	
1997-98	19000.00	14352.00
1998-99	29700.00	16393.97
1999-2000	25000.00	

Source: Annual Report 1999-2000, Ministry of Health and Family Welfare

34. Spraying of insecticides is carried out to protect the population from transmission of malaria. Every year targets for spraying of insecticides is worked out in respect of each state on the basis of epidemiological data. Areas having API 2 and above during the

preceding three years are covered by residual insecticide spray to interrupt transmission. Spray coverage during 1998 was around 60 per cent in 1998 in the States of Arunachal Pradesh, Assam, Gujarat, Haryana, Jammu & Kashmir, Meghalaya, Mizoram, Tripura, UP, Chandigarh and Daman & Diu. Over 168 million people were targeted to be covered by residual insecticide spray in 1998-99 but only 79.26 million could be covered. The technical target for insecticide operation for 1999-2000 was to cover 171.40 million people. The introduction of dedicated mosquito nets has been initiated on a pilot basis in four districts in different eco-epidemiological conditions. For controlling malaria in urban areas, the urban malaria scheme was launched in 1971. Passive surveillance and anti larval measures are the main components of the urban malaria scheme. All towns having more than 40,000 population are to be covered; so far the scheme has been implemented in 132 towns. During 1998, 158890 cases of malaria were reported as compared to 174101 cases during 1997. During 1999 upto October, 158433 cases have been reported. The Programme is being monitored regularly by the Directorate of the National Anti-Malaria Programme through routine epidemiological and insecticidal spray reports as well as through review meetings with State Programme Officers.

35. The following constraints have been reported in implementing the programme:

(i) Development of resistance of malarial parasites to chloroquine.
(ii) Creation of malariogenic condition by construction and development projects.
(iii) Shortage of staff particularly at the field/PHC/Laboratory levels.
(iv) Frequent shifting of programme officers both at State Headquarters and Zonal levels.
(v) Due to budgetary constraints, many State Governments are reluctant to meet the operational expenses for spraying of insecticides etc. and for the cost of freight of insecticides supplied by the Central Government, resulting in inadequate and irregular spraying operations.

Kala-Azar

36. Kala-azar is endemic in 36 districts of Bihar and 10 districts of West Bengal. Periodic out breaks of Kala-azar with high morbidity and mortality continue to occur in these States. Over 90 per cent of the reported cases and over 95 per cent of the reported deaths are from Bihar. Over two-thirds of the cases in Bihar are reported from seven districts. The number of cases and deaths Kala-azar is given in Table 5.4.1.3.

TABLE 5.4.1.3
Kala-Azar Deaths And Cases

Year	Cases	Deaths
1996	27049	687
1997	17429	255
1998	13542	221
1999 (till August)	6694	220

37. There has been a decline in both Kala-azar cases and deaths in spite of inadequacy of the insecticidal spray operations and poor outreach of diagnostic services. It is important to ensure timely insecticidal spray, early detection and prompt treatment of Kala-azar patients so that achievements gained are sustained.

Revised National Tuberculosis Control Programme (RNTCP)

38. Tuberculosis is a major pubic health problem in India. It is estimated that there are about 14 million cases of active tuberculosis. Of these 3.5 million are highly infectious sputum positive tuberculosis cases. With the HIV-TB co-infection the incidence of tuberculosis may increase significantly from the current 1.8 per thousand. The National Tuberculosis Control Programme (NTCP) has been in operation since 1962 as a Centrally Sponsored Scheme. Currently 446 district tuberculosis centres exist in the country. In addition, there are 47,600 TB beds for serious cases in the country, 330 TB clinics in urban areas and 17 State TB demonstration centres. In spite of the availability of effective chemotherapy during the last three decades, the programme has not succeeded in bringing down the disease burden because of low case detection, case holding and cure rates.

39. A major review of NTCP was undertaken during the Eighth Plan to identify inadequacies in the ongoing programmes and suggest remedial measures. Based on the review, a Revised National Tuberculosis Control Programme (RNTCP) was drawn up. External assistance has been obtained from the World Bank to augment the resources available for implementation of the programme in a phased manner. In the Ninth Plan the priorities are as follows: (a) RNTCP will be implemented in 102 districts (b) NTCP will be strengthened in 203 SCC districts as a transitional step to adopt the RNTCP (c) standard regime will be strengthened in the remaining non SCC districts and (d) central institutions, state TB cells and state TB training institutions throughout the country will be strengthened.

40. The targets for the Ninth Plan are: (1) to enhance case detection to at least 70 per cent of the estimated incidence (2) improve cure/completion of therapy rates to 85 per cent amongst smear positive patients of tuberculosis in 102 districts implementing RNTCP and 60 per cent cure rates in 203 SCC districts (3) to reduce the proportion of smear negatives detected under the programme to 50 per cent or less of the total cases (4) to improve the aggregate smear positivity rate at least to 50 per cent and (5) to ensure that the number of TB suspects tested for smear examination is not less than 2.5 per cent of the general OPD attendance of the peripheral health institutions and number of smears examined is at least three per suspected patients. The programme has been operationalised in 1998.

41. The components of the programme are:

(i) Diagnosis through sputum microscopy of patients attending peripheral health facilities at all levels.
(ii) Uninterrupted supply of drugs (SCC drugs are given in patient wise boxes) by the Centre.
(iii) Direct observation of treatment through involvement of peripheral health functionaries, NGOs and community volunteers in the DOTS districts.
(iv) Systematic monitoring, evaluation and supervision at all levels.

42. The performance under the NTCP is shown in Table 5.4.1.4. At the national level sputum examination has been approximately 30 per cent of the target in 1997-98 and 1998-99. In 1999-2000 although there has been some improvement it is still only 50 per cent of the target. There were delays in initiation of RNTCP. The Department of Health is trying to widen coverage taking advantage of funds available.

TABLE 5.4.1.4
National Tuberculosis Control Programme

Year	Sputum Exam.		Sputum Positive		Total New Cases	
	Target	% Achievement	Target	% Achievement	Target	% Achievement
1997-98	14189175	31.84	472980	74.41	1277026	102.56
1998-99	14189175	27.44	472980	68.06	1277026	97.84
1999-2000	4884840	**50.98	488480	*46.38		
2000-2001	4985650		498570			

** Upto December, 1999

* No. of patients (3 smears/ patients)

Performance Of RNTCP Case Finding (1999)

Population covered by 31.12.99 (Lakh)	Total Cases Treated (1999)	New Smear +ve cases treated (1999)	Ratio new smear-; St patients (1999)	Conversion new S+
1381	136404	52774	0.8	86%

Financial Scenario

Year	Outlay	Expenditure
Eighth Plan	8500.00	19442.00
1996-97	6500.00	4180.00
Ninth Plan	45000.00	
1997-98	9000.00	3205.00
1998-99	12500.00	7211.00
1999-2000	10500.00	9500.00

43. Under RNTCP more than 35,000 health staff have been trained. Population of 200 million in 16 States/UTs have been covered. More than 2,50,000 patients have been put on treatment. Even in the RNTCP districts the total smear positive treated is only about 39 per cent of the total cases treated. The utilisation of funds under the programme has also been poor in the Ninth Plan period.

44. The RNTCP is being monitored at all levels. The Central TB Division has been strengthened to cope with the expansion of the programme and its monitoring. In co-ordination with WHO, local supervisors have been hired to work under the direction of Central Government/respective State Governments to ensure effective monitoring and implementation. Periodic visits to States/UTs to for programme review are carried out by the officers from Department of Health and the Central TB Division. A joint review of the programme was undertaken by Government of India and WHO in February, 2000. The review assessed the technical performance of the programme and recommended further phased expansion of the programme.

45. Funds have been released to State and District TB Societies for procurement of four wheelers and two wheelers along with provision of POL to make the supervisory staff more mobile. District TB Societies and State TB Societies have also been strengthened. The Department of Health has also initiated a DFID assisted project covering the entire State of

Andhra Pradesh. The project components include strengthening of Central TB Division, training activities besides implementation of RNTCP. External assistance has also been obtained from DANIDA to implement RNTCP in 14 tribal districts of Orissa. Presently 13 districts are being covered in a phased manner. It is proposed to cover a population of 400 million under the World Bank (WB) Project and about 100 million under DANIDA and DFID projects by 2002.

National Leprosy Eradication Programme

46. The National Leprosy Eradication Programme was launched as a 100 per cent Centrally funded CSS in 1983 with the goal of arresting disease transmission and bringing down the prevalence of leprosy to 1/10000 by 2000 AD. With MDT there has been a sharp reduction in the prevalence of leprosy from 57/10000 in 1981 to 4.5 by March, 2000 (P). While the endemic states of Andhra, Tamil Nadu and Maharashtra have shown a steep decline in the prevalence, prevalence in states like Bihar (10.6), Orissa (10.48), West Bengal (7.9), Uttar Pradesh (6.02) and Madhya Pradesh (6.7) continue to be high. Earlier 50 per cent of the cases were in Andhra Pradesh and Tamil Nadu. Now 70 per cent of the cases requiring treatment are in Uttar Pradesh, Madhya Pradesh, Bihar, Orissa and West Bengal. The performance under NLEP is shown in Table 5.4.1.5.

TABLE 5.4.1.5
National Leprosy Eradication Programme

	Case Detection		Case Treatment		Case Discharge	
Year	Target	% Achievement	Target	% Achievement	Target	% Achievement
1996-97	218240	221.11	218240	208.65	474200	102.41
1997-98	323640	162.08	323640	161.39	431615	127.42
1998-99	323640	241.97	323640	230.65	652400	109.56
1999-2000(P)	286365	172.23	286365		611666	

Financial Scenario

(Rs. lakh)

Year	Outlay	Expenditure/RE
Eighth Plan	14000.00	30328.00
1996-97	7400.00	6533.00
Ninth Plan	30100.00	
1997-98	7900.00	7828.00
1998-99	7900.00	7818.00
1999-2000	8500.00	8200.00

47. An independent evaluation carried out in April, 1997 recommended that:

(i) Modified Leprosy Elimination Campaign should continue.
(ii) Reorganisation and integration of Leprosy Programme into existing Health Care System should be continue

48. Phased integration of the programme into the existing health care service at primary, secondary and tertiary care level in all states has been recommended. The

integration will be attempted last in the States which are currently having high prevalence of leprosy. The leprosy training institutes will provide orientation training to all categories of staff and assist in rapid horizontal integration of the leprosy programme.

49. The contract staff working under the programme may require skill upgradation/retraining and redeployment. NGOs and the Department of Social Welfare will play a pivotal role for evolving and implementing innovative strategies for vocational rehabilitation, socio-economic rehabilitation, re-constructive surgery, training, IEC and other innovative activities.

Modified Leprosy Elimination Campaign

50. Modified Leprosy Elimination Campaign aimed at detection of unidentified cases of leprosy in the community was taken up first in Tamil Nadu in 1997 and then implemented during 1997-98 in Maharashtra, Orissa, Gujarat, Jammu Division of J&K and Daman & Diu. The programme was extended to all the districts during 1998-99. Large number of General Health Care staff were provided. The first round of orientation on leprosy and public awareness activities were undertaken in the State, district and peripheral levels giving emphasis on inter-personal communication. During the six day campaign 4.6 lakh cases were detected and put on treatment.

TABLE 5.4.1.6
New Cases Detected By MLEC And PR Before And After MLEC (1998-99)

Population in Lakh		No. of Suspect Cases	No. of Confirm Cases	No. of Single Lesion	PR Before MLEC	PR After MLEC	% Increase in PR
Enumerated	Examined						
8209.67	6448.71	2858267	454290	53115	4.75	10.02	110.95

51. During the year 1999-2000, the 2nd round of MLEC has been implemented in all the States except in Delhi, Andaman & Nicobar and Dadra & Nagar Haveli. Under 2nd MLEC case detection was through rapid survey for six days in five High Endemic States, and detection was through two days Voluntary Reporting at health centres where doctor is available in the remaining seven major States. In the remaining States, the focus was on orientation of staff, IEC for General Public to encourage suspected cases to report to all the CHCs, PHCs and hospitals for free diagnosis and treatment. During the 2nd MLEC 2.10 lakh new patients have been detected. There has been a decline in the number of confirmed cases in 2nd MLEC.

52. It is important to carefully train the health manpower in existing primary health care system in prevention of leprosy and early detection, management and rehabilitation of leprosy patients. Some of the evaluation studies indicate that during NLEC there was both over diagnosis and under diagnosis in some districts as the detection was done by a large number of persons who were recently trained. However this campaign provided a mechanism for involving the entire health services and had paved the way to the progressive integration of leprosy care within the health service infrastructure.

53. Careful supervision and monitoring of the performance of the programme and process of integration are essential for achieving the goal set in the Ninth Plan. Since the World Bank supported NLEP project was to be completed in March 2000, the project has

been given a six month extension upto September 2000 in order to prepare for the second phase project to complete the remaining task of elimination in all the States/UTs within the next three years. Sikkim, Nagaland, Punjab, Haryana, Tripura, Mizoram, Meghalaya States have achieved the target of elimination of leprosy; another seven States are likely to achieve it soon. For the remaining States, the target has been extended to 2003.

National AIDS Control Programme (NACP)

54. The National AIDS Control Programme (NACP) was initiated in 1992 as a 100 per cent Centrally Sponsored Scheme. Right from its inception the programme has operated through the existing health care system at various levels. Available data indicated that HIV infection exists in all the States both in urban and rural areas. The apparent differences between States/districts/cities might to a large extent be due to differences in the type and number of persons screened. Over the last decade there has been a progressive rise in prevalence of infection in all groups.

55. There had been problems and delays in implementation of the programme in many States. Sentinel surveillance which is an essential component for assessing prevalence of infection in different States and forecasting the future course of the epidemic in the country was not carried out according to protocol in most States. Despite the various shortcomings of Phase I of the programme, the prevalence of infection has been low as compared to many other countries.

56. NACP Phase II funded by Government of India, State Governments, World Bank, DFID and USAID has been initiated in Oct. 1999. The Project has the following five components:

- Reducing HIV transmission among the poor and marginalised section of the community at the highest risk of infection by targeted intervention, STD control and condom promotion;
- Reducing the spread of HIV among the general population by reducing blood based transmission and promotion of IEC, voluntary testing and counselling;
- Developing capacity for community based low cost care for people living with AIDS;
- Strengthening implementation capacity at the National, States and Municipal Corporations levels through the establishment of appropriate organisational arrangements and increasing timely access to reliable information; and
- Forging inter-sectoral linkages between public, private and voluntary sectors.

57. The performance under NACP is given in Table 5.4.1.7. So far 9966 cases of AIDS have been reported till 1999. It is imperative to build up:

- epidemiological data on time trends in the disease.
- details of the specific interventions based on epidemiological data.
- mechanisms for estimating requirements, unit costs, total costs.
- process and impact indicators to monitor the progress in interventions.
- baseline figures and target to be achieved by the end of the project.

TABLE 5.4.1.7
Aids Control Programme - All India (Cumulative)

Year	No Screened (ooo)	Sero-Positive (000)	AIDS Cases	Sero-Positivity Rate (per 1000)
1996	2937	49527	3161	16.8
1997	3227	71400	5145	22.1
1998	3413	82391	6693	24.1
1999	3572	92312	9966	25.8

Year	Zonal Blood Testing Centres	Blood Testing Centres	STD Clinics	Blood Bank Modernised	Sentinel Sites
1996	154	62	504	743	55
1997	154	62	504	815	55
1998	154	131	504	815	180
1999	154	135	504	815	180

Financial Scenario

(Rs. lakh)

Year	Outlay	Expenditure/RE
Eighth Plan	28000.00	27538.00
1996-97	14100.00	11441.00
Ninth Plan	76000.00	
1997-98	10000.00	12301.00
1998-99	11100.00	10800.00
1999-2000	14000.00	*1325.00

* Provisional

58. There are at present 131 blood testing centres and nine reference centres. A sentinel surveillance system has been set up; 180 sentinel sites have been established to monitor the trends of HIV infection in various groups of population. For blood safety, mandatory licensing of the all blood banks has been carried out. One hundred and fifty four Zonal Blood Testing Centres where HIV testing facilities are available have been established, 815 blood banks in public and voluntary sector have been modernised and 40 blood component separation facilities have been established.

59. As per the directives of the Supreme Court, National Blood Transfusion Council at the national level and State Blood Transfusion Council at the State/UT level have been constituted. Professional blood donation has been abolished w.e.f. January 1, 1998; voluntary blood donation is promoted. Percentage of infection transmitted through blood has registered a fall from 8 per cent to 5 per cent during the project period.

60. The programme has also strengthened existing STD Control Programme through provision of essential equipment to 504 STD clinics, financial assistance for STD drugs and other consumables and also for training of staff. Financial allocations have been made to States/UTs for strengthening of Management of RTI/STI in all district level female hospitals

in the country. Five regional STD centres were upgraded to conduct training, research, supervision and monitoring. The guidelines for syndromic management and treatment of STDs were revised. 18,588 Government Medical Officers and 10,000 private health care physicians were trained in syndromic management of STD cases. In the area of condom promotion, emphasis is on social marketing, quality control of condoms was improved and condoms were included in schedule R of the Drugs and Cosmetics Act.

Disease Surveillance And Response

61. Establishment of a functioning system for early detection and prompt response for rapid containment and control of the disease has been identified as one of the high priorities in the Ninth Plan period. The Department of Health has initiated a pilot project in 20 districts for a period of two years to develop a model disease surveillance system at district level. If found feasible, the States could initiate and implement disease surveillance system based on this model to ensure early detection, prompt response and control of outbreaks at district level and develop effective linkages with existing facilities and expertise for epidemiological support and laboratory back-up at identified State level institutions/medical colleges. Disease surveillance is also one of the components of the on-going Health Systems Project in many states; specific on-going programmes for control of communicable disease has a component of disease surveillance. Surveillance for polio is being intensified under the Family Welfare Programme. These efforts need be integrated.

Hospital Waste Management

62. Increasing incidence of hospital-acquired infections and accidental infection in health care providers and waste disposers, renders it imperative that efforts are made to improve infection control and waste management through utilisation of appropriate, affordable technology at all levels of health care. During the Eighth Plan Planning Commission had published a report of the High Powered Committee on Urban Solid Waste Management; one of the issues in the report was hospital infection control. As a follow up Planning Commission had provided ACA to NCT of Delhi for a pilot project in hospital waste management in a tertiary health care institution complex at the end of the Eighth Plan period, which could be replicated in other States. Several States are incorporating the Hospital Waste Management as a part of their Health Systems Project. Funds under the PMGY can be utilised for strengthening hospital infection control and waste management in primary health care institutions.

National Programme For Control Of Blindness

63. National Programme for Control of Blindness (NPCB) was launched in the year 1976 as a 100 per cent centrally sponsored programme with the goal of reducing the prevalence of blindness from 1.4 per cent to 0.3 per cent of population by 2000 AD mainly through cataract surgery as Cataract accounts for 80 per cent of blindness. A World Bank assisted Blindness Control Project was launched in 1994 to reduce the prevalence of cataract blindness in 7 States, where prevalence of blindness was higher than the national average of 1.49 per cent. Though there was substantial increase in cataract surgery, the progress was well below the target set.

64. Facilities surveys and collection of data for rapid assessment on cataract blindness load were carried out in seven selected institutions during December 1997 to February 1998

in two districts in each of the seven project States. Briefly, this survey revealed the following:

(i) There is evidence of reduction in the prevalence of blindness in the Project States.
(ii) The quality of care, as assessed by reduction in failure rate, has improved significantly.
(iii) Proportion of IOL surgery has been on the rise since the inception of the Project.
(iv) The coverage of services has improved (about 50 per cent persons and 70 per cent eyes).
(v) Utilisation of services by women has increased.
(vi) There is some reduction in proportion of operations performed in eye camps.

65. The performance under the NBCP in the Ninth Plan is shown in Table 5.4.1.8.

TABLE 5.4.1.8
National Blindless Control Programme

	1997-1998		1998-1999		1999-2000	
Unit	Target	% Achievement	Target	% Achievement	Target	% Achievement#
Cataract Operations (lakh)	30.00	101.00	33.00	100.00	35.00	96.29
% IOL implantation	20.00	110.00	25.00	*140.00	30.00	153.33

* In World Bank Project
\# Provisional

Financial Scenario

(Rs. lakh)

Year	Outlay	Expenditure/RE
Eighth Plan	10000.00	19297.00
1996-97	7500.00	5858.00
Ninth Plan	44800.00	
1997-98	7000.00	5834.00
1998-99	7500.00	7274.00
1999-2000	8500.00	8383.00

Source: Department of Health

66. Considering that a significant number of cataract operations are performed on unilateral cataract blind persons and second eye of bilaterally blind persons, the rate at which Cataract Surgery would have to be done to clear backlog is well over 400 operations per 100,000 population. However, only three States (Tamil Nadu, Andhra Pradesh and Maharashtra) have reached the level of over 400 cataract operations/100,000 population. Analysis of service data reports indicate that both in medical colleges and in district hospitals the number of cataract operations done per bed or operation per surgery were far below the

expected levels in most of the states. This under utilisation of existing facilities need be immediately corrected. In order to improve the quality of services and follow up, the programme has shifted from the camp approach to increased use of fixed facilities except in under served areas.

Revised National Blindness Control Programme (RNBCP)

67. RNBCP was drawn up for 1998-2002 to cover the entire country and will focus both on prevention of avoidable blindness and restoration of vision in those who have been already been visually disabled irrespective of their capacity to pay. In the last two years there has been reports of ocular infections leading to loss of vision after IOL surgery in district hospitals. It is imperative that steps to minimise sepsis get due attention especially in IOL implantation and to ensure that IOL implantation is done only when these conditions are satisfactory. In tertiary care centres where skilled surgeon and adequate post-operative care is available, use of IOL may be preferred but extending IOL services at or below the district level where skilled surgeons and post-operative care are not available may have serious adverse consequences which has been reported from different parts of the country. IOL services should be provided only at levels where appropriate intra and post-operative care is available. There is a need to document sequel of IOL/ECCE in tertiary, secondary, district and below district levels and in camps.

NATIONAL CANCER CONTROL PROGRAMME (NCCP)

68. NCCP is a Central Sector Programme. Emphasis is on prevention, promotion, health education, early detection and augmentation of treatment facilities. During 1998-99, financial assistance was provided to two States for preventive health education, early detection and palliative care at the district level. Funds were also provided for purchase of equipments including Cobalt Therapy unit for two medical colleges in the country. Financial assistance is also provided to the regional cancer centres.

NATIONAL IODINE DEFICIENCY DISORDERS CONTROL PROGRAMME (NIDDCP)

69. The National Iodine Deficiency Disorders Control Programme (NIDDCP) envisages control of Iodine Deficiency Disorders like mental and physical retardation, deaf mutism, cretinism, high rates of abortion etc. through compulsory iodisation of salt. During 1999-2000 IDD surveys and re-surveys were conducted in the Chamba district of Himachal Pradesh, Keonjhar district of Orissa, Krishna district of Andhra Pradesh and Andaman & Nicobar Islands. For ensuring the quality of iodated salt at consumption level, testing kits for on the spot qualitative testing have been developed and have been distributed to all district health officers in endemic States for awareness.

70. As a part of its drive to prevent IDD among the general public, the Central Government had issued a notification w.e.f. May, 1998 making it mandatory for all manufacturers of edible salt to iodise their product. In view of the strong opinion that such a public health measures should not be enforced through statutory provision, the Central Government have issued a preliminary notification proposing a future withdrawal of the compulsory statutory iodisation of edible salt. The issue is now open for public debate.

INTEGRATED NON-COMMUNICABLE DISEASE CONTROL PROGRAMME

71. In view of increasing prevalence of non-communicable of it is essential that preventive, promotive, curative and rehabilitative services for NCD are made available throughout the country at primary, secondary and tertiary care levels so as to reduce the morbidity and mortality associated with NCD. The Centre is providing funds for strengthening facilities for care (Cancer Control Programme), setting up models for replication (National Mental Health Programme) and pilot projects (Diabetes Control Programme) as a Central Sector Programme. In some states e.g. Kerala, efforts are being made to implement an integrated non-communicable disease control programs at primary and secondary care level with emphasis on prevention of NCD, early diagnosis, management and building up of a suitable referral system. Tertiary care centres are being strengthened so that treatment facilities for management of complications improve.

72. As the anticipated increase in prevalence of NCD over the next few decades is at least in parts due to changing lifestyles, it is imperative that health education for primary and secondary prevention as well as early diagnosis and prompt treatment of NCD receive the attention that they deserve. The increasingly literate population can then be expected to take a pro-active role and help in achieving a reduction in morbidity and mortality due to NCD.

MEDICAL RESEARCH

73. The Indian Council of Medical Research (ICMR) is the nodal organisation for bio-medical research in India. Bio-medical and health systems research is also carried out by universities, research institutions, legal colleges and non-government organisations which are funded by several agencies including Department of Science & Technology, Department of Biotechnology and Council of Scientific & Industrial Research (CSIR) and concerned Ministries. The major thrust of ongoing research includes existing problems of communicable diseases, emerging problems of non-communicable diseases, improvement of health and nutritional status of women and children, and increasing contraceptive acceptance and continuation. In addition development of immuno diagnostic research studies on improved drug regimens to combat emerging drug resistance among several bacteria, alternative strategies for vector control in view of increasing insecticide resistance among vectors tested, development testing and quality control of newer drugs in the Indian system of medicines, operational research for efficient implementation of on-going health programmes are also being undertaken.

OUTLAY

State Sector

74. The Outlay and expenditure in the first three years of the Ninth Plan is shown in Annexure 5.4.1.2. Restructuring of the health care infrastructure, redeployment and skill development of the manpower, development of referral network, improvement in the Health management information system, development of disease surveillance and response at district level are some of the critical steps that have to be taken up by the State Governments in order to improve the functional status and efficiency of the existing health care infrastructure and manpower in the States. The centrally sponsored disease control programmes and the family welfare programme provide funds for additional critical manpower and equipment; these have to be appropriately utilised to fill critical gaps. The ongoing and the proposed EAPs are

additional sources for resources. Health is one of the priority sector for which funds are provided in the central budget under the head Additional Central Assistance (ACA) for basic minimum services. The States will also be able to utilise these funds for meeting essential requirements for operationalising urban and rural health care.

Centre

75. The Table 5.4.1.9 below provides outlay and expenditure for Health sector during first three years of the Ninth Plan.

TABLE 5.4.1.9
Approved Outlay And Expenditure For Health

Eighth Plan Outlay (1992-97)	Ninth Plan Outlay (1997-2002)	1997-98 (BE)	1997-98 (Actual)	1998-99 (BE)	1998-99 (Actual)	1999-2000 (BE)	1999-2000 (Anticipated Expenditure)	2000-2001 (BE)
1712.00	5118.19	920.20	716.15	1145.20	814.34	1160.00	1000.00	1300.00

76. Health is one of the sectors identified under the Special Action Plan. In addition to the funds available from Domestic Budgetary Support, several centrally sponsored disease control programmes are receiving funds from EAPs.

5.4.2 INDIAN SYSTEMS OF MEDICINE & HOMOEOPATHY

97. The Indian Systems of Medicine and Homoeopathy (ISM&H) consist of Ayurveda, Siddha, Unani and Homoeopathy, and therapies such as Yoga and Naturopathy. Some of these systems are indigenous and others have over the years become a part of Indian tradition. There are over six lakh ISM&H practitioners. The majority of the practitioners work in the private sector, in remote rural areas/urban slums and are accepted by the community. The problems faced by ISM&H include lack of well qualified teachers in training institutes and training which is not of requisite standard; lack of essential staff, infrastructure and diagnostic facilities in secondary/tertiary care institutions; potential of ISM&H drugs & therapeutic modalities is not fully exploited and existing ISM&H practitioners are not fully utilised to improve access to health care.

98. The Central Government created the Department of ISM&H in 1995 to provide focussed attention for development and optimal utilisation of ISM&H for the health care of the population; 18 states also have separate directorates of ISM&H. The Ninth Plan envisages that the Department of ISM&H should improve the quality, content and coverage of ISM&H services through infrastructure and manpower development; preserve and promote cultivation of medicinal plants and herbs, complete the pharmacopoeia for all the Indian systems of Medicine, draw up a list of essential drugs, encourage good manufacturing practices, ensure quality control of drugs and encourage research and development in ISM&H with a focus on drug development and patenting.

PRIMARY, SECONDARY AND TERTIARY CARE INSTITUTIONS

99. ISM&H services are being provided at primary, secondary and tertiary care levels by the private and the voluntary sector as well as by government centres/institutes. The current position of medical care, medical manpower and medical education facilities available under ISM&H is given in Table 5.4.2.1.

TABLE 5.4.2.1
Summary Of Medical Care, Medical Manpower & Medical Education Facilities Available Under The Indian Systems Of Medicine And Homoeopathy As On 1.4.1999

S. No.	Facilities	Ayurveda	Unani Medicine	Siddha	Yoga	Naturo-pathy	Homoeo-pathy	Total
1	Hospital	2189	189	204	8	21	243	2854
2	Beds	33145	4157	1681	201	733	9436	49,353
3	Dispensaries	14252	966	357	42	55	7037	*22735
4	Registered Practitioners	366812	40748	12911	-	402	188527	609400
5	i) Under Graduate Colleges	154	31	2	-	-	118	305
	ii) Admission Capacity	6300	1252	150	-	-	5457	13159
6	i) Post Graduate Colleges	33	3	1	-	-	10	47
	ii) Admission Capacity	437	55	24	-	-	99	615

Source Department of ISM&H.
Figures are Provisional.
\- Nil Information.
Figures shown in the brackets are admission capacity in respect of Diploma Courses, otherwise the admission capacity is for Degree Courses. Information as on 1.4.1999 has only been received in respect of Registered Practitioners.
* Includes 26 Amachi Dispansaries.

100. There are at present 22735 ISM&H dispensaries which provide primary health care services. States are making efforts to increase utilisation of ISM&H practitioners working in the Government, voluntary and private sector to improve the outreach of services. The State-wise distribution of ISM&H dispensaries that are functioning is shown in Annexure 5.4.2.1. Madhya Pradesh, West Bengal and Gujarat have ISM&H practitioners as the only medical practitioners in some remote PHCs and they provide primary health care to the needy population. States like Himachal Pradesh and Kerala have ISM&H practitioners in primary health care in addition to physicians of modern medicine so that complementary health care under both systems are being provided depending upon the choice of the patients and the nature of their health problems. Several States are setting up ISM&H clinics in district hospitals. Speciality clinics of Ayurveda and Homeopathy have been set up in Safdarjung Hospital and of Unani Medicine in Ram Manohar Lohia Hospital, as a research activity through the respective Central Councils for Research. Apart from regular OPD, eminent leading Vaidyas/Hakims/Homeopaths are rendering services once a week in these clinics. An advanced Ayurvedic Centre for Mental Health care has also been established at the NIMHANS, Bangalore. The Department of Family Welfare is providing ISM&H drugs as part of RCH drugs in selected States and cities.

101. It is important to:

- increase utilisation of ISM&H practitioners working in the Government, voluntary and private sector in order to improve IEC, counselling, increased utilisation and completion of treatment in National disease control and Family Welfare programmes.
- ensure ISM&H clinics are funded by the respective primary, secondary and tertiary care institutions at the end of the Plan period.
- monitor how the efforts in providing complementary system of health care to patients in the hospitals are utilised by the patients and effect mid course corrections.
- improve tertiary care institutions especially those attached to ISM&H Colleges and National Institutions so that there will be simultaneous improvement in teaching, training, R&D and patient care.
- establish effective referral linkage between primary, secondary and tertiary care institutions.

DEVELOPMENT OF HUMAN RESOURCES FOR ISM&H

Professional Training In ISM&H

102. Nearly 13,000 ISM&H practitioners of various Indian systems graduate every year; many of the ISM&H colleges do not have adequate infrastructure or qualified manpower, lack teaching training material and are functioning sub-optimally. It is essential to improve quality of training so that these graduates can effectively take care of patients. The Department has taken several steps to improve the situation. The Central Council of Indian Medicine and the Central Council for Homoeopathy inspects educational institutions, registers qualified ISM&H practitioners and revises curricula. State and Central Departments of ISM&H provide funds for improving and strengthening of the existing undergraduate and post graduate colleges of ISM&H to enable them to achieve the norms prescribed by CCIM/CCH.

Paraprofessional Training In ISM&H

103. The Department is currently preparing the course for Nursing and Pharmacy in Unani medicine. Some private organisations and State Governments are conducting courses in Ayurvedic Pharmacy. States like Kerala and Rajasthan are conducting courses on Ayurvedic Nursing. These courses are not recognised by any statutory body. Attempts are underway to sort out this problem.

Continuing Medical Education In ISM&H

104. Majority of the ISM&H practitioners have qualified from recognised institutions and could be utilised for improving coverage of National Health Programmes. Most of these practitioners are in the private sector and require periodic updating of the knowledge and skills through continuing medical education courses. It is also important to provide ISM&H practitioners with sufficient knowledge of the on-going national health programmes so that they could provide necessary counselling and act as depot holders for selected items such as condom or ORT packages. The Department of ISM&H has providing scheme for re-orientation/in-service training with a total outlay of Rs.6.10 crore during the Ninth Plan period. Under this scheme one month's course for Teachers and Physicians and two months each for training in specialised fields like Ksharasutra, Pancha Karma therapy and dental practices and training for yoga, of ISM&H personnel are provided. The Department of Family Welfare has sanctioned Rs.68.8 lakh to 30 ISM&H institutions for conducting pre-training programmes each for orientation of RCH programmes for ISM&H practioners.

105. It is important to:

- develop one centre in each system as a National Institute with adequate financial assistance so that it functions as a model centre.
- support Government institutions which submit well defined projects for strengthening.
- ensure accreditation of all educational institutions before they initiate enrolment and mandatory periodic review for continued recognition.
- ensure that students have access to hospitals with requisite number of patient, so that they get clinical training and develop clinical skills.
- ensure uniformity in entry standards, and uniformity in the curricula.
- improve quality and relevance of the undergraduate training and improve clinical skills through a period of internship with possible multi-professional interaction.
- introduce necessary curricular changes in graduate and CME courses, and develop appropriate course contents so as to design learning experiences related to expected task performance, i.e. increasing the involvement of ISM&H practitioners in counselling and improving the utilisation of services under the National Health and Family Welfare Programme.

PRESERVATION AND PROMOTION OF CULTIVATION OF MEDICINAL HERBS AND PLANTS

106. In view of the increasing demand for drugs in ISM&H and the fact that some of the species of medicinal plants are reported to be endangered, the Department of ISM&H has augmented resources for the development and cultivation of medicinal plants, the objective of which is to augment the production of raw herbs of plant origin by providing central assistance for their cultivation and development. States like Himachal Pradesh are investing

in herbal gardens so that drugs required for Ayurvedic dispensaries could be provided by the State Government at an appropriate cost.

107. The Department also has a Central scheme for development of agro techniques and cultivation of Medicinal plants used in Ayurveda, Siddha, Unani and Homeopathy. Under this scheme, central assistance is provided to specialised scientific institutions on project basis for development of agro-techniques of identified medicinal plants. The Department is implementing 34 projects in different organisations to develop agro techniques for about 126 medicinal plants and expenditure of Rs.200 lakh was incurred during 1998-99 on the schemes on medicinal plants.

108. Planning Commission had constituted a Task Force on Conservation, C, Sustainable Use and Legal Protection of Medicinal Plants. The following recommendations were made:

(i) Establishment of 200 Medicinal Plant Conservation Areas (MPCA), covering all ecosystems, forest types and subtypes preferably inside the protected areas already notified under the Wildlife Act.
(ii) For Fifty medicinal plant species which are rare or endangered or threatened, ex-situ conservation may be tried in the established gardens managed by agriculture, horticulture, forest and other departments.
(iii) Three gene banks created by Department of Biotechnology should properly store the germplasm of all medicinal plants.
(iv) Two hundred "Vanaspati Van" may be established in degraded forest areas (with an area of about 5000 hectares each). Intensive production of medicinal plants from these "Vanaspati Vans" will produce quality herbal products and generate productive employment to 50 lakh people, specially women, who are skilled in herbal production, collection and utilisation.
(v) One million hectares of forest area rich in medicinal plants (about 5000 hectares each at 200 places) should be identified, management plans formulated and sustainable harvesting encouraged under the JFM system. Such areas, besides producing herbal products will generate employment for 50 lakh tribals.
(vi) Fifty NGOs, who are technically qualified, should be entrusted the job of improving awareness and availability of plants stock and agro-techniques for cultivation of medicinal plants. Twenty five species having the maximum demand should be cultivated under captive and organic farming.
(vii) All attempts should be made for medicinal plants screening/testing/clinical evaluation/safety regulation as well as research and development safety, efficacy, quality control, pharmacopoeia development should be expedited and completed by 2003.
(viii) Drug Testing Laboratories for ISM&H products should be established with staff qualified to test the plant/mineral based products. Training should be imparted to the laboratory staff, drug inspectors and to the quality control managers/in-charges of the manufacturing units so that they are able to identify the raw-materials for the presence of essential properties of medicinal plants.
(ix) To prevent patenting of our traditional knowledge by outsiders, all the available information should be properly formatted in a digital form by using international standards for wider use both at the national and international level. Efforts should be intensified to create an Indian Traditional Knowledge Base Digital Library.

(x) The Task Force strongly recommended establishment of "Medicinal Plant Board" for an integrated development of the medicinal plants sector. It is expected to formalise and organise medicinal plants marketing and trade, coordinate efforts of all the stakeholders of the sector and ensure health for all by improving the awakening and availability of herbal products, besides generating productive employment to one crore tribals and women on a sustainable basis.

109. Department of ISM&H has been identified as the nodal agency and is currently taking steps to constitute the Medicinal Plant Board.

PHARMACOPOEIAL STANDARDS

110. Availability of good quality drugs at affordable cost is an essential pre-requisite for any health programme. Currently the country is facing problems in ensuring quality of drugs. The Pharmacopoeial Laboratory of Indian Medicine (PLIM) and the Homeoeopathy Pharmacopoeial Laboratory (HPL) at Ghaziabad are the major drug testing laboratories in ISM&H. In addition to these the state governments have also been advised to set up drug testing laboratories. Setting up Pharmacoepoeial Standards has been identified as a priority in the Ninth Plan.

111. The Department has finalised and notified Good Manufacturing Practices for Ayurveda, Siddha and Unani drugs in the last two years. There is still a major problem in ensuring quality control because of lack of adequate number of ISM&H drug testing laboratories.

112. The feasibility of utilising:

- laboratories of CCRAS and the Chemistry and biochemistry laboratories of universities/college Departments may to be explored.
- effective implementation of stringent quality control measures by the Drug Controllers and strict enforcement of the provision of the Drugs and Cosmetics Act and the Magic Remedies Prevention Act are required to eliminate substandard and spurious drugs.

RESEARCH AND DEVELOPMENT

113. The Ninth Plan has emphasised focussed attention on R&D especially clinical trials on new drug formulations, clinical trial of promising drugs through strengthening of the Central Research Councils and coordination with other research agencies. Special emphasis on encouraging research aimed at improving ISM&H inputs in National Health Programmes has been laid. Clinical trials on testing of drugs traditionally used in illnesses and those used in tribal societies for safety and efficacy and research on developing new drug formulations may be conducted.

114. The four Research Councils in ISM&H are currently undertaking clinical research on ISM&H drugs, research studies on drug standardisation, survey and collection of medicinal plants, potency estimation of homoeopathic drugs, as well as shelf life studies of different homoeopathic drugs, clinical Research, drug standardisation in respective disciplines and clinical screening and pharmacological studies of oral contraceptive agents in Ayurveda. In addition to the Research Councils, the Department has a programme of Extramural Research Project under which funds for research projects are given to research

organisations. The ongoing research projects are scattered and few in number; many not from identified priority areas. The linkages between research institutes with educational and service institutions need to be strengthened.

Involvement In National Programme

115. The Department of ISM&H is associated with the RCH Programme of the Department of Family Welfare. Thirty institutes have been identified for providing training to ISM&H physicians in RCH and funds have been provided by Department of Family Welfare for inclusion of Ayurvedic and Unani drugs in the drug kit of ANM. Involvement in all other Central and State Health Sector Programmes e.g. Malaria, Tuberculosis control, diarrhoeal diseases control will have to be taken up in a phased manner.

OUTLAYS AND EXPENDITURE

116. The total outlay proposed for the Department of ISM&H during the Ninth Plan period is Rs.266.35 crore. The outlay and expenditure for Annual Plan 1997-98, outlays for 1998-99 to 2001-2002 are given in Table 5.4.2.2 below.

TABLE 5.4.2.2
Approved Outlay And Expenditure For ISM&H

(Rs. crore)

Eighth Plan Outlay (1997-2002)	Ninth Plan Outlay (1997-2002)	1997-98 (B.E.)	1997-98 (Actual)	1998-99 (B.E.)	1998-99 (R.E.)	1999-2000 (B.E.)	1999-2000 (Anticipated Expenditure)	2000-2001 (B.E.)
108.00	266.35	35.30	32.80	50.00	49.00	59.13	55.00	100.00

117. The Department is continuing all its earlier schemes and proposed/has initiated 17 new schemes. With an annual outlay of Rs.59 to 60 crore, on an average each scheme gets less than Rs.2 crore per annum. This may pose problems from the point of view of efficiency of investment, management and accountability of schemes. Various activities for which assistance is made available to institutions can be brought within the ambit of a major scheme. It is recommended that the Department undertake a restructuring of the ongoing proposed activities in such a manner would prevent the resources being spread too thinly and enable the Department to focus on key areas.

5.4.3 FAMILY WELFARE

118. India, the second most populous country in the world, has no more than 2.5 per cent of global land but is the home of 1/6th of the world's population. The prevailing high maternal, infant, childhood morbidity and mortality, low life expectancy and high fertility and associated high morbidity had been a source of concern for public health professionals right from the pre-independence period. The Bhore Committee Report (1946) which laid the foundation for health service planning in India, gave high priority to provision of maternal and child health services and improving their nutritional and health status. Right in 1951 it was recognised that population stabilisation is an essential prerequisite for sustainability of development process so that the benefits of economic development result in enhancement of the well being of the people and improvement in quality of life. India became the first country in the world to formulate a National Family Planning Programme in 1952, with the objective of "reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy". Thus, the key elements of health care to women and children and provision of contraceptive services have been the focus of India's health services right from the time of India's independence. Successive Five Year Plans have been providing the policy framework and funding for planned development of nationwide health care infrastructure and manpower. The Centrally Sponsored and 100 per cent centrally funded Family Welfare Programme provides additional infrastructure, manpower and consumables needed for improving health status of women and children and to meet all the felt needs for fertility regulation.

DEMOGRAPHIC TRANSITION – OPPORTUNITIES AND CHALLENGES

119. The technological advances and improved quality and coverage of health care resulted in a rapid fall in Crude Death Rate (CDR) from 25.1 in 1951 to 9.8 in 1991. In contrast, the reduction in Crude Birth Rate (CBR) has been less steep, declining from 40.8 in 1951 to 29.5 in 1991. As a result, the annual exponential population growth rate has been over 2 per cent between 1960-1990. Census 1991 showed that India was entering the phase when there will be progressive decline in population growth rate. The rate of decline in birth rate and population growth is likely to be further accelerated in the next decade. The changes in the population growth rates in India have been relatively slow, but the change has been steady and sustained. As a result the country was able to achieve a relatively gradual change in the population numbers and age structure. The short and long term adverse consequences of too rapid decline in birth rates and change in age structure on the social and economic development were avoided and the country was able to adapt to these changes without massive disruption in development efforts.

Population Projections

120. Census1991 recorded that the population of the country was 846.3 million. The population will increase from 934 million in 1996 to 1264 million in 2016. In spite of the uniform national norms set under the 100 per cent Centrally Funded and Centrally Sponsored Scheme (CSS) of Family Welfare, there are substantial differences in fertility and mortality between States. At one end of the spectrum is Kerala with mortality and fertility rates nearly similar to those in some of the developed countries. At the other end, there are States such as Uttar Pradesh, Bihar, Madhya Pradesh Rajasthan and Orissa with high Infant Mortality Rate and Fertility Rates.

121. The five States of Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa, which constitute 44 per cent of the total population of India in 1996, will constitute 48 per cent of the total population of India in 2016. These states will contribute 55 per cent of the total increase in population of the country during the period 1996-2016. The progress in these states would determine the year and size of the population at which the country achieves population stabilisation. Urgent energetic steps are required to be initiated to assess and fully meet the unmet needs for maternal and child health (MCH) care and contraception through improvement in availability and access to family welfare services in the States of Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar in order to achieve a faster decline in their mortality and fertility rates.

122. In the current century nearly half the population of India will be residing in the State of Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan and Orissa. In all the States performance in all the social and economic sector has been poor. The poor performance is the outcome of poverty, illiteracy, lack of organised services to meet the people's needs and poor development which co-exist and reinforce each other. These states have excellent human, mineral and agricultural potential. While the southern and the Western states have achieved substantial proportion of their potential, the potential of the Northern and North Eastern States have been as yet not fully utilised. Human, social and economic development of the country in the present century will to a large extent depend upon these States fully realising their full potential. It is imperative that all steps are taken to ensure that these States achieve their full potential in the shortest possible through planned coordinated efforts from all sectors.

123. The Report of the Technical Group on Population Projections has estimated the probable year by which replacement level TFR of 2.1 will be achieved by different states and India if the recent pace of decline in TFRs observed during 1985-93 or 1981-93 continues in the years ahead (Table 5.4.3.1).

TABLE 5.4.3.1
Year By Which TFR of 2.1 Will Be Achieved

	Year by Which Projected TFR will be 2.1
India	2026 *
Andhra Pradesh	2002
Assam	2015
Bihar	2039
Gujarat	2014
Haryana	2025
Karnataka	2009
Kerala	Achieved In 1988
Madhya Pradesh	Beyond 2060
Maharashtra	2008
Orissa	2010
Punjab	2019
Rajasthan	2048
Tamil Nadu	Achieved In 1993
Uttar Pradesh	Beyond 2100
West Bengal	2009

- Based On Pooled Estimates Of TFR.

124. Goa with relatively high income, literacy and good health care infrastructure was the first administrative unit to achieve the replacement level of fertility. This fitted the classical theory that allowed socio-economic development with decline in fertility; Goa and Pondicherry have been having less than replacement level fertility for over a decade. Kerala, the first State to achieve replacement level of fertility (TFR of 2.1) did so in spite of relatively low per capita income. High status of women, female literacy, age at marriage and low infant mortality were thought to be the factors behind the rapid fall in fertility in Kerala, Tamil Nadu which was the second state to achieve replacement level of fertility did so in spite of low PCI, higher IMR and lower female literacy rate than Kerala. Andhra Pradesh is likely to achieve replacement level of fertility in the next two years. The State has shown a steep decline in fertility in spite of relatively lower age at marriage, low literacy and poorer outreach of primary health care infrastructure. In the North-eastern States of Tripura, Manipur, Mizoram there is substantial difficulty in accessing primary health care facilities, but these States have achieved not only low fertility rates but also low infant mortality, suggesting thereby that a literate aware population can successfully overcome difficulties in access to and availability of primary health care infrastructure. Even in the States with poor health indices, there are districts where the level of health indices are comparable to the national level. It would therefore appear that in the Indian context the decision of the families about their health and fertility is a critical determinant of demographic and health indices.

Implication Of The Projected Changes In Age Structure:

125. The population in the 15-59 age group will increase from 519 to 800 million; there will be no increase in the under 15 population in these two decades (353 million in 1996 to 350 in 2016; the population over 60 will nearly double from 62 to 113 million. For India the current phase of the demographic transition is both a challenge and an opportunity. In the next two decades the population growth will be mainly among the adolescents and young adults who will be more literate, aware and are likely to make optimal use of available facilities. The challenge is to ensure skill development, appropriate employment with adequate emoluments. If the challenge is met we may have the opportunity to utilise abundant human resources to achieve rapid economic development and improvement in quality of life. The current high population growth rate is due to:

- the large size of the population in the reproductive age-group (estimated contribution 60 per cent);
- higher fertility due to unmet need for contraception (estimated contribution 20 per cent); and
- high wanted fertility due to prevailing high IMR (estimated contribution about 20 per cent).

Ninth Plan aims to meet all the unmet needs for contraception and reduce IMR.

FAMILY WELFARE PROGRAMME IN THE NINTH PLAN

126. Reduction in population growth rate is one of the major objectives of the Ninth Plan. Ninth Plan envisages a paradigm shift in the FW programme. The Plan proposes to meet all the felt needs of the family and enable tem to achieve their reproductive goals. If

this were done the families will ensure that the national goal of rapid population stabilisation. Ninth Plan envisages a paradigm shift from:

- Demographic targets to focus on enabling the couples to achieve their reproductive goals.
- Method specific contraceptive targets to meeting all the unmet needs for contraception to reduce unwanted pregnancies.
- Numerous vertical programmes for family planning and maternal child health to integrated health care for women and children.
- Centrally defined targets to community need assessment and decentralised area specific microplanning and implementation of reproductive and child health care (RCH) programme to reduce Infant mortality and reduce high desired fertility.
- Quantitative coverage to emphasis on quality and content of care.
- Predominantly women centred programme to meeting the families health care needs with emphasis on involvement of men in Planned Parent hood.
- Supply driven service delivery to need and demand driven service; improved logistics for ensuring adequate and timely supplies to met the needs.
- Service provision based on providers perception to addressing choices and conveniences of the couples.

127. During the Ninth Plan period efforts will be intensified to enhance the quality and coverage of family welfare services through:

- Increasing participation of general medical practitioners working in voluntary, private, joint sectors and the active cooperation of practitioners of ISM&H;
- Involvement of the Panchayati Raj Institutions for ensuring inter-sectoral coordination and community participation in planning, monitoring and management;
- Involvement of the industries, organised and unorganised sectors, agriculture workers and labour representatives.

128. Efforts are being made to provide adequate inputs to improve availability and access to services to improve performance so that the disparities between states will be narrowed. It is noteworthy that there are districts in these states where CBR and IMR are well below the national levels; steps may have to be initiated to study and replicate these success stories within each of these states so that the existing disparities between states are minimised.

NATIONAL POPULATION POLICY 2000

129. One of the major recommendations of the NDC Sub Committee on Population was that a National Population Policy (NPP) should be drawn up so that it provides reliable and relevant policy frame work not only for improving Family Welfare Services but also for measuring and monitoring the delivery of family welfare services and demographic impact in the new millennium. The Department of Family Welfare has drawn up the National Population Policy 2000. The NPP has been approved by the Cabinet.

130. One of the major objectives of the Policy is that the country should achieve replacement level of fertility by 2010 and population stabilisation by 2045. The National Population Policy 2000 has set the following goals:

- Universal access to quality contraceptive services in order to lower the Total Fertility Rate to 2.1 and attaining two-child norm.
- Full coverage of registration of births, deaths and marriage and pregnancy.
- Universal access to information/counselling and services for fertility regulation and conception with a wide basket of choices.
- Infant Mortality Rate to reduce below 30 per thousand live births and sharp reduction in the incidence of low birth weight (below 2.5 kg.) babies.
- Universal immunisation of children against vaccine preventable diseases, elimination of Polio by 2000 and near elimination of Tetanus and Measles.
- Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.
- Achieve 80 per cent institutional deliveries and increase in the percentage of deliveries conducted by trained persons to 100 per cent.
- Containing of Sexually Transmitted Diseases.
- Reduction in Maternal Mortality Rate to less than 100 per one-lakh live births.
- Universalisation of primary education and reduction in the drop out rates at primary and secondary levels to below 20 per cent both for boys and girls.

NATIONAL COMMISSION ON POPULATION

131. India has reached one billion population on 11th May 2000. On that day Prime Minister announced the formation of the National Population Commission with Prime Minister as the chairman and Deputy Chairman Planning Commission as Vice Chairman. Chief Ministers of all states, Ministers of the related Central Ministries, Secretaries of the concerned Departments eminent physicians, demographers and the representatives of the civil society are Members of the Commission. The Commission has the mandate:

- To review, monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy.
- Promote synergy between health, educational environmental and developmental programmes so as to hasten population stabilisation.
- Promote inter sectoral coordination in planning and implementation of the programmes through different sectors and agencies in Centre and the States.
- Develop a vigorous peoples programme to support this national effort.

MATERNITY BENEFIT SCHEME

132. The Group of Ministers constituted by the Cabinet Secretariat to look into the draft National Population Policy had recommended that the Maternity Benefit Scheme being implemented by the Department of Rural Development may be transferred to the Department of Family Welfare. The two departments involved have been requested to initiate necessary action for the early transfer of the scheme.

STRENGTHENING OF RURAL SUB-CENTRES UNDER NATIONAL HUMAN DEVELOPMENT INITIATIVE MEASURE

133. The Finance Minister in his Budget Speech for 1999-2000 announced a scheme for Strengthening the Rural Infrastructure by sharing responsibilities between the Panchayat, the State Governments and the Central Government for promoting Primary Health Care. In the structure of Primary Health Care, the Rural Sub-centres are the only institution which corresponds to the level of Panchayat. Therefore it is proposed to strengthen the sub-centres, funds for which will be contributed by the Central Government, State Governments and the Panchayats in the ratio of 2:2:1. The scheme envisages assistance to the State Governments and through them to the Panchayats for opening new centres in areas where the existing centres are already overloaded due to large area assigned to it and for strengthening the existing one with building and equipment. The Department of Family Welfare had earlier proposed an outlay of Rs.48 crore for the schemes which was later reduced by the Department to Rs.1 crore as a token provision. Since the scheme was not sent to Planning Commission for approval the Commission did not provide any allocation for the scheme.

INTERSECTORAL COORDINATION AND CONVERGENCE OF SERVICES

134. Effective implementation of Family Welfare Programme involves a great deal of inter-sectoral coordination. The related sectors have to take steps to enhance the status of women, particularly women's literacy and employment, to raise age at marriage, their general development, generating more income in rural areas. The Departments whose activities have close linkages with Family Welfare Programmes are the Department of Women and Child Development, Human Resource Development, Rural Development, Urban Development, Labour, Railways, Industry and Agriculture. All these Departments may involve their extension workers in propagating IEC messages pertaining to reproductive and child health care to the population with whom they work. Concerned Central and state departments like Department of Women & Child Development, Human Resources Development, Rural Development etc. may take steps to improve the status of girl child and of women, improving female literacy and employment, raising the age at marriage, generating more income in rural areas. Some of areas of inter-sectoral coordination are indicated below.

Department Of Education

- Involve all districts Saksharata Samitis in IEC activities pertaining to RCH Programme.
- As a part of socially useful productive work involve school teachers and children in Class V and above in growth monitoring, immunisation and related activities in the village at least once a month.

Women And Child Development

- Involvement of Anganwadi workers in compilation of local events such as births, deaths, identification of pregnant women and in recording of birth weights.
- Utilisation of Anganwadi worker in improving coverage of massive dose Vitamin-A in children and improving compliance in Iron-folic acid medication in pregnant women.

- Identification of undernourished pregnant & lactating women and children below 5 years to ensure that these vulnerable populations get benefit of the food supplementation programmes under ICDS.
- In coordination with members of Panchayati Raj Institutions and agricultural extension workers to promote growing of adequate quantities of green leafy vegetables, herbs and condiments and ensure that these are supplied to anganwadies on a regular basis so that food supplements have also the vitamin and mineral contents.

Rural Development

- With the cooperation from Panchayati Raj Institutions utilise JRY for construction and maintenance of Primary health care institutions specially sub-centres and PHCs.

Rural Water Supply and Sanitation

- Explore feasibility of providing access to safe drinking water and sanitary disposal of wastes in primary health care institutions, Anganwadi, primary schools and panchayats on a priority basis through existing programmes.

Others

- Coordination among village-level functionaries – namely Anganwadi workers, Mahila Swasthaya Sangh (MSS), Traditional Birth Attendant (TBA), Krishi Vigyan Kendra (KVK) Volunteers, School teachers to achieve optimal utilisation of available services.

URBAN HEALTH AND FAMILY WELFARE SERVICES

135. Nearly 30 per cent of India's population lives in urban areas. Urban migration over the last decade has resulted in rapid growth of people living in urban slums. The massive inflow of the population has also resulted in the deterioration of living conditions in the cities. In many towns and cities the health status of urban slum dwellers is worse than that of the rural population. The Department of Family Welfare has been trying to extend the family welfare services to the urban population. Department of Family Welfare is supporting a network of urban family welfare centres with the objective of extending the family welfare services. Besides, externally aided projects like IPP-VIII were aimed to provide the family welfare services to the urban population in selected cities. Similarly, the urban component of externally aided Reproductive and Child Health Care (RCH) Programme provides family welfare services to the urban population.

136. The infrastructure for providing primary health care facilities to the urban population has not been established and a conscious effort need to be made for this. This health care infrastructure will also help in improving the outreach of family welfare services in the urban areas. The state health sector plan programmes should aim to develop the requisite infrastructure in the urban areas. The local bodies like municipalities/municipal corporations should supplement the efforts of the state Governments and the Central Government in this regard.

INVOLVEMENT OF LOCAL SELF-GOVERNMENT INSTITUTIONS

137. With the 73rd and 74th Constitutional amendments the Nagar Palikas and Panchayati Raj Institutions, are becoming operational in many States. These institutions should play increasing role in ensuring planning, implementation and monitoring of health and family welfare services at the local level. They should also ensure effective coordination of programmes at the local level between related sectors such as sanitation, safe drinking water and women and child development, so that optimal benefit from all these programmes become available to the community and the vulnerable segments receive the attention that they need.

INVOLVEMENT OF NON-GOVERNMENTAL ORGANISATIONS AND VOLUNTARY ORGANISATION FOR PROMOTION OF FAMILY WELFARE

138. The Ministry of Health & Family Welfare has initiated several programmes involving Non-Governmental Organisations (NGOs) in efforts to improve Family Welfare Programme. These include:

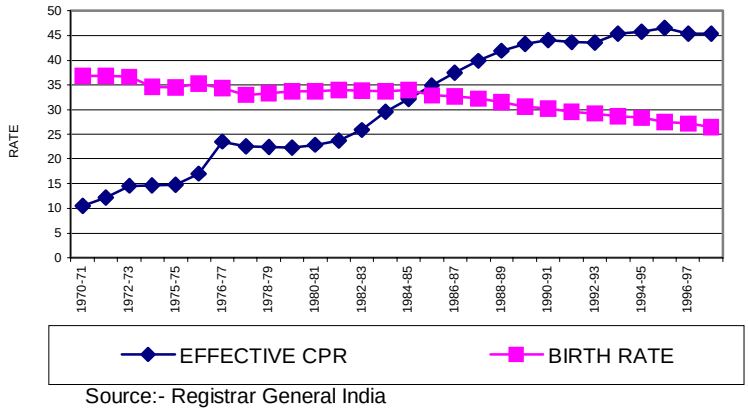
(i) revamping of Mini Family Welfare Centre in areas where the couple protection rates are below 35 percent;
(ii) involvement of ISM & H practitioners;
(iii) area-specific IEC activities through NGOs;
(iv) establishment of Standing Committees for Voluntary Action (SCOVAs) to fund NGO projects promptly;
(v) identification of Government/NGO organisations for training of NGOs in project formulation, programme management and monitoring.

These activities were continued and intensified during the 2000-2001.

Performance Of The Family Welfare Programme

139. Information on CPR and CBR indicate that there has been a steady decline in

FIGURE 5.4.3.1
COUPLE PROTECTION RATE & BIRTH RATE



Source:- Registrar General India

Department of Family Welfare

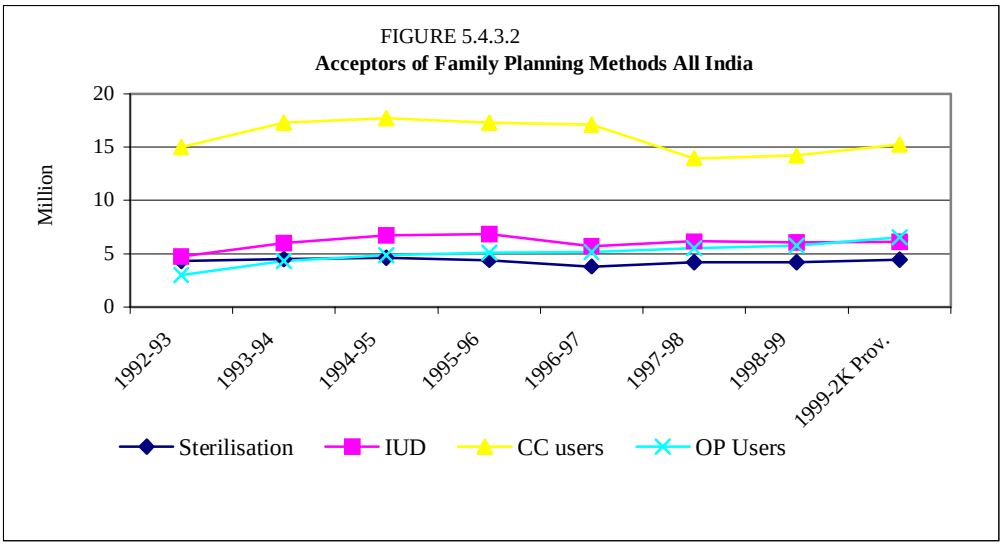
the CBR during the Nineties in spite of the fact that the rise in CPR during the nineties has been very slow (Figure 5.4.3.1). This may indicate that there has been improvement in the

quality of services being provided and appropriate contraceptives are being provided at appropriate time. It is essential that there should be further improvement in providing counselling and quality of services to enable couples to make the appropriate choice; improvement in follow up care appropriate will go a long way in improving continued use of contraceptives to avoid unwanted pregnancies.

140. Data from service reports during the Ninth Plan period indicate that there has been a decline in acceptors of all family Planning methods except IUD as compared to the level of

FIGURE 5.4.3.2

Acceptors of Family Planning Methods All India

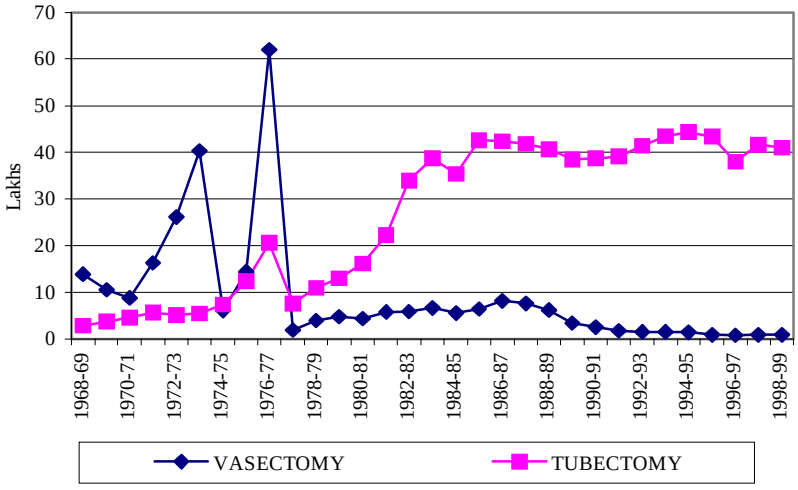


acceptance in 1994-95 (Figure 5.4.3.2). Sterilisation remains to be the most commonly used method of contraception in all states. During the year 1999-2000 the acceptors of sterilisation have shown an increase of 6.3 per cent over the year 1998-99. The major states that have shown significant increase in the acceptors of sterilisation are Assam, Madhya Pradesh, Bihar, Kerala, Tamil Nadu, Punjab, Uttar Pradesh and Maharashtra. The number of sterilisations per ten thousand unsterilised couples varies considerably amongst the States. Andhra Pradesh has highest (939) sterilisations per ten thousand unsterilised couples while Assam has the lowest (76) sterilisations. The States, which are having lower number of sterilisations per ten thousand unsterilised couples as compared to all India average of 372, are Bihar (106), Orissa (252), Rajasthan (310), Uttar Pradesh (164) and West Bengal (282).

141. There had been a steady and progressive decline in the acceptors of vasectomy over the last two decades (Figure 5.4.3.3). Efforts to re-popularise vasectomy, including IEC campaigns and training of surgeons persons in non-

FIGURE 5.4.3.3

ACCEPTORS OF VASECTOMY & TUBECTOMY



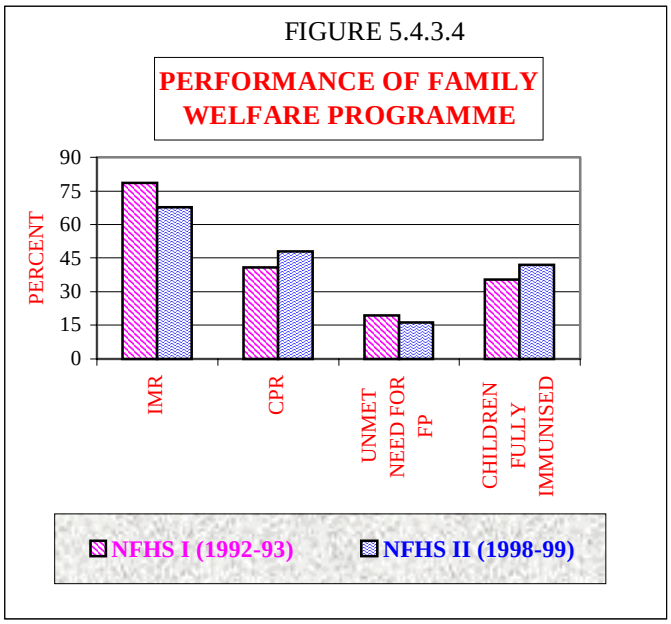
Source:- Department of Family Welfare

scalpel vasectomy has resulted in substantial increase in vasectomies in some districts in Andhra Pradesh; however, similar change has not happened at the national level. It is essential that the efforts to popularise vasectomy are continued by addressing the concerns and conveniences of men and improving the techniques and quality of vasectomy services. This would result not only in improving men's participation in the FW programme but also result in substantial increase in access to sterilisation services, reduction in the morbidity and mortality associated with sterilisation.

142. IUD acceptors have shown only a marginal increase during the year 1999-2000 as compared to 1998-99. The major states that have shown significant improvement in the acceptance of IUD are Assam and Karnataka. The states of West Bengal, Orissa, Maharashtra, Andhra Pradesh and Madhya Pradesh have shown a decline in performance during the year 1999-2000.

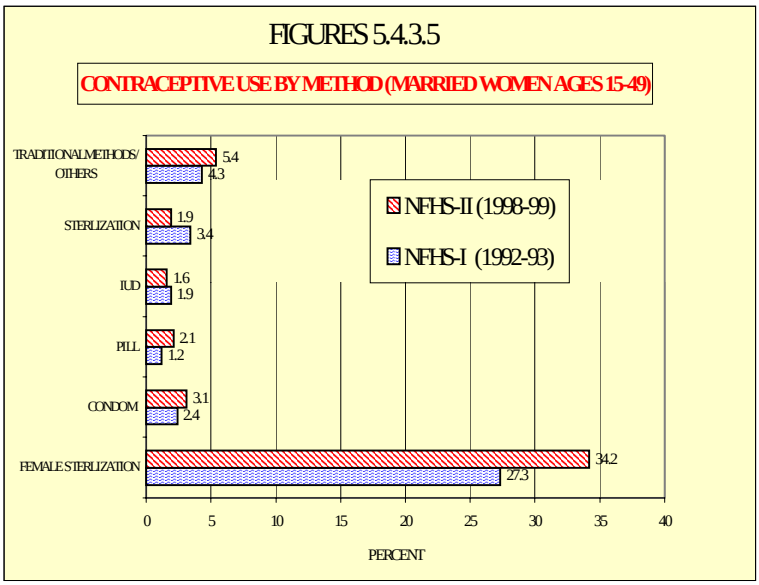
143. The acceptors of oral pill users have increased by 13.6 per cent during the year 1999-2000 as compared to the previous year. Among major states Punjab, Tamil Nadu, Uttar Pradesh, Madhya Pradesh, Haryana and Assam have shown an improvement in performance. The states of Bihar, Andhra Pradesh, West Bengal, Kerala and Karnataka have shown a decline in performance. CC users have shown an increase of 7.1 per cent during the year 1999-2000 as compared to the year 1998-99. All the major States except Tamil Nadu have shown a decline in CC users.

FIGURE 5.4.3.4



144. The National Family Health Survey 1992-93 and 1998-99 provide nationwide data on contraceptive prevalence (Figure 5.4.3.4 & 5.4.3.5).

FIGURES 5.4.3.5



Data from the Survey indicate that contrary to the figures from the service reports from the Department of Family Welfare there has been substantial increase in the sterilisation and OC use in the country. Only IUD and CC use have shown a decline. The reported improvement is supported by the steady decline in the CBR in the nineties reported in the SRS.

145. The reasons for the difference in the CPR figure reported by the Department of Family Welfare and NFHS include the following:

(i) Correction of the earlier over reporting in an attempt to reach the set target.
(ii) Incomplete reporting due to changes in reporting under the Family Welfare Programme during the period.

These need to be looked into and corrected so that service reporting provide reliable indication of progress achieved in the programme.

PERFORMANCE OF THE STATES WITH LARGE UNMET NEEDS

146. It is a mater of concern that in UP and Bihar, as compared to their own performance in 1994-95, there is a fall in the acceptance of all contraceptive methods. In MP, the decline is marginal while Rajasthan has shown some improvement. It is essential

FIGURE 5.4.3.6

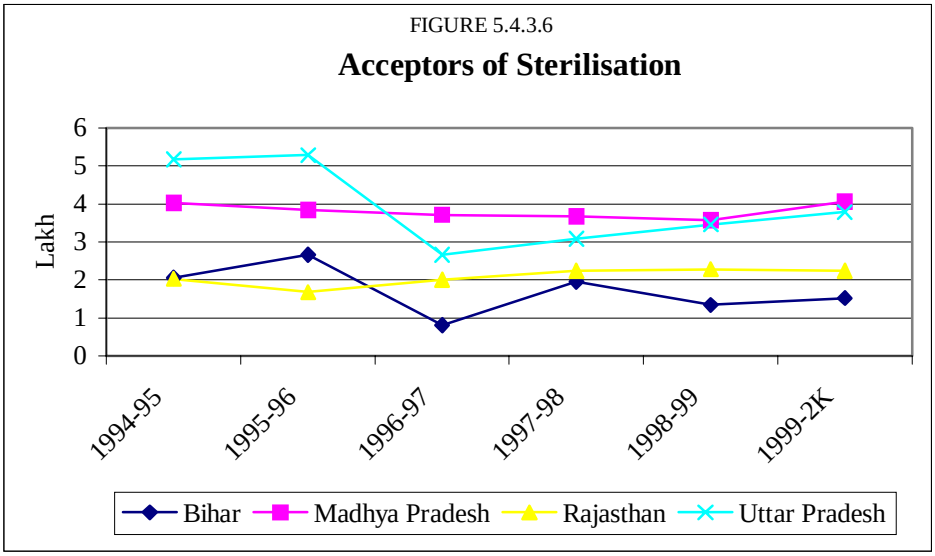
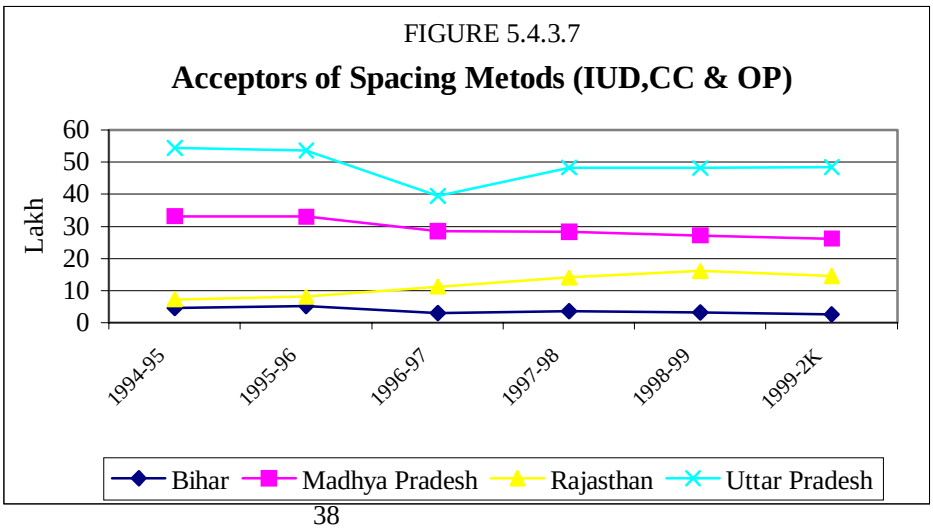


FIGURE 5.4.3.7



that efforts to meet all unmet needs for contraception in these States are made. There are however districts with low CBR in all these States. The States have to study and replicate the performance of these districts; simultaneously there should be efforts to meet all the unmet needs for contraception in all districts.

PERFORMANCE UNDER THE IMMUNISATION PROGRAMME

147. Immunisation coverage during the period 1992-93 to 1999-2000 is shown in

FIGURE 5.4.38

Immunisation Coverage-All India

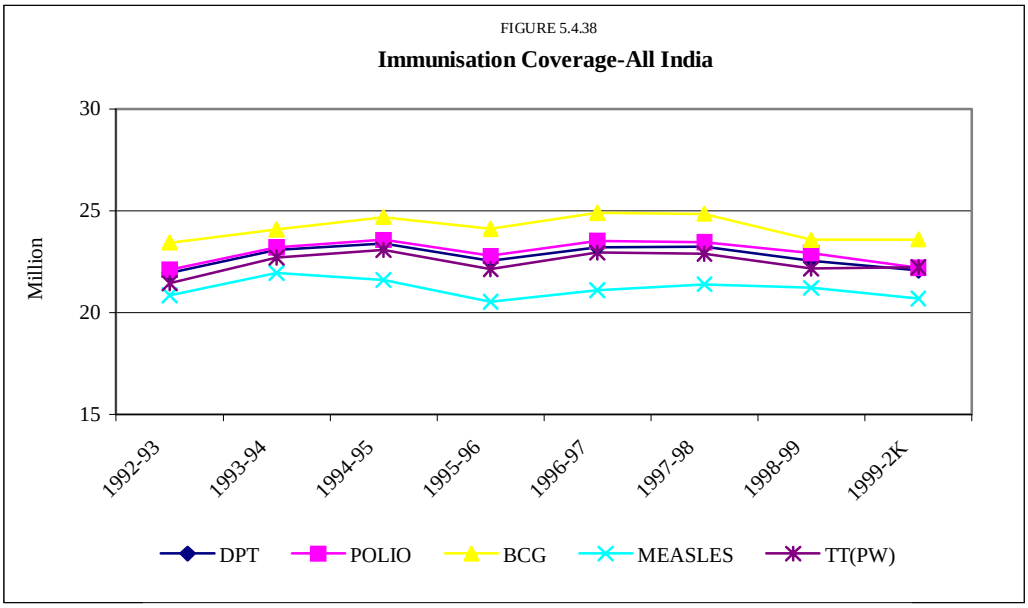
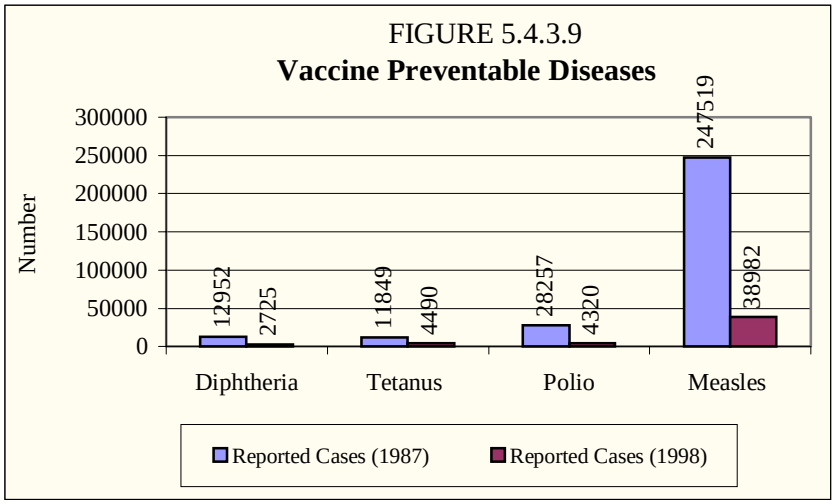


Figure 5.4.3.8. It is obvious that the Eighth Plan target of 100 per cent coverage for all six Vaccine Preventable Diseases (VPD) has not been achieved even by 2000 AD. The immunisation coverage has been stagnating at the same level throughout the nineties in most of the states and in some of the states even the declining trend is being observed. However, it is noteworthy that the reported cases of vaccine preventable diseases have declined over the same period. (Figure 5.4.3.9). The coverage evaluation survey conducted by ICMR and National Family Health Survey shows a wide gap between the reported and evaluated coverage. The drop out rates between the first, second and third doses of oral polio vaccine and DPT have been very high in most of the states. At the national level, the difference between the highest and lowest covered antigens is more than 20 per cent. The difference between the reported and evaluated coverage and high drop out rates is of serious concern. The data from the NFHS-I & II has shown that even though coverage under immunisation programme is substantially lower than the coverage figure reported by service providers;

FIGURE 5.4.3.9

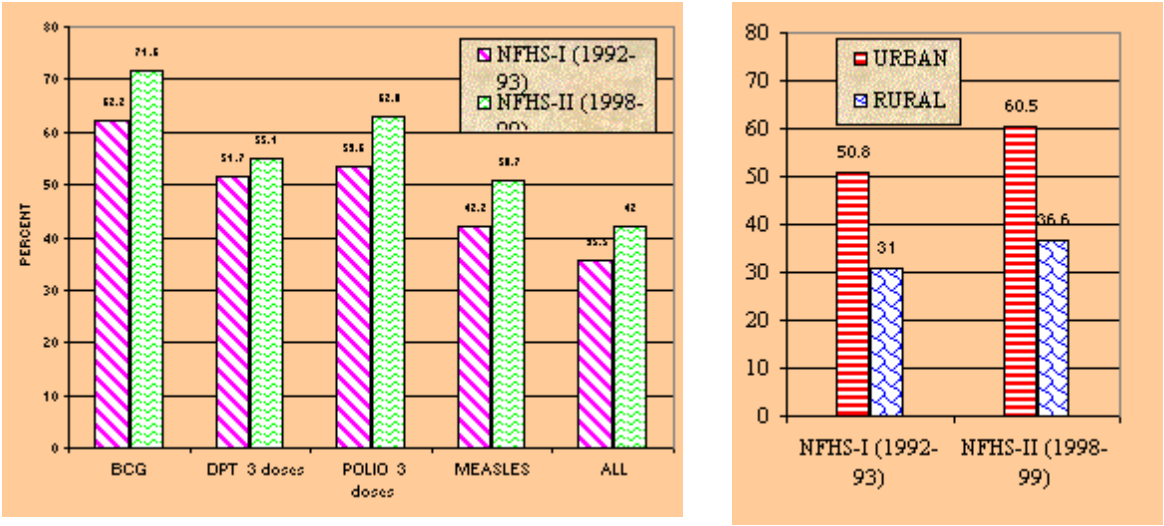
Vaccine Preventable Diseases



however, there has been some improvement in the immunisation coverage (Figure 5.4.3.10). It is essential that all efforts be made to ensure 100 per cent coverage under vaccine preventable diseases.

Figure-5.4.2.10

IMMUNISATION OF CHILDREN 12-23 MONTHS : NFHS-I (1992-93) AND NFHS-II (1998-99)



Pulse Polio Initiative

148. Pulse Polio initiation was taken up by the Department of Family Welfare in 1995 with the objective of achieving elimination of polio by 2000 AD. Initially, the programme consisted of two rounds of pulse polio immunisation of children below 5 years of age during the months of December and January. Since 1995 there has been significant decline in number of reported polio cases from 28257 reported in 1987 to 2810 in 1999; but the reduction was not of the magnitude as to achieve the target of elimination of polio by 2000 AD.

149. The programme was reviewed by the Department of Family Welfare in 1998-99. Following the review and expert advise from national and international agencies, the Department took up four rounds of pulse polio immunisation throughout the country with two additional rounds in eight states with high polio case load for the year 1999-2000. Special efforts were made to cover all the unreached children through a house to house survey after the initial booth based immunisation. Reported coverage levels both in urban and rural areas was high, near 100 per cent even in the districts with poor infrastructure. There were however reports of decline in the routine immunisation in many States; some States like Bihar reported routine immunisation coverage fall below 40 per cent. There were also concerns that routine maternal and child health service coverage was adversely affected in some States.

150. The map at Annexure 5.4.3.1 clearly indicates that in most part of the country over the last three years there has been significant decline in number of polio cases; the decline is sub-optimal in States of Delhi, Uttar Pradesh, Bihar and West Bengal. Many States like Kerala, HP, Jammu & Kashmir and north eastern States have not reported any case

during last 2-3 years. During 1999 Orissa has also joined these states and not reporting any case even though there was outbreak in Ganjam district in 1998. The major states like Tamil Nadu, Andhra Pradesh, Rajasthan, Haryana, Punjab have not reported as yet any confirmed case during 2000.

151. The Department of Family Welfare has come up with the revised proposal for pulse polio immunisation during 2000-01 that there will be two rounds of NIDs throughout the country in December and January; one additional round will be given in six States where cases of polio have been reported in 1999-2000 and two additional rounds in the States of UP, Bihar, West Bengal and Delhi which account for over 80 per cent of cases of polio reported in the country. Every effort will have to be made to ensure that the near 100 per cent coverage both during routine immunisation and the pulse polio rounds.

152. In spite of severe global shortage of oral polio vaccine, India has been able to persuade UNICEF, WHO and global manufacturers to provide the necessary vaccine during 1999-2000. With the goal to achieve polio eradication by the end of year 2000, all the other endemic countries have accelerated their efforts and during 2000-2001, there would be severe shortage of vaccine globally. It will be important for all the states to minimise the wastage rate which is 25 per cent at present and exercise strict monitoring to control any unwanted wastage. It would be important also to retrieve unused vaccine from the periphery which is more than their requirement for routine immunisation programme and store them at appropriate place with adequate cold-chain facility.

153. There is also a need to identify the areas of low coverage so as to intensify PPI activities in such areas. Near hundred per cent coverage of children for providing OPV both during routine immunisation and PPI is critical to achieve and sustain the goal of elimination of polio. The States and UTs should identify at a micro level, areas with low routine coverage, areas with low PPI coverage etc. to intensify immunisation activities and extending the outreach of services in these areas.

POLIO SURVEILLANCE

154. Efficient surveillance is essential for all disease control programmes. The Department has strengthened the surveillance for polio and achieved substantial improvement in the reporting of cases. The programme is being extended to cover other vaccine preventable diseases. This in turn should be integrated with the ongoing disease surveillance programme being funded by the Department of Health so that over the next five years the country builds up a sustainable disease surveillance and response system.

155. The district wise surveillance data for the year 1998 and 1999 shows that there are large number of districts which have low surveillance indicators and would therefore require special attention in improving surveillance system at the earliest. The data also needs to be used in developing the action plan for identifying high risk districts and blocks in the State. In Andhra Pradesh, the districts of Chittoor and Warangal needs special attention to improve the surveillance system. In Assam, the districts of Barpeta and Bongaigaum, Nalbari and Shibsagar have reported non polio AFP rate less than 1. It is essential that polio surveillance is strengthened further and all cases are detected. It is important that along with this, there is an effort to improve the surveillance against all six vaccine preventable diseases. It is also important that linkages are developed with the ongoing national initiative on disease

surveillance so that within the next five years a reliable disease surveillance and monitoring mechanism is built up.

PPI EVALUATION

156. The Department of Family Welfare has carried out independent coverage evaluation surveys for the immunisation programme and the pulse polio initiative. The coverage evaluation survey report indicate that the actual coverage is substantially lower than the figures reported through service channels. It is imperative that steps are taken to improve coverage both under the routine immunisation and under pulse polio immunisation.

EVALUATION OF RCH PROGRAMME

157. Monitoring indicators do not provide any information on the quality of care or appropriateness of the services. The programme must evaluate `quality of care' of the services being provided. Efforts should be made to collate and analyse service data collected at the district level and respond rapidly to the evolving situations. Available data from census, demographic and health surveys undertaken in the district by various agencies including the Population Research Centres needs to be analysed and utilised at the local level for area-specific micro planing. The Department of Family Welfare has constituted regional evaluation teams which carry out regular verifications and validate the acceptance of various contraceptives. Besides, the information generated through ad hoc surveys such as National Family Health Survey (NFHS) must also be utilised to identify the shortcomings of the programme and to initiate requisite remedial measures. The Department of Family Welfare has completed rapid household surveys under RCH project in about fifty per cent of the districts during the year 1998-99 and 1999-2000. The main focus of the survey was on estimating coverage under ante-natal care and immunisation, proportion of safe deliveries, contraceptive prevalence rate, unmet need for family planning, utilisation of health/family welfare services and users satisfactions. The information collected provided useful feed-back for evaluation of the implementation of the programme. The census reports, studies conducted through Population Research Centres, ad hoc surveys and district surveys under RCH provide data for evaluating the impact of the programme. The data generated through these reports and surveys should be utilised to evaluate the family welfare programme at the PHC level.

DISTRICT FACILITY SURVEYS

158. To assess the availability and utilisation of facilities in various health institutions in the country, district-wide facility surveys have been initiated. Information is collected from district hospitals/sub-divisional level hospitals/CHCs/PHCs. Reports from about 240 districts have been received. The survey results are being analysed and disseminated to the respective districts as well as the State governments for remedial measures.

DISTRICT SURVEYS

159. District surveys have been initiated by the Department of Family Welfare with the objective of ascertaining the status of individual component of RCH programme. Under these surveys, a sample of 1000 households in every district will be selected to ascertain which RCH facilities are reaching the people and to what extent. Half the districts are being taken up every year. In the first phase, the survey was conducted in 270 districts by

independent agencies under the aegis of IIPS during 1998-99. In 1999-2000, survey in another 250 districts has been completed. The reports are being made available to the respective State Governments. Workshops were also arranged with the help of Regional Family Welfare Centres and State Institute of Health & Family Welfare so that the action points emerging out of the reports are implemented. The salient results of the second phase of survey are given below:

- The districts having the higher order of birth less than 20 per cent, are observed in 5 districts out of 7 districts in Kerala, two out of ten in Karnataka, one out of eleven in Tamil Nadu, one in Goa (all), and one out of two in Pondicherry, out of 253 districts surveyed.
- The per cent of pregnant women who had IFA tablets is more than 74 per cent, are in respect of only 37 districts out of 253 surveyed; these are 5 districts in Andhra Pradesh, one in Gujarat, 6 each in Karnataka and Kerala, 5 in Maharashtra, 2 in Tamil Nadu in major states. 50 to 75 per cent coverage was observed in 75 districts in the country. The IFA tablets coverage is weak in many States, especially in Bihar, MP, Rajasthan and UP where more than 50 per cent of the districts had a coverage of IFA tablets of less than 30 per cent.
- The National Programme provides for three ante-natal check up to take care of complicated pregnancies/deliveries. The districts in States had more than 75 per cent pregnant women had undertaken 3 ante natal check up are mainly AP (almost all), Karnataka (80 per cent), Kerala (all), Tamil Nadu (all). In the country only about 18 of the districts have more than 75 per cent of the pregnant women had all 3 ANCs.
- Only 9 per cent of the districts had more than 75 per cent of the deliveries conducted in hospitals out of 253 districts surveyed in 2nd phase. The States are mainly Kerala (all), Tamil Nadu (9 out of 11) and Pondicherry (1 out of 2). The States where less than 30 per cent deliveries were conducted in hospitals are Assam, Bihar, Haryana, MP, Orissa, Rajasthan and UP amongst major States. At all India level, in 57 per cent of the districts, institutional deliveries have been less than 30 per cent.
- The usage of ORS packets was inadequate with no districts reporting usage of ORS packets in more than 75 per cent of the cases of diarrhoea in the country. 87 per cent of the districts reported usage of ORS in less than 25 per cent of the episodes of diarrhoea.
- The percentage of children who have been fully immunised with 3 doses of Polio, 3 doses of BCG, Measles and DPT have been more than 75 per cent in only 27 per cent of the districts.
- The widely accepted method in family planning, sterilisation has been highly accepted in the states of Andhra Pradesh, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Tamil Nadu.

FUNDING OF FAMILY WELFARE PROGRAMME

Financing Of Non-Plan Activities Through The Plan Funds

160. Family welfare programme is an important programme and was initiated as a plan scheme so that adequate attention is paid with regard to positioning of requisite manpower at various health care delivery institutions. The programme is a hundred per cent centrally

sponsored programme and is being implemented through the State Governments. The Department of Family Welfare provides funds to the State Governments for the maintenance of health and family welfare infrastructure and implementation of the programme according to certain fixed norms. The plan funds of the Department of Family Welfare are being utilised for meeting the expenditure on the programme activities such as salaries, recurrent provision for rent, medicines, contingencies etc. which are essentially non-plan in nature. This committed non-plan expenditure on salaries and maintenance of infrastructure leaves the Department of Family Welfare with no funds to take up any new innovative programmes. Department of Family Welfare has requested the Finance Commission for transfer of the non-plan activities to the Non Plan side. Planning Commission has also supported the request of the Department in this regard. The decision of the Finance Commission is awaited.

The Problem Of Arrears, Need For Reorganisation Of The Programme And Involvement Of States

161. The Department of Family Welfare provides funds for the maintenance of 97,757 sub-centres out of 1,36,339 functioning sub-centres. Planning Commission had repeatedly emphasised the need for financing all the functioning sub-centres so that the ANMs which are crucial peripheral workers for implementation of the Family Welfare Programme are in position at all the sub-centres. The Department of Family Welfare bears the cost of maintenance of rural family welfare sub-centres, Postpartum Centres, Urban Family Welfare Services and training activities according to certain norms which were fixed long back. There is a wide gap between the actual funds required to maintain the above services and the funds being provided according to the norms. Thus, it results in the accumulation of arrears payable to the States. The delay in the payment of arrears to the states adversely affects the family welfare services in all the states especially those with fiscal problems; many of these States such as Bihar, UP, MP and Rajasthan are also the ones who have make all efforts to improve performance in family welfare programme. In view of this the Planning Commission had suggested that there is an urgent need to review the norms for providing funds to the states for implementation of the family welfare programmes.

162. As suggested by the Planning Commission, the Department of Family Welfare constituted a Consultative Committee to review these norms, evolve realistic norms for salary, contingency and other expenses for different types of infrastructure and manpower funded by the Department of Family Welfare. The Consultative Committee constituted by the Department of Family Welfare to revise norms has also looked into rationalisation of infrastructure and manpower created in rural and urban areas so that Centre and states both fund the relevant portions of the programme. The Department of Family Welfare has circulated draft report of the Committee to the States for their comments; it is expected that the report will be finalised and the recommendations implemented in the current year.

EXTERNALLY AIDED PROJECTS

163. Area Development Projects have been taken up under National Family Welfare Programme in different States with financial assistance from external agencies such as the World Bank, United Nations Population Fund (UNFPA), Overseas Development Agency and Danish International Development Agency (DANIDA) with the objectives of reducing maternal and child mortality, morbidity and birth rate.

164. IPP VIII and IPP IX projects, Family Health Support Project in Maharashtra assisted by German Government, DANIDA Phase III Project in Tamil Nadu, ODA Phase III Project in Orissa and UNFPA assisted district projects in five districts of Kerala, Bihar, Maharashtra, Rajasthan and Himachal Pradesh would continue during 1999-2000. The USAID assisted project in UP would also continue during 2000-01 for which a provision of Rs.250 crore has been made.

REPRODUCTIVE AND CHILD HEALTH PROGRAMME

165. The CSSM and related programmes have been reorganised into Reproductive and Child Health (RCH) Programme. This programme seeks to integrate and expand family welfare services, upgrade their quality and make them easily accessible to the people. The essential feature of this programme is balanced and pointed attention to contraception issues, maternal health issues and child survival issues without leaving out any of their components unattended. Efforts are being made to improve the health status of women and children and thus ensure a decline in population growth. Focussed attention is being paid to improve the service delivery systems.

166. The total cost of the project which is to be implemented during the Ninth Plan period is Rs.5112 crore out of which Rs.3600 crore is expected to be the external assistance and the balance amount is to be provided by the Government of India for sustaining the on-going maternal and child health care activities and for counter part funding for the RCH Project. A provision of Rs.743 crore has been made for different programmes under RCH Programme for the Annual Plan 2000-01.

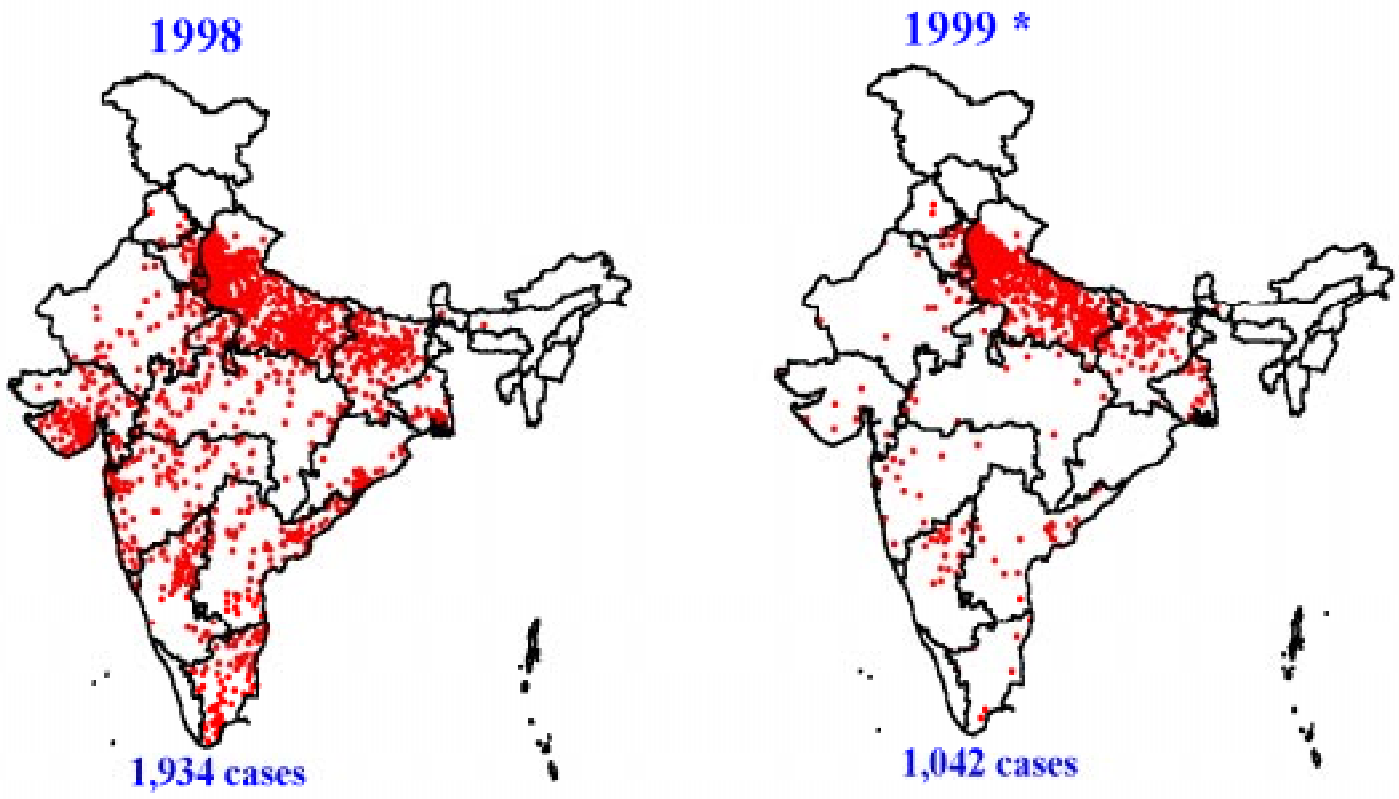
OUTLAYS FOR 2000-01

167. The outlay for Annual Plan 2000-01 the Department of Family Welfare is Rs.3520 crore. Planning Commission did not support the scheme of supply of mopeds to ANMs and observed that the evaluation of scheme must be completed so as to take a decision on continuation of the scheme during the future annual plans. The Planning Commission reduced the provision for the scheme of Supply/Procurement of Laproscopes in view of the fact that the evaluation studies have shown that laproscopic sterilisation at Camps settings is associated with higher morbidity. The provision for the scheme on procurement of cold chain equipment was reduced in view of the poor expenditure during the annual plan 1999-2000. The provision for the schemes RCH Contractual Staff & Services, Training Activity under RCH, Involvement of NGOs, IEC activities, Research Activities under RCH, Special Project for Tribal and Urban Slums and other RCH interventions was reduced in view of the fact that these programmes are being implemented for the last two years and outlays for these activities was felt to be de-escalated. Planning Commission approved an increased outlay under arrears so as to liquidate all the arrears payable to the States for implementing the family welfare programme as per the norms fixed by the Department of Family Welfare. The Group of Ministers constituted by the Cabinet Secretariat to make recommendations on the draft National Population Policy had recommended that the Maternity Benefit Scheme being now implemented by the Department of Rural Development be transferred to the Department of Family Welfare. Planning Commission had requested the Department of Rural Development and the Department of Family Welfare to initiate steps for early transfer of the scheme. A token provision of Rs.1 crore was approved by Planning Commission for the Maternity Benefit Scheme under the Annual Plan 2000-2001. The scheme-wise allocation of the approved outlay is shown in Annexure 5.4.3.2.

ANNEXURE 5.4.3.1

Locations of polio virus in India

1 dot = 1 case



* data as on 5th February 2000

ANNEXURE 5.4.3.2

Department Of Family Welfare

Annual Plan 2000-2001 (Rs. in crore)

	Scheme	1999-2000 Approved outlay	1999-2000 Anticipated Expnd.	2000-2001 Proposed outlay	2000-2001 approved outlay	
					GBS	EAP
	1	2	3	4	5	6
1	Rural Family Welfare Centres	350.00	350.00	637.00	375.00	
2	Sub-Centres	525.00	525.00	1102.00	575.00	
3	Maintenance of urban FW Centres	27.00	27.00	53.02	28.00	
4	Revamping of urban level organization	31.00	31.00	47.85	32.00	
5	Direction & Administration	185.50	115.50	171.00	116.00	
6	Sterilization beds	1.70	1.70	1.90	1.50	
7	Post Partum Centres	120.00	120.00	236.48	120.00	
8	Basic Training Schools	61.90	61.08	96.29	63.75	
9	Village Health Guides Scheme	10.00	10.00	10.00	10.00	
10	Sterilization and IUD insertion	140.00	110.00	162.00	120.00	
11	Community incentive scheme	0.00	0.00	108.00	0.00	
12	Transport	43.00	43.00	129.00	48.00	38.00
	(a) Maintenance of vehicle already available	30.00	30.00	35.00	30.00	
	(b) Procurement of vehicles to replace exiting	3.00	3.00	56.00	10.00	
	(c) Supply of Mopeds to ANMs	10.00	10.00	38.00	8.00	8.00
13	Contraceptives	267.70	212.70	349.58	223.70	41.00
	(a) Free distn. Of Conventional Contraceptive	50.00	50.00	108.00	50.00	
	(b) Free Supply of Lippies, loops & Cu-T.	22.50	22.50	24.02	22.50	
	(c) Free Supply of oral pills	15.00	15.00	14.00	15.00	
	(d) Social marketing of contraceptives	140.00	105.00	127.59	106.00	20.00
	(e) Supply /Procurement of Laparascopes	20.00	20.00	30.00	10.00	
	(f) Testing Facilities	0.20	0.20	0.25	0.20	
	(g) No-Scalpel Vasectomy					1.00
	(h) Logistics Improvement	20.00	0.00	45.72	20.00	20.00
14	Procurement of cold chain Equipment	50.00	0.00	38.17	20.00	
15	Hindustan Latex Ltd.	0.10	0.10	0.05	0.00	
16	Travel of Experts/Conferences /Meetings etc.	1.50	0.50	1.50	1.00	
17	Research Institutes	25.30	25.30	32.62	28.45	
18	International Contribution	1.30	1.30	1.60	1.60	
19	Information, Education and Communication	31.20	31.20	35.91	30.00	
20	Strengthening of National Immunization Programme and Eradication of Polio					45.00
21	Reproductive & Child Health Project	676.80	889.80	1505.81	715.00	1019.00
	(a) Procurement of vaccines/equipment/drugs	325.00	555.00	702.00	475.00	
	(b) RCH Contractual Staff and services	30.00	12.00	24.21	10.00	
	(c)Training activities under RCH	50.00	25.00	50.00	20.00	
	(d) Involvement of NGOs and SCOVA	26.00	20.00	34.50	15.00	
	(e) Information, Education and Communication	88.80	138.80	167.60	80.00	
	(f)Research Activities under RCH	20.00	14.00	21.50	10.00	
	(g) Special Project for tribal and urban slums	12.00	0.00	41.00	5.00	
	(h) Other RCH Interventions and services	100.00	100.00	405.00	50.00	
	(I) RCH District Projects	25.00	25.00	75.00	50.00	
22	Area Project	100.00	130.00	367.00	250.00	200.00
23	USAID Assisted U.P.Project	70.00	70.00	70.00	60.00	60.00
24	Arrears	200.00	700.00	900.00	700.00	
25	FW Counsellor Scheme	1.00	0.00	0.00	0.00	
26	Maternity Benefit Scheme	0.00	0.00	0.00	1.00	
	GRAND TOTAL	2920.00	3455.18	6056.78	3520.00	1403.00