HEALTH

10.28 There has been some improvement in the quality of health care over the years (Table 10.13), but wide inter-State, male-female and rural-urban disparities in outcomes and impacts continue to persist. While population stabilization is in the Concurrent List, health is a State subject. The reproductive and child health services reach community and household levels through the primary health care infrastructure. Inadequacies in the existing health infrastructure have led to gaps in coverage and outreach services in rural areas.

10.29 India's position on health parameters compared even to some of its neighbours continues to be unsatisfactory. While India has improved with respect to some important health indicators over the years, it compares poorly with countries like China and Sri Lanka (Table 10.14).

National Rural Health Mission (NRHM)

10.30 The National Rural Health Mission was launched on April 12, 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality.

Table 10.13 India — Selected Health Indicators

Sl. No.	Parameter	1981	1991	Current level
1.	Crude Birth Rate (CBR) (Per 1000 Population)	33.9	29.5	23.5 (2006)
2.	Crude Death Rate (CDR)(Per 1000 Population)	12.5	9.8	7.5 (2006)
3.	Total Fertility Rate (TFR)(Per women)	4.5	3.6	2.9 (2005)
4.	Maternal Mortality Rate (MMR) (Per 100,000 live births)	NA	NA	301 (2001-03)
5.	Infant Mortality Rate (IMR)(Per 1000 live births)	110	80	57 (2006)
6.	Child (0-4 years) Mortality Rate per 1000 children	41.2	26.5	17.3 (2005)
7.	Life Expectancy at Birth:	(1981-85)	(1989-93)	(2001-05)
	Male	55.4	59.0	62.3
	Female	55.7	59.7	63.9

Source: Office of Registrar General India.

NA: Not Available.

Table 10.14 Some health parameters: India and its Neighbours

Country	Life expectancey at birth (years)	Under-five mortality rate (per 1000 live births)		Infant Mortality Rate (per 1000 live births)		Maternal mortality Rate (per 1,00,000 live births)
	2000-05	1990	2005	1990	2005	2005
China	72	49	27	38	23	45
India	**62.9**	**123**	**74**	**80**	**56**	**450**
Nepal	61.3	145	74	100	56	830
Pakistan	63.6	128	99	96	79	320
Sri Lanka	70.8	23	14	19	12	58
Bangladesh	62.0	144	73	96	54	570
South Asia	62.9	126	80	84	60	NA

Source : UNDP, Human Development Report 2007-08.

NA: Not available. Figures shown for India are at variance with the official figures of the Office of Registrar General of India (RGI) for Maternal Mortality Rate and Infant Mortality Rate. Data shown in the table are as per the methodology and adjustment made by UNDP.

Under the NRHM, the focus was on a functional health system at all levels, from the village to the district.

10.31 NRHM has successfully provided a platform for community health action at all levels. Besides merger of Departments of Health and Family Welfare in all States, NRHM has successfully moved towards a single State and District level Health Society for effective integration and convergence. Through a concerted effort at decentralized planning through preparation of District Health Action Plans, NRHM has managed to bring about intra-health sector and inter-sectoral convergence for effectiveness and efficiency. In all the States, specific health needs of people have been articulated for local action. With the establishment of public institutions like the Village Health and Sanitation Committees (VH&SCs), Hospital Development Committees and PRI led Committees, it is the civil society to which the health system is being made increasingly accountable. Through untied and flexible financing, NRHM is trying to drive reforms that empower local communities to make their own decisions. It is thus a serious effort at putting people's health in people's hands (Box 10.7).

Funding for Support Mechanism of ASHA

10.32 One of the key strategies under the NRHM is a community health worker, i.e., Accredited Social Health Activist (ASHA) for every village at a norm of 1,000 population. The role of ASHA vis-à-vis that of Anganwadi Worker (AWW) and Auxiliary Nurse Mid-wife (ANM) is also clearly laid down. Under the implementation framework for the NRHM, the scheme of ASHA has now been extended to all the 18 high focus States. Besides, the scheme would also be implemented in the tribal districts of the other States. In the new

Box 10.7 Broad achievements under the Mission

- 5,43,315 ASHAs/Link Workers have been selected so far in the States.
- 1,86,606 ASHAs/Link Workers have drug kits.
- In all the States, ASHAs/Link Workers have facilitated the households' links with the health facilities.
- 1,77,578 VH&SCs are already functional. Many other States have also issued Government Orders in this regard and are in the process of activating the Committees.
- Of the 1,41,492 functional Sub-Health Centres, 1,11,979 have operationalized a joint bank account of ANM and Sarpanch for united funds.
- ANMs are playing an important role in the organization of Village Health and Sanitation Days and nearly 4.8 lakh such days have been organized in the last two years.
- 25,987 ANMs have been appointed on contract so far. 14,440 Sub-Centres are reporting 2 ANMs.
- Strengthening of the PHCs for 24x7 services is a priority of NRHM. Of the 22,669 PHCs in the country, only 1,634 of them were working 24x7 on March 31, 2005 (before the NRHM). The number of 24x7 PHCs today, as reported by the States is 8,755 signifying the great leap forward in getting patients to the government system.
- 2,852 PHCs having three nurses
- More than 50 lakh women have been brought under the Janani Suraksha Yojana (JSY) for institutional deliveries in the last two-and-a-half years.
- So far, 4,380 other para medical staff have been appointed on contract.
- 6,232 doctors, 2,282 specialists, 11,537 staff nurses have been appointed on contract in the States so far, reducing the human resource gaps in many institutions.
- 2,335 CHCs have completed their Facility Surveys and 441 their physical upgradation so far.
- IPH standards have been finalized and a first grant of Rs. 20 lakh was made available to all the District Hospitals of the country to improve their basic services, given the increased patient load due to JSY and other programmes.
- State level Societies have merged in 32 States/UTs and 527 districts so far.
- Project Management Units have been set up in 506 district and 2,432 blocks of 30 States.
- The Indian Public Health Standards developed for eight different level of public institutions in health, provide a basis for all programmes in the health sector.
- Most States have completed the Facility Surveys up to CHCs.
- 319 districts have received funds for Mobile Medical Units.
- So far, 188 Mobile Medical Units are operational in the States.

Table 10.15

Trends in Health care Infrastructure

	1991	2005/ 2006
SC/PHC/CHC[a] (March 2006)	57353	171567
Dispensaries and Hospitals (all)[b] (1.4.2006)	23555	32156
Nursing Personnel (2005)[b]	143887	1481270
Doctors (Modern System) (2005)[b]	268700	660801

[a] **RHS: Rural Health Statistics in India-2006 – Special Revised Edition**

[b] **National Health Profile, 2006**

implementation framework, a provision has been made for an expenditure of Rs. 10,000 per ASHA during a financial year. This ceiling does not include the performance-based compensation, which the different programme divisions would disburse from their own funds. The earlier ASHA guidelines had visualized an expenditure of Rs. 7,415 per ASHA. The increased outlay gives a valuable opportunity to further strengthen the support mechanism.

Strengthening of Primary Health Infrastructure & Improving Service delivery

10.33 Though there has been a steady increase in health care infrastructure available over the plan period (Table 10.15) as per the Bulletin on Rural Health Statistics in India-2006 – Special Revised Edition, as in March 2006, there is a shortage of 20,903 Sub-Centres (SCs), 4,803 Primary Health Centres (PHCs) and 2,653 Community Health Centres (CHCs) as per 2001 population norm. Further, almost 50 per cent of the existing health infrastructure is in rented buildings. Poor upkeep and maintenance and high absenteeism of manpower in rural areas have also eroded the credibility of the health delivery system in the public sector. NRHM seeks to strengthen the public health delivery system at all levels. In addition to strengthening the health delivery system under NRHM, several other programmes in the area of health are being implemented in the country (Box 10.8).

Integrated Disease Surveillance Project (IDSP)

10.34 Integrated Disease Surveillance Project (IDSP) was launched in November 2004. It is a decentralized, State-based Surveillance Program in the country. It is intended to detect early warning signals of impending outbreaks and help initiate an effective response in a timely manner. In Phase-I, 9 States, in Phase-II, 14 States and in Phase-III, 12 States are included. Major components of IDSP are integration and decentralization of surveillance activities, strengthening of public health laboratories, human resource development and use of information technology for collection, collation, compilation, analysis and dissemination of data.

User charges in government health facilities in India

10.35 User charges came to be levied from patients belonging to families above poverty line for diagnostic and curative services offered in health institutions while free or highly subsidized services continued to be provided to the poor and needy patients. A majority of States have introduced user charges for services in public health facilities although there are differences in levying, collecting and utilizing user charges among the States. User charges, as an option of financing health care delivery system, need to be supported by efficient system of collection and utilizing user charges combined with improvement in the quality of health services and facilities for patients in health institutions. At the same time, access of poor and needy patients to health care should not suffer

10.36 India has one of the highest out of pocket household expenditure for health services. User charges further augment this expenditure. Hence it is pertinent that mechanisms of risk pooling are designed and implemented towards improving access to health services. Under NRHM, Rogi Kalyan Samitis (RKS)/Hospital Development Committees have been created as legal entities to enable greater flexibility and retention as well as use of resources that they generate through their services. All the Samitis have also been provided untied funds to carry out locally relevant action to ensure better services for the poor households that visit the Government facilities. RKS have the mandate to ensure that the poor

Box 10.8 Major Public Health Programmes

Universal Immunization Programme

The coverage of the programme, first launched in the urban areas in 1985, was progressively extended to cover the entire country by 1990. Between 1988 and 2006, there has been a decline of 83 per cent in diphtheria, 83 per cent in pertussis, 59 per cent in measles, 94 per cent in neonatal tetanus and 97 per cent in poliomyelitis. Hepatitis-B vaccination programme which was started in 2002 in 33 districts and 15 cities as a pilot has been expanded to all districts of good performing States. Vaccination against Japanese encephalitis was started in 2006.

Pulse Polio Immunization Programme

An outbreak of polio has been witnessed in 2006 with the spread of polio virus. During 2007 (as on 14.12.2007) a total of 471 cases have been reported. To respond to this, supplementary immunization activities have been intensified in the high risk areas. The initiatives include use of Monovalent Oral Polio Vaccine (mOPV1 & mOPV3) in the high risk districts and States to enhance immunity against P1 and P3 virus,vaccinating the children in transit and covering children of migratory population from Uttar Pradesh and Bihar. Special rounds have been conducted in Haryana, Punjab, Gujarat and West Bengal during August, September, October and November 2007.

National Vector Borne Disease Control Programme

The National Vector Borne Disease Control Programme (NVBDCP) is being implemented for prevention and control of vector borne diseases like malaria, filariasis, kala-azar, Japanese encephalitis (JE), dengue and chikungunya. Most of these diseases are epidemic prone and have seasonal fluctuations. During 2007 (till October), 0.99 million positive cases, 0.44 million plasmodium falciparum cases and 940 deaths have been reported. Currently about 100 districts are identified as highly malaria endemic where focused interventions are being undertaken. To achieve NHP-2002 goal for Elimination of Lymphatic Filariasis by 2015, the Government. of India initiated Annual Mass Drug Administration (MDA) with single dose of Diethylcarbamazine citrate tablets to all individuals living at risk of filariasis excluding pregnant women, children below 2 years of age and seriously ill persons. During 2007, MDA has been observed in 19 States. The reported coverage of 19 States is 87.28 per cent.

Kala-azar is endemic in 4 States of the country, namely Bihar, West Bengal, Jharkhand and Uttar Pradesh. However, about 80 per cent of the total cases are reported from Bihar. During 2007 (up to October), 37,525 cases and 169 deaths have been reported. The National Health Policy (2002) envisages kala-azar elimination by 2010. Under the elimination programme the Central Government provides 100 per cent operational cost to the State Governments, besides anti kala-azar medicines, drugs and insecticides.

Acute Encephalitis Syndrome (AES)/Japanese encephalitis (JE) has been reported frequently from 12 States/ UTs. During 2007 (till 28.12.07), 3,887 cases and 910 deaths have been reported. Dengue is prevalent in different parts of the country but the outbreak of the disease is reported mainly in urban areas. However, in the recent past, dengue is reported from rural areas as well. In 2007 (up to December), 5,025 cases and 64 deaths have been reported. During 2006, chikungunya fever had re-emerged in the country in epidemic proportions after a quiescence of about three decades.. During 2007 (up to 28.12.2007), 56,355 suspected chikungunya fever cases have been reported. The Government has taken various steps to tackle the vector borne diseases (VBDs) including dengue and chikungunya which, include implementation of strategic action plan for prevention and control of chikungunya by the State Governments,

Revised National Tuberculosis Control Programme (RNTCP)

The Revised National Tuberculosis Control Programme (RNTCP) using Directly Observed Treatment Short-course (DOTS) is being implemented with the objective of curing at least 85 per cent of the new sputum positive patients initiated on treatment, and detecting at least 70 per cent of such cases. Since its inception, RNTCP has initiated more than 8.4 million TB patients on treatment, thereby saving over 1.4 million additional lives. Deaths have been reduced from over 5 lakh per year at the beginning of programme to less than 3.7 lakh per year currently. Good quality assured anti-TB drugs are provided in the patient-wise drug boxes, free of cost. Padiatric Patient Wise Drug Boxes have been introduced in the programme from January 2007. The treatment success of new infectious TB cases under RNTCP has consistently exceeded the

global benchmark of 85 per cent. RNTCP detected 66 per cent of the estimated new infectious cases in 2006, which is close to the global target of 70 per cent. In the third quarter of 2007, the detection rate was 70 per cent. The national programme has initiated the DOTS plus services for management of Multi drug resistant TB (MDR-TB), The community based Drug resistance surveillance (DRS) conducted in Gujarat and Maharashtra recently estimated the prevalence of MDR-TB to be around 3 per cent among new cases, in terms of absolute numbers the burden is quite significant.

National AIDS Control Programme

Nearly 20,408 AIDS cases were reported in 2007 (December 2007), out of which, 87.4 per cent of the infections were transmitted through the sexual route and pre-natal transmission accounted for 4.7 per cent of infections. About 1.8 per cent and 1.7 per cent of infections were acquired through injecting drug use and contaminated blood and blood products respectively. The HIV prevalence among high risk groups continues to be nearly 6 to 8 times greater than that among the general population. Based on the HIV Sentinel Surveillance data from the last three years (2004-06), districts have been classified into four categories. About 156 districts have been identified as category A where the HIV prevalence among ANC clinic attendees is greater than 1 per cent and 39 districts have been classified as category B where HIV prevalence among high risk population has been found to be more than 5 per cent. These districts are being given priority attention. National AIDS Control Organisation has tried to increase access to services and communicate effectively for behavior change. Government of India has launched National AIDS Control Programme Phase III, with the goal to halt and reverse the epidemic in the country over the next 5 years by integrating programmes for prevention, care, support and treatment.

During NACP III, an investment of Rs. 11,585 crore is required. Of this, an amount of Rs. 8,023 crore is provided in the budget, the rest being extra budgetary funding largely from private donations, direct funding from bilateral and UN organizations. A total expenditure of Rs. 482.94 crore upto 15th January 2008 has been made for implementing various interventions during the financial year 2007-08. An outlay of Rs. 11,585 crore has been approved for the next 5 years (2007-12).

and needy receive cashless hospitalized treatment and to charge for services only from those who can pay. However, since the state of public health facilities sometimes force the poor and needy patients also to approach private health care facilities which are available at high cost, health insurance and other innovative schemes in this area are vital.

Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH)

10.37 Under AYUSH, there is a network of 3,203 hospitals and 21,351 dispensaries across the country. The health services provided by this network is largely focused on primary health care. The sector has a marginal presence in secondary and tertiary health care. In the private and non-profit sector, there are several thousand AYUSH clinics and around 250 hospitals and nursing homes for in-patient care and specialized therapies like Panchkarma. The key interventions and strategies in the Eleventh Five Year Plan include training for AYUSH personnel, mainstreaming the system of AYUSH in National Health Care Delivery System, strengthening the regulatory mechanism for ensuring quality control, R&D and processing technology involving accredited laboratories in the Government and non-Government sector, and establishing centres of excellence.

Family Planning Programme

10.38 The Family Planning Programme is now repositioned as a “Family planning program for achieving MDG goals” as this is one of the major means through which both maternal and child mortality and morbidity can be reduced. Increasing age at marriage and spacing between births are major interventions for achieving both these objectives. Intra-uterine Device (IUD) services in the country is being given a thrust as this is one of the most effective spacing methods available in the country. An alternative training methodology in IUD is being introduced through which expansion of services as well as ensuring their quality is being addressed. This is expected to increase the demand on IUD along with scaling up information. Education and Communication (IEC) on IUD is presently introduced in 12 States

as a pilot project. Increasing the basket of choice in contraceptives through introduction of newer contraceptives is essential for increasing contraceptive acceptance. Government has now modified the earlier compensation scheme for sterilization and has increased the payment to compensate for loss of wages to those accepting sterilization. Quality of care in family planning is one of the major thrust areas and monitoring of quality of services in family planning is done through quality assurance committees set up at State and district levels. Government introduced a National Family Planning Insurance Scheme which provides compensation to sterilization acceptors as well as to provide indemnity insurance to the provider (qualified doctors) against failures, complications and deaths following sterilizations. These measures are introduced as confidence building mechanisms among the family planning clients. Increased availability of infrastructure as a result of NRHM would assist in increasing access to family planning services.