

**REPORT OF THE WORKING GROUP ON
HEALTH OF WOMEN AND CHILDREN
FOR THE
ELEVENTH FIVE YEAR PLAN
(2007-2012)**



**GOVERNMENT OF INDIA
PLANNING COMMISSION**

NEW DELHI

CHAPTER - 1

INTRODUCTION

This Working Group under the Chairmanships of the Secretary (H&FW) was formed in the context of formulation of the Eleventh Five Year Plan (2007-12) and was to deliberate on issues related to health of Women & Children. The composition of the working Group is given in **Annexure I**. Following were the specific terms of reference for the Group.

- i) Assessment of procedures for estimating Mortality/Morbidity in women & children.
 - ii) Review of ongoing major Reproductive and Child Health programmes.
 - iii) Review of the functioning of family welfare infrastructure and manpower in rural and urban areas and suggesting measures for rationalizing, restructuring the infrastructure, strategies for improving efficiencies of implementation of the programme and for the delivery of services.
 - iv) Methods for improving Reproductive and Child Health activities at secondary and tertiary care levels.
 - v) Projecting financial/ physical requirements for implementation of these programmes during the Eleventh plan.
 - vi) Other recommendations relevant to the above topics.
2. While deliberating on the tasks assigned to it, the Working Group took note of the strategies and approaches articulated in the National Programme Implementation Plan (PIP) for the second phase of the Reproductive and Child Health (RCH-II), Implementation Framework document for the National Rural Health Mission (NRHM), findings / recommendations made by the National Commission on Macroeconomics and Health (NCMH), 10th Plan Mid-term Appraisal document, Approach Paper (draft) for the 11th Plan prepared by the Planning Commission and documents prepared by other stakeholders.
3. The Working Group noted that the NRHM holds the biggest potential so far for improvement in the health status of women and children, making it possible thereby to achieve the MDG goals. The Broad Framework for Implementation of NRHM is given in **Annexure II**. However, the challenge lies in the implementation of the Mission particularly in tackling the issues identified in the 11th Plan Approach Paper

prepared by the Planning Commission, namely, non-availability absenteeism of doctors/health providers in the rural areas, low levels of skills in medical professionals , inadequate supervision/monitoring of the programme etc.

The Working Group was of view that while NRHM and RCH-II address many critical issues of concern to the health of women and children, the ambit of these programmes needs to be widened in the 11th Plan to address additional concerns. Therefore, an attempt has been made to prepare a self-contained document responding to the issues to be considered, keeping in view the strategies and interventions already included in the RCH-II and the NRHM, however, suggesting what needs to be done beyond these programmes.

CHAPTER - 2

A REVIEW OF PROCEDURES FOR ESTIMATING MORTALITY AND MORBIDITY IN WOMEN AND CHILDREN

1. Mortality and morbidity indicators in a country provide a broad profile of the status of its health and economic conditions and also reflects the lifestyle of the people contributing to chronic diseases. Such data also reflect the responsiveness of the health institutions in tackling major diseases; and chronic conditions like obesity, malnutrition, eating habits, geriatric conditions etc, the geographical spread of the incidence; and other related factors.. Though such data is typically culled out from available records like death certificates, municipal records, hospital records, etc, it is often corroborated through random surveys of the household. In India, the Registration of Births and Deaths Act, 1969 (RBD) is coordinated and administered by the Registrar General and Census Commissioner of India (RGI) and designated State level authorities in the State Govts. Though the registration of births and deaths is mandatory under the RBD Act, yet the extent of registration of births and deaths is not satisfactory across the states. Consequently, the proportion of births and deaths that are reported and registered through the official machinery, on an average, is only around 58% and 54% respectively. To supplement it, the Sample Registration System (SRS) of the RGI also provides periodic estimates of births, deaths, mortality rates like CDR, IMR etc. cross classified by rural-urban residence status and also by gender. The SRS is a dual record system and involves continuous enumeration of births and deaths in a sample of villages/ urban blocks by a resident part-time enumerator, followed by an independent six monthly retrospective survey by a full-time supervisor. It is perhaps the largest demographic sample survey in the world covering over a million households and six million population. The Vital Statistics Division of the Office of the Registrar General, India at national level, coordinates, looks after implementation of the system, formulates and prescribes requisite standards, provides appropriate instructions and guidance, and undertakes tabulation and analysis of data and its dissemination in the form of SRS Bulletin, Annual Report and Life Tables.

2. The RGI is taking various initiatives to improve the Civil Registration System (CRS). However, these initiatives are mainly related to several provisions of the RBD Act and mainly focus on how to improve administering the RBD Act, 1969, like making people themselves responsible for registration of births and deaths making penalties more stringent etc.. The proposed changes have been circulated to the major stakeholders for their comments before a final shape is given to the RBD Act. Another initiative being proposed is the National Photo-Identity Card (NPIC) System, which is being conceived/evolved and is going to be piloted in a few States. It is however relevant to mention that the success of any RBD activity needs to be linked to the socio-economic life of its citizens. Thus the necessity of a Birth Certificate for School admissions, passport etc; a Death Certificate for property transfer to heirs ; media messages; etc are all such initiatives to improve the CRS.

Mortality and Morbidity Indicators estimated through Surveys carried out under MoHFW programmes

3. **National Family Health Survey (NFHS)** : The main feature of NFHS is to provide important demographic and health database in India covering fertility and family planning, mortality and morbidity, health, health care and nutrition and also prevalence of HIV/AIDs. The first round of NFHS was conducted in 1992-93 and the second round during 1998-99. The current survey of NFHS was undertaken during 2005-06 covering 1.1 lakh households and interviewing about 2.3 lakh eligible men and women. The results of a few states are being disseminated while those at national level are expected during end of 2006-07.
4. **District Level Household Surveys (DLHS)**: Since the indicators estimated through SRS and NFHS are confined to state level only, the concept of providing similar indicators at district level had been perceived through DLHS. While first round of DLHS was undertaken in 1998-99, the second DLHS was undertaken during 2002-04. The results of the second round of the DLHS (2002-2004) were released in March, 2006 to serve as the Base-line survey for the NRHM. The

preparatory work for the third round of the DLHS (2006-2007) is on and would serve as the Mid-line Survey of the NRHM. The DLHS-II covered 1000 households per district and the DLHS-III would have a varying sample size ranging from 1000 to 1500 households in each of 600 odd districts in the country depending on the variability of health parameters. The DLHS-III would yield estimates for ANC and immunisation services, safe deliveries, contraceptive prevalence rate, RTI/STI, HIV Aids, utilisation of services etc.

5. Worldwide, about 500,000 women die every year from pregnancy and childbirth related causes and most of these deaths occur in developing countries (WHO, 1999). Reliable national estimates of maternal mortality are not available for most countries since most of the demographic surveys do not have samples large enough to produce reliable direct estimates of maternal mortality. Both NFHS and SRS suffer from these limitations. However, an attempt had been made by the office of the Registrar General of India to estimate MMR through verbal autopsy and the results are expected shortly.
6. The successful implementation of NRHM and tracking the impact of interventions under it require reliable estimates of mortality and morbidity at the district level. Since none of the existing mechanisms provide district level estimates, there is an urgent need to evolve a system that can provide suitably reliable district level estimates of IMR, MMR, leading causes of death and morbidity.
7. Recently, the National Commission on Population (NCP), chaired by the Hon'ble Prime Minister, desired that an **Annual Health Survey (AHS)** be carried out to prepare a Health Profile of all the Districts in the country. The MoHFW explored the feasibility of involving the machinery of the National Sample Survey Organisation (NSSO) and the Registrar General of India. A Task Force has been set up under the Chairmanship of Addl DG (Stats), MoHFW, to identify the list of indicators that ought to be collected at the District-level, its frequency/ periodicity and also to suggest the infrastructure required for undertaking the Survey. This Task Force has met once and discussed various issues and alternatives as also the

- status of the AHS vis-à-vis the DLHS and the machinery required for undertaking the survey.
8. The RGI had submitted a proposal for undertaking the AHS by strengthening the SRS network which was examined by the Task Force and it was of the opinion that the proposal needs to be revised keeping in view the overall data requirements (scope and periodicity) that would be necessary to prepare a District Health Profile which could cover both morbidity and mortality aspects. The Task Force was of the opinion that the major Health Indicators at the District Level do not change that frequently and thus it would be economically and technically desirable to spread out the survey work over a period of 2 to 3 years so that each District is profiled once in 2 to 3 years. A revised proposal from the RGI is awaited. Once the AHS is commenced and the process stabilised, the possibility of phasing out the DLHS can also be explored.
 9. The Government of India set up a permanent National Statistical Commission (NSC) on 1st June 2005 and its members are from various fields of specialization on social and environment statistics, population and health etc. The functions of the NSC among others also include evolving standard statistical methodologies and strategies for data collection of core statistics. Therefore the issue of carrying out the Annual Health Survey, including the development of methodologies should be referred to NSC.

Problems in making estimates – remedial suggestions

10. In India, as brought out elsewhere, the data reporting machinery under the RBD Act does not capture all the births and deaths, except those that occur in Health Institutions. Further, the social aversion towards performing autopsy, except per force in medico-legal cases, makes the information on causes of death weak and susceptible to errors. Thus the data reporting system being weak, the causes of death, as ascertained from the official records also fail to be flawless and the position is dismal for deaths occurring in private health institutions and for deaths at home.

In view of the incomplete coverage from the data reporting system under the Civil Registration System (CRS) and the inadequacies of the Sample Registration System (SRS) in terms of its coverage and scope, it is necessary to explore the feasibility of capturing this information through periodic surveys till such time the CRS can be strengthened.

11. Village Health Surveys

The Implementation Frame work approved by the Union Cabinet includes a proposal for having periodic village level (Health) household surveys to be conducted by ASHA (Accredited Social Health Activist) the Community Worker with the support of village Health & Sanitation Committee. If this can be strengthened it would provide for a system of reporting & collection of data at the village level, facilitate development of village block & District Level Health Action Plans under NRHM.

12. Suggestions : The Working Group made the following suggestions in this regard:-

Improve the record keeping system in hospitals and health institutions (both public and private) by specifying mandatory records and registers to be maintained and regularly updated, inter-alia specify formats and periodicity of statutory returns. The steps involved in this would include:

- Amendment of RBD Act – to make registration of births and deaths mandatory while also making it more *citizen-friendly*. Using Health Workers as a medium for providing information on incidence of births and deaths; and as a medium for delivery of birth and death certificates as an *outreach activity*. This would aim to improve the coverage of the CRS and SRS. However, it may not be able to capture the detailed cause of death vis-à-vis the ICD-10.
- Computerization of births and deaths including making the process on-line/web-based through e-governance initiatives.
- Promulgate a Health Information Act that would make it mandatory for registered Health Institutions and medical practitioners, both Private and Public, to provide

periodic information on specified returns. This aims to capture information from births and deaths that are attended to in registered institutions and by medical practitioners.

- The States prepare an Eligible Couple Register (ECR) for the Health and Family Welfare interventions on the basis of a household survey in the villages undertaken by the Health Workers (ANMs etc). While some States update the ECR each year, the position varies in other States. However, as the record keeping process of the household survey is by and large manual, it is susceptible to the errors of manual updation including omissions and duplication. Some States like Andhra Pradesh have undertaken a Household Survey and have given unique FW numbers to each household, which is updated each year and the ECR is computerised at the PHC level. If expanded, this could form the *frame for tracking births and deaths* that could then be followed up by focussed surveys.
- Strengthen the Monitoring of Information and Evaluation System (MIES) for NRHM and to explore the possibilities of enacting a Health Information Act.
- Concurrent Monitoring through Medical Colleges. The State of Uttar Pradesh has piloted a scheme of concurrent monitoring and evaluation through the Medical Colleges. This protocols developed under this pilot could be used as a model for evolving an independent mechanism to monitor the RCH indicators along with the causes of death [see **Annex-III** for a more detailed description].

CHAPTER – 3

REVIEW OF MAJOR REPRODUCTIVE AND CHILD HEALTH PROGRAMMES

RCH Project, Phase-I

- 1 The first phase of Reproductive and Child Health (RCH) Programme was launched in 1997 by integrating all on-going fertility regulation and maternal and child health schemes of the Ministry under a single umbrella, adopting a holistic target free approach¹.

The specific objectives for the RCH I project were set as assisting the National Family Welfare Programme (NFWP) to:-

- (a) improve management performance by nationwide implementation of policy change referred to as the "participatory planning approach," and institutional strengthening for timely, coordinated utilization of project resources;
- (b) improve quality, coverage and effectiveness of existing FW services;
- (c) progressively expand the scope and content of existing FW services to include more elements of a defined package of essential reproductive and child health (RCH) services; and
- (d) in selected disadvantaged districts and cities, increase access by strengthening FW infrastructure while improving its quality.

Impact of RCH-I: An assessment

- 2 Conceptually, RCH-I was designed to promote decentralization and offer a broad-based financial envelope to the States. However, the project came to represent a stream of schemes, each having its own norms and reporting requirements, which called for very strong capacities in the Directorates of Health & Family Welfare in the States. Since the States' capacities varied, the results have not been uniform (Table-3.1). The following weaknesses were identified in the program :
 - There was limited involvement of States in designing the Project and, therefore, limited ownership of the programme by the States.
 - The pace of implementation was slow.

¹ Adoption of the so-called Target Free Approach, which was positioned as the 'USP' of the Programme, actually meant to re-orient the fertility regulation interventions so that the services are rendered according to the clients' choice. This was the central theme under lying the Community Needs Assessment Approach.

- Low utilization of public health facilities.
- Infrastructure (that was planned) was not completed within the project timeframe.
- Limited management capacity at various levels.
- Weak financial management systems.
- Project lacked vision and policy guidelines.
- RCH-I was implemented as a project; there was a need to incorporate well defined outcome indicators.
- RCH-I had a “one size fits all” design.
- RCH-I suffered from “stand alone” project approach with little focus on sector management and reform and strengthening of systems.
- RCH-I focused almost exclusively on the supply side.

Table-3.1: Targets and achievements under RCH-I (selected indicators)

Impact /outcome Indicator	Base line estimate	Target	Actual / latest estimate
Infant Mortality Rate	74 (SRS, 1995)	60	63 (SRS, 2002)
Contraceptive Prevalence Rate	47.7% (RHS-I, 1998-99)	60 %	52% (RHS-II, 2002-03)
Institutional Deliveries	35% (RHS-I, 98-99)	60%	40% (RHS-II, 2002-03)
% of children fully immunized	52% (RHS-I, 98-99)	60%	44.6% (RHS-II, 2002-03)
Unmet needs for family planning services [% of couples wanting to limit or space but not currently using any FP method]	19.5% (RHS-I, 98-99)	Less than 10%	15.9% (RHS-II, 2002-03)

- 3 One of the key goals of the project was to reduce the disparities in RCH between the regions, socio-economic groups, etc. However, comparison of RHS data for EAG states² for both the rounds of Rapid Household Surveys indicate no reduction in disparities in RCH status (3.2). Home visit by outreach workers have declined everywhere but more sharply in rest of the country than the EAG states.

² Bihar, Chhatisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal

Table-3.2: Comparison of EAG States with All India Performance

Indicator	RHS I 1998-99		RHS II [^] 2002-03		Gap (India - EAG)	
	India (%)	EAG (%)	India (%)	EAG (%)	1998-99	2002-03
CPR any method	48.6	33.7	49.0	41.4	11.0	7.6
Unmet Need	25.3	31.6	18.6	21.9	-6.0	-3.3
Full ANC	31.8	18.1	20.1	8.4	13.7	11.7
Instl. Delivery	34.0	19.7	46.9	24.1	14.3	22.8
Safe Delivery	40.2	26.7	62.1	39.4	13.5	22.7
Full Immunization	54.2	41.8	49.5	36.6	12.4	12.9
Home visit*	14.8	9.8	6.4	4.7	5.0	1.7
[^] Based on 50 % of districts covered in Phase I of Round II						
* Any Health Worker during 3 months prior to survey						

Sector Investment Programme

- 4 In 1997, GoI and European Commission signed a Financing Agreement for channeling latter's financial and technical assistance to the National Family Welfare Programme. Called the Sector Investment Programme (SIP), the objectives of the partnership was to promote systems development and sector reforms. Under the original Financing Agreement, a grant assistance of 200 million Euros was pledged over a 5-year period. Following a devastating earthquake in Gujarat (January, 2001), the Financing Agreement was amended to provide for an additional amount of Euro 40 million to support the post-earthquake re-construction / re-development work in the State. The programme period has also been amended (current end date of the Financing Agreement is December, 2006).
- 5 The SIP began with implementation of State and district plans in the 11 participating States. Over time, more States joined taking the number of participating States to 22 consisting of the 8 most backward States (termed EAG States)³, 8 North-Eastern States and the States of Andhra Pradesh, Gujarat, Haryana, Himachal Pradesh, Kerala and Maharashtra.

³ The GOI had set up an Empowered Action Group (EAG) in year 2000 for focussed attention to improve population stabilization issues in the States of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Uttaranchal. These States are, therefore, collectively referred to as EAG States.

- 6 A major weakness of the programme design was that while the overall EC contribution to GOI was known, the programme coverage was not pre-defined in geographical terms, either in terms of the number of States or, within a State, in terms of districts. As a result, while the planning process was emphasising more efficient use of existing resources, the districts and States were appearing to focus on maximising their share under the programme. This led the MoHFW to introduce the so called MoU based financing of sector development activities in the States. Introduction of the MoU mechanism was adopted from a similar concept introduced by the Planning Commission⁴ and consisted of following features:
- A pre-announced allocation of funding, taking due account of the degree of backwardness of the state. Thus, 50% of the remaining programme funding at the date of introduction of the system (end of March 2002) was ear-marked for the EAG states, 10% for the north-eastern states, 10% for national activities and 30% for the non-EAG states admitted to the programme;
 - A mutually agreed health sector reform agenda. A series of milestones (often consisting of 2 or more sub-milestones) were agreed which would indicate the degree of progress towards implementation;
 - An agreed spending plan for the allocation. The valuation of the milestones was calculated on the basis of a rough estimate of the implementation cost of the state's proposed reform agenda as well as other expenditure purposes.
 - Advance but performance based funding. Estimated requirement of funds was released upon MoU execution. However, subsequent releases required, besides achievement of agreed milestones, minimum 50% utilization of previous releases.
- 7 The key elements of the reform processes formalised under the MoUs were drawn from the national level policy documents such as 9th / 10th Five Year Plan, National Population Policy (2000), National Health Policy (2002) etc. and included, among others, the following:
- re-structuring /re-organisation of primary health care delivery infrastructure,
 - strengthening of planning and programming skills,
 - decentralisation,

⁴ Rashtriya Sam Vika Yojana.

- community participation, including establishment of autonomous hospital management societies (Rogi Kalyan Samitis or equivalent) and involvement of Panchayati Raj Institutions (PRI)
- improved logistics and warehousing of drugs and medical supplies,
- strengthening of secondary hospitals for improved access to basic health care services, including emergency services,
- horizontal integration of vertical structures,
- human resource development through cadre re-structuring, multi-skilling, development of training / transfer policy
- re-structuring and strengthening of health management information systems,

A total of 15 MoUs were executed between June, 2003 and February, 2005⁵. The financial performance under the programme has witnessed an acceleration in funds disbursement and utilization after the introduction of the MoU mechanism. The final evaluation of the programme, conducted in July, 2006, has highlighted the use of MoU as a key ‘driver’ of programme. Facilitation by an independent technical assistance team has been cited as another contributing factor⁶.

RCH-II

8. Planning process for RCH-II started in year 2002 with a detailed consultation process involving the States, Development Partners, the civil society and other stakeholders.

The main issues identified during the consultation / preparation processes have been responded to through the design of RCH-II which represents the mid-course correction in the 10th Plan. The specific issues identified during mid-term review / consultations and the measures to address the same under the RCH-II are listed in **Annex- IV**.

The vision underlying RCH-II is to bring about outcomes as envisioned in the Millennium Development Goals, the National Population Policy 2000 (NPP 2000), the Tenth Plan document, the National Health Policy 2002 and Vision

⁵ Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jharkhand, MP, Maharashtra, Orissa, Rajasthan, UP, Uttaranchal and West Bengal. Remaining 9 States were allowed to continue with their existing State plans.

⁶ European Commission Technical Assistance (ECTA) consists of a full time team located at New Delhi, another full time team based at Gandhinagar to assist the post-earthquake re-construction work in Gujarat and ECTA State Facilitators in Assam, Bihar, MP, Rajasthan, UP and Uttaranchal.

2020 India, minimizing the regional variations in the areas of reproductive and child health and population stabilization through an integrated, focused, participatory program, meeting the unmet demands of the target population and provision of assured, equitable, responsive quality services.

Table-3.3: RCH-II goals vis-à-vis MDGs, NPP and 10th Plan

Indicator	Tenth Plan Goals (2002-2007)	RCH Phase II Goals (2005-9)	National Population Policy 2000 (By 2010)	Millennium Development Goals
Population growth	16.2% (2001-11)	16.2% (2001-11)	-	-
Infant Mortality Rate	45/1000	35/1000	<30/1000	-
Under 5 Mortality Rate	-	-	-	Reduce by 2/3 from 1990 levels
Maternal Mortality Ratio	200/100000	150/100000	<100/100000	Reduce by 3/4 by 2015
Total Fertility Rate	2.3	2.1	2.1	-
Couple Protection Rate	65%	65%	Meet 100% needs	-

The principles underlying the design of RCH-II are as follows:

- Improving health outcomes is a shared responsibility of providers, local governments, households and communities.
- There should be no discrimination in access to essential quality health services.
- The poorest have the right to get value for money being spent by government or out of pocket.
- Service providers should be responsible for outputs and outcomes, suitably empowered, and made accountable within the principle of subsidiary.
- Female children have an equal right to health, emergency medical aid, and to live with human dignity.
- The program would include voluntary and informed choice in administering family planning services. Responsibilities of service providers would be clearly outlined with careful regard for human resources. Clear tasks would be laid out for service providers to provide quality services to meet unmet needs of family planning and spacing methods in desirable quantities.

- The strengths of public and private sectors should be harnessed to achieve the RCH program goals.
 - The RCH program will protect people in accordance with the statutes.
 - The RCH program efforts will consistently focus on the most vulnerable.
9. The RCH-II also represents another step towards adoption of the so-called *Sector Wide Approach(SWAp)*, a process that began with Sector Investment Programme and taken further along under the NRHM. The ‘sector’ level policies articulated under national Programme Implementation Plan (PIP) have been subsumed and further refined under the NRHM.

Box-3.1: ‘Sector’ level policies governing RCH-II design and implementation

- Bring about inter-sectoral collaboration through networking at the highest levels and then percolating to the different levels.
- To include public health as a specialization into the medical education curriculum in order to bring out trained public health managers to manage the public health and bringing in public health as a function.
- To revitalize the human resources policy such as district cadres of MOs and block cadres of ANMs and also address the career movement, posting and training issues.
- Open up primary health care to groups of professionals/individuals willing to take on such service provision functions especially at the primary levels accompanied by appropriate governance mechanisms.
- Activating voluntary level societies/ community level workers for bringing in additional funds into the sector (ZSS, RKS+ JSK, ASHA)
- Address adolescent health as an important issue and develop packages for activating this aspect.
- Integrate with the on going National AIDS Control Program (NACP) and establish linkages with HIV prevention programs.
- Develop separate plans for dealing with the problems of vulnerable groups including a tribal action plan and an action plan for the urban poor.

10. The RCH-II is being implemented through State Programme Implementation Plans (PIPs) prepared within broad parameters of national PIP, allowing the States the freedom to choose their own programmatic / management interventions for the

national objective of reducing TFR, IMR and MMR. Funding of the State PIPs is done through Annual Work Plans.

11. The Technical Strategies and interventions relating to Reproductive, Maternal and Child Health envisaged under RCH-II programme are detailed at **Annex-V**.
12. In keeping with the SWAp principles, the programme will be jointly evaluated by the MoHFW, Development Partners and the State Governments on a six-monthly basis. The second Joint Review is scheduled to be completed in mid-October, 2006)⁷.

Promoting Institutional delivery

13. Encouraging the pregnant women to deliver in health centers /institutions has been one of the core strategies for reducing infant and maternal mortality. At the national level, institutional delivery rate prior to the RCH Phase I, as per the NFHS-II (1998-99) was only around 33.6 %. Several new initiatives were taken during RCH-I for improving safe motherhood. The rate of institutional deliveries as per the DHS-II (2002-04) was only 41.5 %. Inter state variations and variations among the different income groups have been quite significant. Though, results of 12 states as per the NFHS-III (**at Annexure- IX**) conducted in 2005-06 are showing an increasing trend too, a large number of women, especially from the poor families living in the weak states still deliver at home. Even among the weaker states, there is significant differential in institutional deliveries between rural and urban areas.
14. The NPP goal aims to achieve overall 80 % institutional deliveries by 2010. The NRHM envisages reducing the MMR and IMR to 100 per 100,000 live births and 30 per 1000 live births by 2012, respectively.
15. As a strategy to change the behavior of the community to access health institutions for delivery, the Ministry has modified the **National Maternity Benefit Scheme**

⁷ The First Joint Review took place in February, 2006.

(NMBS), from that of nutrition improving initiative to that of addressing the entire aspect of maternal health.

JANANI SURAKSHA YOJANA (JSY) – under the XI Five Year Plan (2007-2012)

16. The Hon’ble Prime Minister launched Janani Suraksha Yojana (JSY) on 12th April 2005. The scheme has the dual objectives of reducing maternal and infant mortality by promoting institutional delivery among the poor women.

17. Though the JSY is implemented in all States and UTs, focuses especially in states having low institutional delivery rate. In states where the institutional delivery rate is abysmally low, namely in the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam and Jammu and Kashmir have been categorized as Low Performing States (**LPS**). The remaining states have been named as High performing States (**HPS**). The institutional delivery rates in key States is given at **Annexure VI**.

18. The scheme is a 100 % centrally sponsored and integrates cash assistance with maternal care. It is funded through the RCH flexi-pool mechanism. The JSY scheme targets -

- All pregnant women in the low performing States (LPS).
- All BPL pregnant women of age 19 years or above, in High performing states (HPS)
- All ST and ST pregnant women from both LPS & HPS states,

19. Scale of Cash Assistance per delivery:

Category	Rural Area		Total Rs.	Urban Area		Total Rs.
	Mother’s Package	ASHA’s Package		Mother’s Package	ASHA’s Package	
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

- **In LPS states:** Mother’s package is available to all women **including all SC and ST women**, delivering in any public or accredited private institutions. No age or

BPL certification would be insisted upon. Similarly, restriction on number of childbirths has also been removed.

- **In HPS states:** Mother's package is available to all BPL pregnant women including all **SC and ST women**, aged 19 years and above, up to 2 births, delivering in any public or accredited private institutions.
- In addition, all BPL pregnant women aged 19 years or above **preferring to deliver at home** will receive cash assistance @Rs.500/- per delivery, up to 2 live births.

20 ASHA package available in LPS and NE states consists of transport assistance to the mother and compensation assistance to the ASHA in the rural areas. In the urban areas, the money is only for ASHA to meet her transactional cost of accompanying the pregnant women for delivery. In addition, the scheme has **other benefits:**

(a) If hospitalization for delivery is followed immediately by Tubectomy / laparoscopy, the beneficiary would get compensation money available under the existing Family welfare scheme at the hospital itself.

(b) Where Government specialists are not available in the Govt's health institution, for managing complications, assistance up to Rs. 1500/- per case is being given to the health institution **for hiring services of experts** in a Government medical facility. **If a private medical expert is not available**, expert doctors working in the **other Government set-ups** may even be empanelled, provided his/her services are spare.

21. Under the **Tenth plan**, a sum of Rs. 500.00 crores was allocated for NMBS of which around Rs.212.00 crores was released to the states. It is anticipated that around Rs.200.00 crores would be expended this year. Due to the recent modifications approved by the Mission Steering Group in the meeting held on 22.9.2006, the estimated cost of implementation, as per the existing parameters is anticipated as follows:

Year	Estimated Requirement of fund (In crores)
2007-08	250.00
2008-09	300.00
2009-10	350.00
2010-2011	400.00
2011-12	450.00
Total	1750.00

Reivew of the Universal Immunization Programme. (UIP)

X Plan

Immunization Programme in India was introduced in 1978 as Expanded Programme on Immunization with limited reach mostly in urban area. The programme was universalized in 1985-86 to cover six vaccine preventable diseases under Universal Immunization Programme in phased manner and covered all districts in the country by 1989-90. The reported coverage data from 1990 to 2005-06 is at **Annexure VII**. In 1986, the programme became part of the Technology Mission and monitored under 20 point programme by Prime Minister's Office. From 1992, the programme formed a part of the CSSM programme and subsequently under RCH programme from 1997.

The district level survey conducted in 2002-04 (**Annexure-VIII**) indicated that the immunization coverage has decline in the country when compared to 1998-99 district level survey. This decline has been more pronounced in the EAG States, NE States. Under the NRHM immunization has been the thrust areas and more focus has been given to improve the coverage. Some of the intervention carried out for the first time to improve coverage are as under

Introduction of AD syringe : In the immunization programme glass syringes were used after sterilization for injection. The INCLIN study revealed that 17% of the injections were due to immunization and 2/3 of the injections given were unsafe. In order to address to injection safety and increase efficiency in the programme the Ministry of Health and Family Welfare introduced Auto Disable (AD) syringe in the immunization programme in the last quarter of 2005. The AD syringe is now been universally available for use in the immunization programme across the country.

The Multi year plan is the basis for strengthened routine immunization. Under this plan the States have made their State specific project implementation plan (PIP) ie PIP part-C of NRHM. The PIPs covers area for strengthening the Service delivery component of Routine immunization. These are:

- i. **Alternate vaccine delivery:** The last storage point of vaccine is PHC. For this purpose every PHC and above has been provided with twin set of Ice Line Refrigerator (ILR) and Deep Freezer (DF). Every district has been provided with one vaccine van. The vaccine is being transported from the State HQ to PHC with the help of these vaccines Van. However, there was no support for transportation of vaccine from PHC to village session site, as a result ANM used to collect and transport vaccine to session site thereby consuming lot of valuable time which otherwise could have been use for conducting immunization session. In order to bring in efficiency and fidelity to the program, support has been provided to deliver the vaccine in the village and other outreach session site as per microplan. The flexibility has been provided to use the available local means of transport. However, there has to be appropriate maintenance of record for transparency.
- ii. **Alternate Vaccinators:** It was observe that most of the plan sessions are not held as the vaccinator is not available. In order to ensure that every plan session as per microplan is held, a provision has been made for alternate vaccinators who are not

part of the system by providing honorarium @ Rs 350 per session conducted. Therefore, such session will be conducted either at Urban Slum, Un-served or under-served areas. In order to operationalised the alternate vaccinator each district should have list of such vaccinator prepared well in advance so that these worker could be pressed for conducting sessions at the short notice.

- iii. **Social Mobilization** : Social mobilization of beneficiaries by the ASHA (Accredited Social Health Activist) / Link Worker / Aanganwari worker (AWW) / local RI mobilizer etc is one of the important activity to improve coverage. The social mobiliser should be assign specific task of mobilising (i) all children who dropped out the last session. For this purpose ANM will prepare list of defaulter using Tickler boxes/bags/other methods and hand over one copy to the mobiliser. (ii) Social mobiliser to prepare a list of all new born delivered in between two sessions mobilised them for vaccination. (iii) Besides this she would also inform all other beneficiaries the next date of vaccination and mobilised them. For this purpose ASHA or link worker is provided Rs 150 per session in ASHA State and Rs 100 in non ASHA state.
- iv. **Strengthening Supportive supervision** : Each district has been provided a sum of Rs 50,000 for mobility support to carryout supportive supervision. In bigger State a sum of Rs 1,00,000 has been provided at the State level for the mobility support of the State officials for supporteive supervision. Each such visit should be followed by a written report of the visit and feedback to all other sessions on the observations.
- v. **Half yearly meeting at State with districts** : Support has been provided for organisiting half yearly meeting with district officials at the State. A central government representative must be invited in such meeting.
- vi. **Support for POL** : In order to run genset some State has been provided support of POL.
- vii. **Printing** : Printing of Immunization card, Immunization register, temperature chart, tickler box etc must be carried out by the State. There will be no further supply from the center. However, to maintain universality of these immunization cards, immunization register, State will stick the design and format of the center.
- viii. **Downsizing BCG vaccine vial** : The BCG vaccine vial has been down sized from 20 dose to 10 dose to ensure that the vaccine is available in every session site.
- ix. **Computer assistant** : for e-reporting and e-monitoring
- x. **Miscellaneous Support for POL etc to run gen-set for maintenance of cold chain**

Hepatitis B vaccination : The Hepatitotis B vaccine has been introduced as a pilot project in 33 district and 15 cities with support from GAVI. With the successful implementation of the pilot project in has been decided to expand the Hepatitis B vaccination in the 11

good performing States were the evaluated coverage of DTP 3rd dose is more than 80% with plans to expand in the remaining States.

Japanese Encephalitis (JE) vaccination : JE vaccination using SA-14-14-2 vaccine has been carried out in the 11 high risk district covering children between 1 to 15 years of age starting from May 2006 and approximately 9.03 million children received JE vaccine during this campaign. It is planned to cover the remaining high risk district in phase manner.

SURVEILLANCE OF VACCINE PREVENTABLE DISEASES

Although reporting of VPDs is a component of the CNAA reporting format, the Department of Family Welfare has to resort to the data made available by CBHI since the CNAA reporting is neither regular nor complete.

In order to further strengthen the VPD surveillance certain new initiatives have been taken.

Measles Surveillance has been integrated with the existing AFP surveillance in three states of Tamil Nadu, Karnataka and Andhara Pradesh and there are plans to expansion to other States.

Neonatal tetanus (NT) elimination

NT is a global goal; elimination is defined as an annual rate of less than 1 case of NT per 1000 live births in every district in the country.

The Government of India (GOI), Universal Immunization Program (UIP) is planning to demonstrate elimination of Maternal & Neonatal Tetanus in the country by 2009. Already in seven States (Andhra Pradesh, Kerala, Tamil Nadu, Karnataka, Maharashtra, Haryana, and West Bengal) this validation exercise has been carried out. It is planned to validate the remaining States in the next three year. For this purpose 6 to 7 states are identified each year. The Union Territories and smaller states will be clubbed for validation purpose.

The validation process involves collection of district wise data for the last three year for TT pregnant women coverage, Institutional delivery rate, NNT cases etc. The said data is used for identification of worst performing district where chances of finding NNT higher compared to other district. The identified district is then surveyed for Lot Quality Assessment Cluster Sampling surveys (LQA-CS.) Through LQA all death of IMR are subjected to verbal autopsy for identification of NNT death.

Recommendations after validation of NNT elimination:

- (i) maintaining high TT vaccination coverage to pregnant women,
- (ii) improve institutional delivery practices
- (iii) Strengthen surveillance of NNT.

Polio Eradication Programme:

10th Plan Period

During the 10th plan period remarkable progress has been made in controlling the transmission of polio virus in India. Compared to 1600 cases detected in year 2002, only 66 cases were reported in 2005 throughout the country. The geographical spread also declined from 159 districts in 2002 to 35 districts in year 2005. Of the three main types of virus causing polio, type 2 was eliminated in 1999 (with the last case identified in western Uttar Pradesh). The type 3 virus is only circulating in Moradabad district of UP. The type 1 polio virus, the main cause of disease in India, had been eliminated from all but parts of two states – western Uttar Pradesh, and northern Bihar. Of the 14 genetic families of type 1 virus circulating in 2002, 12 genetic families have become extinct and only 2 are in circulation.

This year has seen an outbreak of disease in Moradabad, western UP which now threatens the substantial gains made over the last few years. Data on the pulse polio vaccination campaign coverage showed that in late 2005 and early 2006, increased numbers of children did not receive the polio vaccine. This gave an opportunity to the polio virus to maintain its circulation and infect and paralyse the susceptible children. This polio virus from UP has now re-infected other districts in UP and other states which had previously eliminated the polio virus circulation. During this year so far 352 cases have been reported from the country out of which 312 are from UP, 20 from Bihar, 5 each from Haryana and Uttaranchal, 2 each from MP and Maharashtra and one each from Delhi, Chandigarh, Punjab, Gujarat, Jharkhand and West Bengal.

A new scheme of **corrective surgery and rehabilitation of polio affected children** was approved for undertaking corrective surgery of 20,000 affected children in the age group of 3-18 years during 2006-07 and 2007-08 as pilot for which a provision of Rs.20cr. have been made. A scheme for its implementation has already been prepared by a committee under the Chairmanship of Additional Director General Health Services. The same has also been examined by the IFD and concurred. The scheme is being disseminated initially to the States having high incidences of polio in the past for undertaking corrective surgery at the district / state hospitals by involving NGOs already in the for mobilization and other supports. Funds for this scheme will be routed through State Health Societies under NRHM.

11th Plan Period:

The current strategy of pulse Polio Programme of vaccinating the children between 0-5 years of age during NID and SNIDs will be implemented during the 11th Plan period to achieve zero transmission and obtaining polio free certification. To get certification, the country will sustain the zero transmission status for consecutive three years.

The Scheme of corrective surgery may also be undertaken during 11th plan period to provide facility of corrective surgery to cover the remaining polio affected children in the age group of 3-18 years.

XI Plan

- Continuation of the existing programme
- Continue expansion of Hepatitis B vaccine in the country
- Phase expansion of JE vaccination to high risk districts
- Introduction of newer vaccine in the immunization programme based on disease burden or recommendation by the experts.

Interventions under the NRHM

The Implementation Frame Work under NRHM (Annexure II) as approved by the Union Cabinet takes a holistic view of Primary Health Care in the country especially in relation to its goals of reduction of IMR, MMR and TFR. The infrastructure/logistical support for providing drugs and equipments and availability of manpower, requirements, for making facilities fully functional, leading to service guarantees and clear health outcomes have been fully taken care of under the Mission. However, some of the additional issues as noted above need to be fully addressed to improve the health status of women and children under the Five Year Plan.

CHAPTER – 4

REVIEW OF THE FUNCTIONING OF THE FAMILY WELFARE INFRASTRUCTURE.

State of Public Sector Service Infrastructure

1. When the Family Welfare Programme was initiated in the early 1970s, the infrastructure for providing maternal and child health and family planning services was inadequate at the primary health care level, and sub-optimal in the secondary and tertiary care levels. In order to quickly improve the situation, the Department of Family Welfare, Government of India created and funded post-partum centres, urban family welfare centers/health posts and provided additional staff to the then existing block level facilities (usually block PHCs). In addition, the posts of ANMs in the sub centres, created after the initiation of the Family Welfare Programme, were also funded by the Department. The Department of Family Welfare also created state and district level infrastructure for carrying out the programmes and setting up training institutions for pre/in-service training of personnel. All these activities were being funded through Plan funds.
2. Over the last three decades, there has been considerable expansion and strengthening of the health care infrastructure by the States. Family welfare services are now an integral part of services provided by primary, secondary and tertiary care institutions. The staff funded by the Department of Family Welfare under the scheme of rural family welfare centres and post partum centers are state health services personnel functioning as part of the state infrastructure. In view of this, the Ninth Plan recommended that the funding should be taken over by the state Department of Health. States have since taken over the responsibility of funding post-partum centers and rural family welfare centers from 1 April 2002. The fact remains, however, that service delivery network remains extremely weak both in terms of physical infrastructure as well as human resources. Resource mismatch makes the matters worse: specialists are posted to a facility not meant / equipped to provide specialist services and vice versa⁸.

⁸ Planning Commission report on *Evaluation of Functioning of Community Health Centres*.

3. Although 8th, 9th and 10th Plans have been emphasizing that infrastructure planning requires equal emphasis on reorganizing / re-structuring various types and kinds of health facilities, most planning exercises by the States have treated the primary health care infrastructure to consist only of Sub-centres, Primary Health Centres and Community Health Centres; ISM dispensaries and hospitals and the public health facilities outside the administrative control of the health department are most often than not ignored.
4. There have been two large scale facility surveys during RCH-I period, both conducted by International Institute of Population Sciences, Bombay. The first survey was conducted in 1999 covering 221 districts, followed by another survey in 2003 covering the remaining 370 districts.
5. The findings of the first facility survey (1999), covering 210 district hospitals, 760 FRUs, 866 CHCs and 7,959 PHCs indicated acute shortage /inadequacy of basic physical infrastructure at the PHC and CHC levels (Table 4.1).

4.1: Summary of findings of the facility survey 1999

Sl. No.	FACILITY	Availability in FRU	Availability in CHC	Availability in PHC
1.	Own buildings	98%	96%	92%
2.	O T	93%	86%	----
3.	Labor room	36%	28%	28%
4.	Over head water storage tank & pump	82%	71%	----*
5.	Blood bank / BSF / Linkage with D BB	17%	9%	----
6.	Diesel Generator	71%	52%	----
7.	Telephone	80%	62%	20%
8.	Computers	2%	2%	----
9.	Functional vehicle	73%	61%	29%
*62 % of the PHCs surveyed are having water supply facility only but not having storage tanks & pumps, etc.				

6. The 2003 survey, which covered a much larger number of facilities, including the AYUSH facilities⁹, confirmed the findings of the first survey (Tables 4.2, 4.3 and

⁹ Survey covered 370 district hospitals, 1882 First Referral Units, 1625 CHCs, 9688 PHCs, 18385 Sub-centres, 2151 AYUSH Hospitals and 7064 AYUSH dispensaries.

4.4). However, the second survey also revealed the huge latent potential for improved access through reorganizing /re-structuring exercise (Table 4.5).

Table 4.2: Functional adequacy of District Hospitals, FRUs and CHCs

	District Hospital	FRU	CHC
Proportion (%) of facilities having....			
Separate aseptic labor room	44.4	33.3	31.0
Telephone facility	96.7	74.8	62.2
OPD facility for RTI/STI	56.4	24.9	16.0
Linkage with district blood bank	67.5	27.2	15.8
Regular blood supply	60.5	27.7	10.5
Quarters for obstetrician / gynecologist	40.1	28.5	21.0
Facility adequately equipped in terms of ...			
Infrastructure @	93.0	76.0	63.0
Medical Staff @@	80.0	37.0	14.0
Paramedical Staff (*)	32.0	37.0	41.0
Supply(**)	45.0	32.0	24.0
Equipment #	84.0	61.0	46.0
Referred delivery cases attended during last three months ##	37.0	39.0	46.0
<p>@ Overhead tank and pump facility, electricity in all parts of the hospital, availability of generator, telephone, functional vehicle, laboratory, operation theatre, separate aseptic labour room</p> <p>@@ Includes obstetrician / gynecologist, pediatrician and anesthetist.</p> <p>(*)Include staff nurse, ANM, pharmacist, laboratory technician, PHN, health assistant male and female.</p> <p>(**)Includes tubal ring, set of standard surgical kits, emergency obstetric care kit, new born care kit, RTI/STI kits and delivery kit 1</p> <p># Includes Boyle's apparatus, shadow-less lamp and oxygen cylinder.</p> <p>## Calculated from the number of health facilities which have conducted delivery.</p>			

Table 4.3: Proportion of Primary Health Centres adequately equipped

Proportion (%) of PHCs having	
Own building	89.2
Labour room	48.4
Telephone	19.8
Staff quarter for MO	52.0
Proportion (%) of PHCs adequately equipped (at least 60%) in terms of	
Infrastructure @	31.8
Staff @@	48.2
Supply \$	39.9
Equipment \$\$	41.3
Training #	19.9
<p>@ Includes tap water, regular supply of water, electricity, telephone, toilet, functional vehicle and Labour room available</p> <p>@@ Includes Medical officers male, female and paramedical staff</p> <p>\$ Includes IUD kits, delivery kits, mounted lamp supply of OP, measles, IFA large and ORS</p> <p>\$\$ Includes deep freezer, BP instrument, autoclave, labour room equipment, MTP suction and oxygen cylinder</p> <p># Includes only medical officers who are currently in position</p>	

Table 4.4: Adequacy of inputs at the Sub-centres

Proportion (%) of Sub-centres having	
Own (govt) buildings	45.2
Electricity	43.2
Health Worker (Female) in position	95.1
Health Worker Male in position	67.7
Paramedical staff trained in IUD insertion	1.2

Table 4.5: Availability of infrastructure under AYUSH network

Proportion having	AYUSH Hospital	AYUSH dispensary
Own Building	16.7	30.0
At least one Bed	92.8	Not applicable
Medical Officer in Position	76.8	83.2
Sisters in Position	72.4	62.0
Staff Nurse in Position	76.0	87.2
Pharmacist in Position	84.4	77.1

7. Following issues emerge from the above data generated through the facility surveys:

- A very significant part of the so-called infrastructure shortage – number of PHCs, number of doctors, nurses and pharmacists can be met through the re-organization exercise. This is particularly so as a large proportion of AYUSH hospitals / dispensaries and PHCs are operating from rented premises.
- Non-availability of aseptic labour rooms and lack of access to safe blood are the leading barriers to access to emergency services.
- Technical skills of providers are extremely weak or inadequate with less than 2% ANMs having received IUD insertion training and less than 20% of PHC medical officers having received adequate training.
- The NRHM initiatives addresses the infrastructure gaps. The associated institutional reforms [functional autonomy to Rogi Kalyan Samiti] will also contribute to improving efficiencies. However, the delivery network will remain sub-optimal unless the investments are preceded by a district specific health infrastructure development plan based on a resource mapping exercise. This is a specialized task calling for a steering role for the Ministry of Health & Family Welfare. The working group noted that facilities surveys have been under taken by the States prior to their taking up their upgradation to IPHS. While under the RCH-II all Community Health Centers in the country are being converted to First Referral Units (FRUs) their upgradation to IPHS has also been taken up under NRHM. IPHS is being finalized by the task force for PHCs and Sub-centers. The Implementation Framework of NRHM approved by the Union Cabinet fully takes the entire infrastructure issues under consideration. A few States [e.g. UP and Chhattisgarh] have developed GIS based tools which can be used for this exercise.

8. Public - Private Partnerships : Issues and options

Public – Private Partnerships can be used as an effective instrument for achieving public health goals and a number of initiatives have been introduced by the States with positive results. Some recent examples are:

- Establishment of diagnostic services and CT-scan units in West Bengal; positive results led the State to expand the arrangement to rural hospitals / block PHCs in the year 2004.
- Management of 133 ambulances by NGOs for emergency transport in rural areas of West Bengal.
- Outsourcing of ambulance services, diet, laundry, cleaning, installation and management of X-ray /pathology services in Bihar

- Contracting-out of PHCs in Arunachal Pradesh, Bihar, Karnataka and Gujarat
- The “Chiranjivi” scheme in Gujarat for delivery care of BPL women.

While efforts to strengthen and optimize existing public facilities with more investment and better management should receive priority, collaborating with non-government stake holders will still be required due to the Governments’ limitations in mobilizing the required capital for meeting the growing demand and more importantly, the expertise and skill base that the private sector attracts. Collaboration must, however, be funded on a regulatory framework and insurance system licensed by the GoI to ensure that there is no adverse selection and risk-sharing is facilitated.

Evidence and good practice from several developed countries show that protocols exist that can be usefully adopted and adapted to address quality and appropriateness of care, measurable against volumes delivered at different levels of the system from hospital to outpatient and ambulatory care. The single most effective way of managing the sector and speeding the restructuring process of provider markets is through standards and treatment protocols and having a system for enforcing them. Standard-based payment systems help in enforcing provider accountability and also check unethical practices and conflicts of interest. However, they need intensive and extensive training and capacity building aiming at deploying controllers and assessors who are conversant with new techniques of technical and financial audit and evaluation. There is also a need to establish parameters and system for remuneration of outsourced accredited providers, based on health accounts that are currently lagging in the health system

9. The Challenge of human resource requirements Health being a human resource intensive sector, it is imperative that a long term perspective plan is developed and adopted to ensure that adequately trained and effective health providers are available in sufficient numbers at all levels. While this issue has been debated in the past, the distribution of medical colleges, nursing and paramedical training institutions have come up in different parts of the country without any relationship with the geographical needs [**Annex-IX (a)**] development of specialties in different disciplines have not kept pace with the actual requirement of specialized services, particularly in public health field and in rural areas. The total annual intake for specialists related to maternal care, for example, is highly insufficient [**Annex-IX (b)**]

10. The nursing education sector is characterized by a similar skewed distribution: UP has only 30 ANM training centres for 70 districts and Bihar only 27 whereas Andhra Pradesh has 30 ANM training schools, 182 institutions recognized for GNM course and 107 recognized for B.Sc. Nursing course [**Annex-X (a)**]. Although there has been a sharp increase in the nursing training institutions in the last couple of years [**Annex-X (b)**] indicating number of institutions existing as on 31st March, 2004), the network will need to be expanded on a much faster rate to be able to catch up with global doctor-nurse ratio.

11. Nursing Educational Institutions

Independent Nurse Practitioner: The Indian Nursing Council developed a new nursing course / discipline called the *Independent Nurse Practitioner(INP)*. The INP course is an 18 month post basic diploma in midwifery¹⁰ and imparts all skills necessary to handle obstetric emergencies (including blood transfusion). The INP is authorized to and can establish her own, independent practice. The course has been piloted by INC in West Bengal and 2 of the 4 trainees have been assigned to a CHC to manage obstetric cases.

The Sri Lanka experience quoted in the 10th Plan MTR indicates that the IPNs, whose skill levels would be equivalent to that of the Sri Lankan Public Health Midwife (PHM), would be a more suitable choice for MCH care at the community level, that is, the Sub-centre. Given the limited training capacity, such large numbers can not be trained in the immediate future. As such, this option can not be exercised till the training capacities has been expanded. However, the INP training must be started in as many places as possible and the States should consider sponsoring suitable candidates who are willing to establish their private practice in rural areas. The Hospital Management Societies should also be encouraged to engage the INPs on the basis of a monthly retainer-ship basis plus payments linked to cases handled.

12. Following other suggestions are made with regard to Nursing Educational Institutions:
- A dedicated Nursing and Paramedical Manpower Division / Unit should be established at the National and State levels.

¹⁰ In INC terminology, Diploma in General Nursing and Midwifery (GNM) and B.Sc. Nursing are called basic nursing course.

- All medical colleges should be mandated to establish a College of Nursing offering courses in B.Sc. Nursing, M. Sc. Nursing and Post-Basic Diploma courses in specialty nursing areas.
 - All District Hospitals should be mandated to establish a school of nursing offering ANM and Diploma in General Nursing and Midwifery,
 - Smaller hospitals in public sector having at least 30 OBG beds should be encouraged to start ANM training
 - Private sector hospitals having at least 30 OBG beds should also be allowed to start ANM training programme and the concerned State Government should allow selected public sector rural facilities for their field training.
13. Deployment of AYUSH practitioners for MCH services: The availability of AYUSH doctors is far better in the rural areas. The hospital management societies should be encouraged to engage these personnel for conducting deliveries of the training in the hospitals. The compensation package should be on similar lines as that suggested above for the INPs if their midwifery skills can be upgraded through their attachment to district hospital.

14. Medical Education Institutions

The Ministry under the NRHM had setup a task force on medical education. The recommendations made by the task force are far reaching. The Ministry needs to examine them early for the purpose of adopting them to meet the manpower requirements in the rural areas.

15. A contributing factor for poor access levels in the rural areas is that the States have not sanctioned sufficient staff / specialist positions for the rural areas. On an overall basis, for example, the States had sanctioned only 7582 posts of specialists till September, 2005, as against the requirement of 13384 posts for the 3346 CHCs (1 surgeon, 1 OBG specialist, 1 physician and 1 pediatrician for each CHC)¹¹.
16. The NRHM has adopted a set of revised staffing norms for the Sub-centres, PHCs and CHCs which will add to the human resource needs in the rural areas. For the ANM, the requirement has doubled as 2 ANMs have been sanctioned for every Sub-centres. The Sub-centre will continue to be the critical facility for the

¹¹ Rural Health Statistics, 2006 (Ministry of Health and Family Welfare)

delivery of health care of women and children in rural and remote areas where no other facility exists. The objective of making 2000 facilities as fully functional FRUs will require at least 2000 specialists in OBG, anesthesia and pediatrics (each) and 20,000 staff nurses. The objective of making 10,000 PHCs as 24/7 facilities equipped for institutional delivery implies an additional requirement of 30,000 Public Health Nurse Practitioners / General Nurse and Midwives (GNMs). The NRHM provides for additional manpower at CHC, PHC & Sub-Center levels. The NRHM provides for additional manpower at CHC, PHC & Sub-Center levels. A number of strategies and interventions have been proposed to overcome the shortage of manpower in rural areas including compulsory rural postings using interns, using NGOs, multi skilling of doctors, pre service training for medical graduates in anaesthetic skills, training in Obstrectic Care and Skilled Birth Attendance, providing for local recruitment of nurses/ANMs, contractual appointment of doctors, training of Rural Medical Practitioners. Given the capacity constraints, it is unlikely that these numbers will become available in the immediate future. Therefore, a systematic, district specific approach will be required to expand the network of fully equipped facilities. Following suggestions are made in this regard:

- Ensure that the district hospitals are fully equipped for the FRU services,
- Strengthen midwifery skills of existing ANMs/Nurses through their attachment to district hospital; add more facilities for skill-development training after they are fully equipped for FRU services,
- Involvement of non-govt. stake holders in running facilities. Scale up the training of doctors/ANMs in Skill Birth attendance.
- Training of RMPs.
- Setting up of a nursing cadre in all States.

CHAPTER - 5

METHODS OF IMPROVING REPRODUCTIVE & CHILD HEALTH SERVICES AT THE SECONDARY AND TERTIARY LEVELS.

A separate Working Group has been set up by the Planning Commission to look into the different aspects of service delivery at the Secondary and Tertiary levels. The group, therefore, did not go into the details of this issue.

CHAPTER – 6

FINANCIAL AND PHYSICAL REQUIREMENTS FOR IMPLEMENTATION OF RCH PROGRAMMES UNDER 11th PLAN.

The RCH-II carries an approved outlay of Rs 40,000 crore over a 5-year period FY 2005-06 to FY 2009-10. As the NRHM has since been approved for implementation over a 7-year period starting FY 2005-06 including 11th Plan period and its outlays subsume the same for RCH-II, the base cost of extension of RCH-II till the end of 11th Plan period appears to have been covered under NRHM outlays, as indicated in Table 6.1 (assuming an annual growth of 10% for sustaining on-going technical interventions).

Table 6.1: Budgetary requirements for RCH-II during 11th Plan (Rs crore)

Year	Total NRHM budget			RCH-II budget			Balance for other NRHM activities
	Non-recurring	Recurring	Total	DBS	EAP	Total	
2005-06			6500	2507	3693	6200	300
2006-07	500	9000	9500	2771	3729	6500	3000
2007-08	1350	11000	12350	2949	4551	7500	4850
2008-09	4290	13000	17290	3137	6363	9500	7790
2009-10	8000	16206	24206	3312	6988	10300	13906
2010-11	10000	23884	33884	3650	7690	11340	22544
2011-12	5000	42439	47439	4015	8460	12475	34964
Total –NRHM duration			151169			63815	87354
Total -11 th Plan period			135169			51115	
No separate budget approved; figures are estimates assuming 10% nominal enhancement							

The Working Group recommends following two suggestions keeping in view the integration of RCH-II with NRHM :

- Allow the external grant assistance (with zero debt liability) mobilized by the Ministry of Health and Family Welfare as an additionality to the domestic budget, as recommended in the 10th Plan Mid-Term Evaluation Report.

- Develop a year –wise, activity wise detailed expenditure plan for the NRHM, integrating RCH-II [and other schemes which are subject to international negotiations / agreements] but retaining their separate ‘financial’ identity within the same.

The NRHM Implementation Frame Work approved by the Union Cabinet has projected the financial and physical needs to fully operationalise the mission to meet its stated goals based on the projections made by the National Commission on Macroeconomics and Health in its report. The group felt that this projections fully cover the requirements of the Maternal and Child Health programmes.

CHAPTER - 7

RECOMMENDATIONS

Some of the important issues concerning women and children's health and welfare which requires special and immediate attention during the 11th Plan are listed below, on the basis of the recommendations made by the Group.

- *Gender Based Violence*

Large-scale datasets indicate that one in every four women has experienced spousal violence at least once in her marital union. From an epidemiological view point the violence results into unwanted pregnancy, pregnancy complications, miscarriages and other maternal morbidities. Besides impacting reproductive health, violence also results in variety of medical and psychological problems, which may assume serious consequences requiring access to treatment and counseling facilities.

The Eleventh Five-Year Plan should consider public health interventions so as to prevent gender-based violence in community and also address screening and management of violence through the network of public health institutions.

- *Pre-natal Sex Selection – Need for stabilising sex ratios*

While family size has become smaller, with more and more families wanting only two children, the desired family composition in terms of the sex of the children has not changed. The preference for at least one son is evident. This further puts daughters at risk, as families want to ensure that one out of the two children is a son. This finding is further reaffirmed in the recent NFHS 3 study. Low ratios further lower women's status – violence, movement of 'brides', resurgence of negative cultural practices such as polyandry.

Both the mid-term appraisal of the tenth and the eleventh plan approach paper emphasise the need for stabilising the child sex ratios and for ensuring effective implementation of the Act accompanied by efforts to influence behaviour change. The Ministry is actively addressing the issue. To improve the implementation of the Act it has recently constituted a National Support and Monitoring Cell. The inspection committee of the Ministry is undertaking routine visits to district for assessment of records and full

compliance of the providers with the provisions of the Act. Computerisation of the records is underway to facilitate close monitoring and timely action against defaulters. Other steps for integration of the issue of pre-natal sex selection in the ministry's initiatives and programmes include the following:

- Community awareness through ASHAs,
- integration of the issue in training modules and programme and in IEC/BCC material,
- adding information on sex selection to the medical curriculum,
- including indicators on improvement in sex ratios and birth registration as a part of monitoring target/indicators under RCH 2/NRHM
- inclusion of the issue in district level programme planning and implementation processes,
- promoting greater convergence with other departments of ministries such as DWCD, Panchayati Raj, Youth affairs for a comprehensive service side and community level response to address the issue

Additional strategies that can be addressed through the Eleventh Plan include:

- Developing targets and monitoring : Develop clear targets of natural **sex ratio at birth** (SRB) which is 105 males per 100 females and give financial benefits to states that have improved SRB. The Annual Health Survey should also include estimating the SRB at the district level from 2007 on wards. Planning Commission could also consider obtaining independent estimates of the SRB at the district level each year. The states should be encouraged to monitor the SRB of the institutional deliveries by parity for each of the facility and for the districts.
- Resource transfers: Improvement in SRB should be included as one of the indicators for arriving at decisions on planned assistance to states.
- Data for tracking: Improve data availability, access and quality, especially on sex ratio at birth. The option of PHC level enumeration can be considered to monitor the sex ratio at birth on a routine basis. Adequate financial resources should be programmed for capacity building, awareness generation and strict enforcement of PC & PNDT Act. The PNDT Act should be amended to provide for the independence of the Appropriate Authorities at the district level from the district health administration and their accountability to the National Board under the Act. The amendment should also provide for the National Appropriate Authority to supervise the functioning of the state and district level authorities..

- **Promoting institutional deliveries**

(a) As per the demand from the HPS states, enhancement of cash assistance to mother to be brought at par with that of the LPS states. This would raise the cash benefit from the existing scale of Rs.700/Rs.600 per delivery to Rs.1400/Rs.1000/- per delivery in rural and urban areas, respectively.

(b) Considering that the poor families whether in LPS or HPS states, avoid going to institutions mainly due to lack of financial support, and that non availability of BPL certificates impedes access to the benefits of the scheme in many states, like in the LPS states, all pregnant women in the HPS states, accessing public or accredited private health institutions should be brought under the fold of JSY.

(c) Considering that obtaining age certificate is difficult specially in the rural areas due to low rate of registration of births, like in LPS states, age restrictions should be removed in HPS states.

(d) Considering that women with high fertility and parity are at grater risk of mortality and that the JSY is mandated for safe motherhood, restrictions on number of child, like in LPS states, should be removed for HPS states.

(e) The annual estimated cost of the implementing the JSY would be around Rs.500.00 crores.

- **Infertility**

Nearly 5-8 percent couples report infertility in India. The social consequences of infertility are disaster to women, as “female sex” is invariably blamed for not producing children. She may be abandoned and husband may remarry. Prevention and management of infertility in primary health care setting should be included in service package delivered in the NRHM, especially in the states with performing well on programme delivery indicators.

- *Problems of older women*

Though reproductive life span ceases at 50 years, many women continue to suffer with health problems related to reproductive systems. Community based studies have indicated significant burden of diseases attributable to chronic reproductive morbidities such as obstetric fistula, pelvic organ prolapse, and osteoporosis.

- *Reproductive cancers*

Data from cancer registry in the country suggest high prevalence of cervical and breast cancer amongst women. In the XI FYP attempt should be made to introduce HPV (Human Papilloma Virus Vaccine) in the programme especially in the states with high prevalence. Similarly centre of excellence should be developed to screen, diagnose and manage reproductive cancers in women.

- *Mental Health problems of the women*

Burden of diseases attributable to mental health problems amongst women is also high. The range of mental health problems includes anxiety disorders, depression and psychosis. Considering limited access to qualified mental health professionals, primary mental health care should be an integral component of NRHM. Several evidence based interventions such barefoot counselors (may be ASHAs) could be considered as a first point of care.

- *Occupational health problems of women*

The proportion of women (15-59 yrs) in terms of workforce participation has gone up in the last census to 40 percent. Most women are in the unorganized sectors and are not covered for safety provisions. Health hazards to women working in agriculture include exposure to pesticides, injuries due to mechanized farm equipments and snakebites etc. Women are employed in hazardous occupation such as mining, chemical industries and plantations as well. Similarly women are also exposed to indoor air pollution especially in rural areas, where clean fuels are still not available for cooking purposes. Indoor air pollution is also linked with causation of Acute Respiratory Infections amongst under-five children.

- Women and Children' health in Disaster situations

Pregnant women are susceptible to trauma in disaster situations and high incidence of spontaneous abortions in the post disaster period is very well documented. Women are also more vulnerable to violence during these situations. Similarly, children invariably bear the brunt, as they are unable to run away from the disaster sites. Since mobility is restricted during disasters, programmes should focus on addressing health care needs of women and make provisions for supply of reproductive health commodities including sanitary kits.

Other recommendations:-

- (a) The Working Group noted that the strategies and interventions proposed under the NRHM and RCH-II are extremely relevant and hold the biggest potential for improvement in the health status of women and children. The thrust on implementing these strategies must receive the highest priority during the 11th Plan.
- (b) There is a need to enlarge the ambit of NRHM and RCH-II technical interventions to include issues such as gender based violence, pre-natal sex selection, infertility, problems of older women, reproductive cancers, mental health problems, health related ability issues occupational health problems of women and women and children's health in disaster situations.
- (c) Both NRHM and RCH-II need to adopt a life cycle approach towards the health of women and children and in doing so convergent action in association with related programmes of the health sector as well as of associated Ministries needs to be taken and reflected in the women and child health programme of the Ministry. This amongst others will require specific components to be built in for women and children in the HIV / AIDS, Communicable (T.B., Malaria, Leprosy etc.) and Non-Communicable Diseases (Cancer, Diabetes, Circulatory diseases etc.) programmes. Similarly nutrition including anemia, substance abuse (tobacco, alcohol, drug dependence), sanitation, drinking water and other issues having a bearing on the health of children and women would need to be attended by developing effective linkages so as to ensure a holistic approach towards the health care of women and children.
- (d) The issues identified in the Approach Paper to 11th Plan like absenteeism of doctors/health provides, low levels of skills, inadequate supervision/monitoring and callous attitude are critical issues and must be

attended to with all seriousness at both the Central Government and State Government levels.

- (e) The working group is concerned that there is no accurate methodology for estimating Maternal Mortality Rates at State and District levels. Steps must be initiated by the RGI to ensure 100 percent registration of births and deaths need to be implemented quickly. ASHAs/Health Workers should be fully utilized. In the registration of births and deaths at the village level.
- (f) Despite all the investments made till now the service delivery network remains extremely weak both in terms of physical infrastructure as well as human resources. The development of appropriate crucial technical manpower resources has to be in the long term matched with the field requirements of various specialties considered crucial for saving lives of women and children. The group recommended the up scaling of the trainings initiated by the States to ensure availability of Skilled manpower to enable operationalisation of First Referral units in the Community Health Centres to deal with Obstetric emergencies and childhood illness.
- (g) While efforts to strengthen and optimize existing public facilities with more investment and better management should receive priority, collaborating with the private sector, especially the NGO network will still be required due to the Governments' limitations in mobilizing the required capital for meeting the growing demand and more importantly, the expertise and skill base that the private sector attracts. Collaboration must, however, be funded on a regulatory framework and insurance system licensed by the GoI to ensure that there is no adverse selection and risk-sharing is facilitated.
- (h) Organisational set up and structure of State Health Departments / Directorates differ widely. While there should be no objection to this, Central Government must insist on clearly defined roles and responsibilities at least where it is making financial contribution.
- (i) The Block with the block hospital as the apex technical and administrative unit has been rightly positioned as the basic unit for organizing service delivery. There is need to have atleast one CHC functional per block in the first phase of RCH-II. However, in order to make the block health system optimally functional, there is a need to develop model organogram and job description for each functionary. This is necessary for functional integration of the various technical interventions including TB, Malaria and HIV /AIDS.

- (j) There is an urgent need for developing model protocols for realizing the communitisation objective defining the processes and procedures involved.
- (k) Health Worker Schemes taken up by some States to cover urban slums under RCH-II needs to be expanded to all the States. They should be linked to health posts and hospital to establish a referral chain.
- (l) Considering that a rapid expansion in infrastructure manpower is envisaged under NRHM, there is a need for involving the district level institutions in training and skill upgradation. Therefore, a systematic, district specific approach will be required to expand the network of fully equipped facilities. Following suggestions are made in this regard:
- Ensure district hospital is fully equipped for the FRU services,
 - Strengthen midwifery skills of existing ANMs through their attachment to district hospital; add more facilities for skill-development training after they are fully equipped for FRU services,
 - Adopt multiskilling as the main strategy for strengthening service delivery, both for doctors as well as the paramedical staff.
- (m) Nursing / paramedical manpower will have a crucial role in delivery of health care services and for achieving the MDG goals. The Group strongly feels that investments in this area will provide more returns in terms of impact and therefore makes following suggestions:
- All states should take action for having a nursing cadre set up in the State.
 - A dedicated Nursing and Paramedical Manpower Division / Unit should be established at the National and State levels.
 - All medical colleges should be mandated to establish a College of Nursing offering courses in B.Sc. Nursing, M. Sc. Nursing and Post-Basic Diploma courses in specialty nursing areas.
 - All District Hospitals should be mandated to establish a school of nursing offering ANM and Diploma in General Nursing and Midwifery,
 - Smaller hospitals in public sector having at least 30 OBG beds should be encouraged to start ANM training
 - Private sector hospitals having at least 30 OBG beds should also be allowed to start ANM training programme and the concerned State Government should allow selected public sector rural facilities for their field training.

- The cadre of Independent Nurse Practitioner developed by the Indian Nursing Council needs to be rapidly expanded through sponsorship.
- (n) The internship period in medical colleges is mostly utilized for preparing for the post graduate courses at the cost of actual field training. This is the major reason for the doctors posted to rural areas not being in tune with the realities of health care in field setting. Ways have to be found to arrest this phenomenon.
 - (o) The allocation of seats under PG medical courses needs urgent revision to provide for more seats in the specialties required in the rural areas.
 - (p) The recommendations made by the Task Group on Medical Education setup by the Ministry need to be examined and finalized quickly to revamp medical education in the country to match the needs of NRHM.
 - (q) Rural Medical practitioners should be trained and utilized in providing improved quality of service to the rural population.
 - (r) A robust MIS needs to be developed by triangulating data and information from routine reporting systems, external programme evaluations and community based assessments of programme implementation.
 - (s) The National Statistical Commission should be approached to guide on the modalities for undertaking the Annual Health Survey at the district level.
 - (t) The PNMT Act should be amended to provide for the independence of the Appropriate Authorities at the district level from the district health administration and their accountability to the National Board under the Act. The amendment should also provide for the national Appropriate Authority to supervise the functioning of the state and district level authorities. ASHAs/Health Workers should be fully involved at the village level for advocacy and tracking of cases.
 - (u) The NGO Sector should be revitalized and Strengthened to support activities under NRHM. The MNGOs selection for all districts in the country should be completed and they be fully utilized for a variety of delivery of services under various national programmes.

- (v) The IMNCI (Integrated Management of Neonatal and Childhood Illnesses) needed to be extended to all the districts phase-wise. Home based New born care, which is envisaged for ASHAs under NRHM should be taken up on priority.
- (w) All interventions for Maternal and Child Health need to be closely monitored component-wise by the ministry.
- (x) Managerial Support as envisaged under the RCH-II/ NRHM should be extended to the block & PHC level to track funds and monitor the programmes.
- (y) Organization of monthly health day by integrating ICDS and health activity should be closely monitored and every level and periodically evaluated to provide women and children all essential services and monitor and implement nutritional intervention.

Annexure I (a)

No.2(10)/06-HFW
Government of India
Planning Commission
(Health, Family Welfare & Nutrition)

Yojana Bhawan
Sansad Marg
New Delhi
25th May 2006

ORDER

Subject: **Constitution of Working Group on Health of Women & Children for the Eleventh Five Year Plan (2007-2012)**

In the context of formulation of the Eleventh Five Year Plan (2007-12) it has been decided to set up a Working Group on Health of Women & Children under the Chairmanship of Secretary, Department of Health & Family Welfare, Government of India. The composition of the Working Group is as follows:

1	Secretary(HFW), Ministry of Health and Family Welfare, New Delhi.	Chairman
2	Secretary/Representative, Ministry of Women & Child Development, New Delhi.	Member
3	Director General, ICMR, Anasri Nagar, New Delhi.	Member
4	Representative, DGHS, New Delhi.	Member
5	Secretary(Health), Government of Tamil Nadu	Member
6	Secretary(Health), Government of Himachal Pradesh	Member
7	Secretary(Health), Government of Kerala	Member
8	Secretary(Health), Government of Maharashtra	Member
9	Secretary(Health), Government of Uttar Pradesh	Member
10	Shri A.Kumar, Director(H&FW), Planning Commission, New Delhi	Member
11	Shri K.M.Gupta, Director, Ministry of Finance, New Delhi.	Member
12	Representative, WCD Division, Planning Commission, New Delhi.	Member
13	Dr.S.Menon, Faculty, NIHF, New Delhi.	Member
14	Dr.F.Ram, Professor, IIPS, Mumbai	Member
15	Dr.Dileep Mavalankar, Professor, IIM, Ahmedabad	Member
16	Dr.V.a.Pai Panandiker, New Delhi.	Member
17	Dr.Saswati Swain, NIAHRD, Cuttack	Member
18	Ms.C.P.Sujaya, New Delhi.	Member
19	Dr.H.Helen, CEPHAD Foundation, Hyderabad	Member
20	Ms.Sundari Ravindran, Hon.Prof.RCH, Achuta Menon Centre for Health Sciences, Thiruvananthapuram.	Member
21	Dr.Enakshi Thakural, Centre for Child Rights, Mumbai	Member
22	Dr.Nerges Mistry, FRCH, Mumbai	Member
23	Dr.Hanif Lakrawala, Sanchetna, Ahmedabad	Member
24	Ms.Ena Singh, Assistant Representative, UNFPA, New Delhi	Member
25	Ms.Sudha Tewari, Pariwar Sewa Sansthan, New Delhi.	Member
26	Shri Shikhar Agarwal, Udaipur, Rajasthan	Member
27	Joint Secretary, Department of Health & Family Welfare, New Delhi.	Member Secretary

2. The Terms of Reference of the Working Group will be as under:
- 1) To assess the procedures for estimating mortality / morbidity in women and children with respect to:
 - a) Sources of data
 - b) Accuracy, reliability and geographical distribution
 - c) Problems in making estimates
 - d) Suggested remedial measures in ongoing programmes
 - e) Assessing the achievement in reproductive and child health vis-à-vis targets set in the National Population Policy 2000 & NRHM.
 - f) Initiatives during Eleventh Plan to obtain better estimates.
 - 2) To review ongoing major reproductive and child health programmes with respect to:
 - a) Objectives, strategies, targets and achievements, outlays and expenditure during 10th Plan period
 - b) Problems identified, midcourse corrections made during the 10th Plan
 - c) Proposed strategies, objectives, programmes, targets and outlays during the Eleventh Plan
 - d) Health manpower-current status, projected requirements, initiatives to achieve required number and type of manpower.
 - 3) To review the functioning of family welfare infrastructure and manpower in rural and urban areas and suggest measures for rationalizing, restructuring the infrastructure, strategies for improving efficiency of implementation of the programme and for the delivery of services.
 - 4) To suggest methods for improving reproductive and child health activities at secondary and tertiary care levels through:
 - a) Improving NGO / private sector / organized sector involvement in reproductive and child health services;
 - b) Increasing financial resources available for reproductive and child health;
 - c) Improving utilization of existing facilities
 - 5) To project financial / physical requirement for implementation of these programmes during the Eleventh Plan.
 - 6) To deliberate and give recommendations on any other matter relevant to the topic.
3. The Chairman may form sub-groups and co-opt official or non-official members as needed. The Working Group will submit its report by 31st August, 2006.
4. Smt. Radha R.Ashrit, SRO (H&FW), Room No.343, Planning Commission, New Delhi-110001 will be the nodal officer for all further communications. (Tel.No.23096666-2383. Email ID: radha-pc@nic.in)
5. The expenditure on TA/DA in connection with the meetings of the Working Group in respect of the official members will be borne by the parent Department / Ministry to

which the official belongs as per the rules of entitlement applicable to them. The non-official members of the Working Group will be entitled to TA/DA as per permissible to Grade I officers of the Government of India under SR 190 (a) and this expenditure will be borne by the Planning Commission.

Sd/-
(Ambrish Kumar)
Director (H&FW)
Tel No.23096530
(ambarish.kumar@nic.in)

To Chairman and Members of the Working Group.

Copy to:

1. PS to Deputy Chairman/MOS(Planning)/
Members (KP)/(AS)/(VLC)(BLM)/SH/(BNY)(AH)/Member Secretary, Planning
Commission, New Delhi.
2. All Pr.Advisers/Advisers/HODs in Planning Commission
3. Prime Minister's Office, South Block, New Delhi.
4. Cabinet Secretariat, Rashtrapati Bhawan, New Delhi.
5. US(Admin.I)/Pay & Accounts Officer/Accounts-I Section, Planning Commission/
DDO, Planning Commission
6. Information Officer, Planning Commission.

(Ambrish Kumar)
Director(H&FW)

Annexure I (b)

Composition of the Sub Group

Sl.No.	Name & Designation	Sub Group Status
1	Mr.S.S.Brar, JS, MoHFW	Chairperson
2	Dr.Ranjana Kumar, DFID	Member
3	Mrs.Sudha Tewari, Parivar Kalyan Sansthan	Member
4	Dr.Vinod Paul, Professor of Pediatrics, AIIMS	Member
5	Dr.I.P.Kaur, DC (MH)	Member
6	Dr.N.Namshum, DC (Trg.)	Member
7	Dr.M.S.Jayalakshmi, DC (RSS)	Member
8	Dr.Manisha Malhotra, AC(MH)	Member
9	Mr.A.P.Singh, Director(DC)	Member
10	Dr.Rattan Chand, Director (PNDT)	Member
11	Mr.K.D.Maiti, Director (MH)	Member
12	Mr.Sanjeev K.Gupta, Dy.Director(DC)	Member
13	Mrs.Sushma Rath, US (ID & PNDT)	Member
14	Dr.H.Bhushan, AC (MH)	Convenor

NRHM : BROAD FRAMEWORK FOR IMPLEMENTATION

A. Action at the Central level

1. For development of an effective health system, a broad overview of the current health status, and development of appropriate policy interventions is necessary. Regulations and setting standards for measuring performance of public/private sector in health, issuing guidelines to help the states, development of partnership with non governmental stakeholders, developing framework for effective interventions through capacity development and decentralization including transfer of schemes and financing in the states are areas where the Central Government would continue to play a role. Effective monitoring of performance, support for capacity development at all levels, sharing the best national and international practices, and providing significantly more financial resources to drive reforms and accountability, disease surveillance, monitoring & evaluation will be the thrust of the Central Government's interventions.

B. Leadership of States

2. The NRHM is an effort to strengthen the hands of States to carry out the required reforms. The Mission would also provide additional resources to the States to enable them to meet the diverse health needs of the citizens. While recognizing the leadership role of the states in this regard, it is proposed to provide necessary flexibility to the States to take care of the local needs and socio-cultural variations. In turn, States will decentralize planning and implementation arrangements to ensure that need based and community owned District Health Action Plans become the basis for interventions in the health sector. The States would be urged to take up innovative schemes to deal with local issues. Keeping in view the decentralization envisaged under the NRHM, the States would be required to devolve sufficient administrative / financial powers to the PRIs. At the same time, the States are also required to take action to increase their expenditure on health sector by at least 10% every year over the Mission period. The States would also be expected to adhere to mutually agreed milestones which would be reflected in a MOU to be signed with each State. It may be mentioned here that even though under RCH-II, an effort has been made to integrate a number of schemes, there still exists many schemes for which the funds flow to the States is in a tied manner thus hampering flexibility and presenting difficulties in monitoring them. Verticality of the programmes has also led to

duplication of efforts and thereby wastage of scarce resources. The Central Government on its part would decentralize most, if not all of the schemes to the states. The States would also be supported in their endeavor to build capacity for handling the complex health issues.

C. Institutionalizing community led action for health

3. Nearly three fourth of the population of the country live in villages. This rural population is spread over more than 10 lakh habitations of which 60% have a population of less than 1000. If the Mission of Health for All is to succeed, the reform process would have to touch every village and every health facility. Clearly it would be possible only when the community is sufficiently empowered to take leadership in health matters. The Panchayati Raj institutions, right from the village to district level, would have to be given ownership of the public health delivery system in their respective jurisdiction. Some States like Kerala, West Bengal, Maharashtra and Gujarat have already taken initiatives in this regard and their experiments have shown the positive gains of institutionalizing involvement of Panchayati Raj institutions in the management of the health system. Other vibrant community organizations and women's groups will also be associated in communitization of health care.

4. The NRHM would seek to empower the PRIs at each level i.e. Gram Panchayat, Panchayat Samiti (Block) and Zilla Parishad (District) to take leadership to control and manage the public health infrastructure at district and sub district levels.

- The Village Health and Sanitation Committee (VHSC) will be formed in each village (if not already there) within the over all framework of Gram Sabha in which proportionate representation from all the hamlets would be ensured. Adequate representation to the disadvantaged categories like women, SC / ST / OBC / Minority communities would also be given.
- The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of VHSCs.
- The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located. All other Gram Panchayats covered by the PHCs would be suitably represented in its management.
- The block level PHC and CHC will have involvement of Panchayati Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

- The Zilla Parishad at the district level will be directly responsible for the budgets of the health sector and for planning for people's health needs.
- With the development and capacities and systems the entire public health management at the district level would devolve to the district health society which would be under the effective leadership and control of the district panchayat, with participation of the block panchayats.

5. To institutionalize community led action for health, NRHM has sought amendments to acts and statutes in States to fully empower local bodies in effective management of the health system. NRHM would attempt to transfer funds, functionaries and functions to PRIs. Concerted efforts with the involvement of NGOs and other resource institutions are being made to build capacities of elected representatives and user group members for improved and effective management of the health system. To facilitate local action, the NRHM will provide untied grants at all levels [Village, Gram Panchayat, Block, District, VHSC, SHC, PHC & CHC]. Monitoring committees would be formed at various levels, with participation of PRI representatives, user groups and CBO / NGO representatives to facilitate their inputs in the monitoring planning process, and to enable the community to be involved in broad based review and suggestions for planning. A system of periodic 'Jan Sunwai' or 'Jan Samvad' at various levels would empower community members to engage in giving direct feedback and suggestions for improvement in Public health services.

D. Promoting Equity

6. This is one of the main challenges under NRHM. Empowering those who are vulnerable through education & health education, giving priority to areas/hamlets/households inhabited by them, running fully functional facilities, exemption for below poverty line families from all charges, ensuring access, risk pooling, human resource development / capacity building, recruiting volunteers from amongst them are important strategies under the Mission. These are reflected in the planning process at every level. Studies have revealed the unsatisfactory health indicators of socially and economically deprived groups and NRHM makes conscious efforts to address this inequity. The percentage of vulnerable sections of society using the public health facilities is a benchmark for the performance of these institutions.

E. Promoting Preventive Health

7. As stated earlier, the Health System in the country is oriented towards curative Health. The NRHM would increase the range and depth of programmes on Health Education / IEC activities which are an integral part of activities under the Mission at

every level. In addition it would work with the departments of education to make health promotion and preventive health an integral part of general education. The Mission would also interact with the Ministry of Labour for occupations health and the Ministry of women and child for women and child health to ensure due emphasis on preventive and promotive health concerns.

F. Dealing with Chronic Diseases

8. India has one of the highest disease burdens in the world. The number of deaths due to chronic diseases are expected to rise from 3.78 million in 1990 (40-47% of all deaths) to 7.63 million by 2020 (66.7% of all deaths). Tobacco, cancer, diabetes and renal diseases, cardio vascular diseases, neurological diseases and mental health problems and the disability that may arise due to the chronic diseases are major challenges the Mission has to deal with. The already over stretched health system has to absorb the additional burden of chronic diseases, especially in the rural areas. Both preventive and curative strategies along with mobilization of additional resources are needed. It is proposed to integrate these with the regular health care programmes at all levels.

G. Reducing child and maternal mortality rates and reducing fertility rates – population stabilization through quality services

9. NRHM provides a thrust for reduction of child and maternal mortality and reduce the fertility rates. The approach to population stabilization is to provide quality health services in remote rural areas along with a wide range of contraceptive choices to meet the unmet demand for these services. Efforts are on be to provide quality Reproductive Health Services (including delivery, safe abortions, treatment of Reproductive tract infections and Family Planning Services to meet unmet needs, while ensuring full reproductive choices to women). The strategy also is to promote male participation in Family Planning. Reduction of IMR requires greater convergent action to influence the wider determinants of health care like female literacy, safe drinking water, sanitation, gender and social empowerment, early childhood development, nutrition, marriage after 18, spacing of children, and behavioral changes etc. Within the health sector, the thrust is on promoting Integrated Management of Neo natal and child care (IMNCI). The main strategy for maternal mortality focuses on safe/institutional deliveries at functional health facilities in the governmental and non-governmental sectors. Efforts to develop competencies needed for Skilled Birth Attendants (SBAs) in the entire cadre of Staff Nurses and ANMs as also in select medical officers will also be undertaken. Regular training of select Medical Officers to administer anesthesia has been taken up. Also multi skill training

of Medical Officers, ANMs and Para-medics will be initiated to close specialist skill gaps. Intensified IEC would be pursued to ensure behavioral changes that relate to better child survival and women's health i.e. breast feeding, adequate complementary feeding of the young child, spacing, age at marriage, education of the girl child. Adolescent health is another area of action under the NRHM. CHCs are being upgraded to FRUs for providing referral services to the mother and child and taking care of obstetric emergencies and complications for provision of safe abortion services and for prevention, testing/counseling in respect of HIV AIDS. Reduction in IMR/MMR will also be closely monitored through social audit, which is being introduced at the Panchayat level.

H. Management of NRHM activities at State / District / Sub district level

Block Level Pooling

10. The success of decentralization experiment would depend on the strength of the pillars supporting the process. It is imperative that management capacities be built at each level. To attain the outcomes, the NRHM would provide management costs upto 6% of the total annual plan approved for a State/district as has been introduced under the RCH-II programme. Apart from medical and para-medical staff, such services would include skills for financial management, improved community processes, procurement and logistics, improved collection and maintenance of data, the use of information technologies, management information system and improved monitoring and evaluation etc. The NRHM would also establish strong managerial capacity at the block level as blocks would be the link between the villages and the districts. At the district level the Mission would support and insist on developing health management capacities and introducing policies in a systematic manner so that over time all district programme officers and their leadership are professionally qualified public health managers. Management structures at all levels will be accountable to the Panchayati Raj institutions, the State Level Health Mission and the National Level Missions/Steering Group.

11. The amount available under the management cost could also be used for improving the work environment as such improvements directly lead to better outcomes. The management structure holds the key to the success of any programme and efforts to develop appropriate arrangements for effectively delivery of NRHM with detailing, will be a priority. Clarity of tasks, fund flows, powers, functions, account keeping, audit, etc. will be attempted at all levels.

12. Based on the outcomes expected in NRHM, the existing staff of Health Departments at SHC, PHC, CHC, Block, District, State and National levels are being carefully assessed to see how structures can be reoriented to deliver more efficiently and effectively. States will constantly undertake review of management structure and devolution of powers and functions to carry out any mid course correction. Block Level Pooling will be one of the priority activity under the NRHM. Keeping in view the time line needed to make all facilities fully functional, Specialists working in PHCs would be relocated at CHCs to facilitate their early conversion to FRUs. Outreach programmes are being organized with “block pooled” CHCs as the nodal point. NRHM will attempt to set up Block level managerial capacities as per need. Creation of a Block Chief Medical Officer’s office to support the supervision of NRHM activities in the Block, would be a priority. Support to block level CHCs will also aim at improving the mobility and connectivity of health functionaries with support for Ambulances, telephones, computers, electric connection, etc.

I. Human resources for rural areas

13. Improvement in the health outcomes in the rural areas is directly related to the availability of the trained human resources there. The Mission aims to increase the availability through provision of more than 4 lakh trained women as ASHAs / Community Health Workers (resident of the same village/hamlet for which they are appointed as ASHA). The Mission also seeks to provide minimum two Auxiliary Nurse Mid-wives (ANMs) (against one at present) at each Sub Health Centre (SHC) to be fully supported by the Government of India. Similarly against the availability of one staff nurse at the PHC, it is proposed to provide three Staff Nurses to ensure round the clock services in every PHC. The Out-patient services would be strengthened through posting/ appoint on contract of AYUSH doctors over and above the Medical Officers posted there. It will be for the States to decide whether they would integrate AYUSH by collocation at PHC or by new contractual appointment. GOI support will be for all new contractual posts and not for existing vacancies that States have to fill up. The Mission seeks to bring the CHCs on a par with the Indian Public Health Standards (IPHS) to provide round the clock hospital-like services. As far as manpower is concerned, it would be achieved through provision of seven Specialists as against four at present and nine staff nurses in every CHC (against seven at present). A separate AYUSH set up would be provided in each CHC/PHC. Contractual appointment of AYUSH doctors will be provided for this purpose. This would be reflected in the State Plans as per their needs.

24. Given the current problems of availability of both medical as well as paramedical staff in the rural areas, the NRHM seeks to try a range of innovations and

experiments to improve the position. These include incentives for compulsory rural posting of Doctors, a fair, transparent transfer policy, involvement of Medical Colleges, improved career progression for Medical / Para Medical staff, skill upgradation and multi-skilling of the existing Medical Officers, ANMs and other Para Medical staff, strengthening of nursing / ANM training schools and colleges to produce more paramedical staff, and partnership with non governmental stakeholders to widen the pool of institutions. The Ministry has already initiated the process for the upgradation of ANMs into Skilled Birth Attendants (SBA) and for providing six month anaesthesia course to the Medical Officers. Convergence of various schemes under NRHM including the disease control programmes, the RCH-II, NACO, disease surveillance programme, would also provide for optimum / efficient utilization of all paramedical staff and help to bring down the operational costs.

J. National and State level Resource Centres for capacity development

15. Decentralized Planning, preparation of District Plans, community ownership of the health delivery system and inter-sectoral convergence are the pillars on which the super-structure of the NRHM would be built. The implementation teams particularly at district and state levels would require development of specific skills. Even at the Central level, the program management unit within the MOHFW would need technical and management support from established professionals in the field. The institutions like National and State Institutes for Health and Family Welfare which were primarily conceived as research and training organizations may not fit the bill for this purpose. The National Health System Resource Centre (NHSRC), which is envisaged as an agency to pool the technical assistance from all the Development Partners, would be ideal for this purpose. Mandated as a single window for consultancy support, the NHSRC would quickly respond to the requests of the Centre/ States /Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general. It is proposed to have one NHSRC at the national level and another Regional Centre for the North Eastern region. State level Resource Centres will be provided for EAG States on a priority to enable innovations and new technical skills to develop in the health system. In addition to the above a number of already existing reputed bodies with national caliber may be strengthened and facilitated to mentor state health resource centres and district resource groups so that they are able to support the state level planning efforts.

16. The NRHM would also require a comprehensive plan for training at all levels. While efforts are being made to strengthen the NIHFW, the States have been asked to closely examine the training infrastructure available within the state including State

Health & Family Welfare Institute, ANM Training Centres, Medical Colleges, Nursing Colleges etc. and identify the investment required in them to successfully carry out the training/sensitization programmes. Comprehensive training policy is being developed to provide support for capacity building at all levels including PRIs/Community. NRHM will particularly encourage involvement of Medical Colleges and Hospitals to strengthen systems of capacity building in the rural health care set up.

K. Drug supplies and logistics management

17. Timely supply of drugs of good quality which involves procurement as well as logistics management is of critical importance in any health system. The current system in most states leaves much to be desired. However, there are a few notable exceptions like Tamil Nadu which has developed a very effective system of supplies and logistics. Under most of the Centrally Sponsored Programmes, it is the Central Government which does the procurement of equipments and medicines on behalf of the States. Most States are reluctant to take responsibility for procurement primarily because they lack the capacity to take up large scale procurement of goods and services.

18. At the level of the Central Government, with the support of the World Bank and the DFID, an Empowered Procurement Wing (EPW) has been set up which would be the nodal agency for all procurement matters. While as an interim measure, till such time that the capacities are built in the States, the EPW would get rate contracts for drugs, quality testing etc. with the assistance of public sector agencies like HLL, HSCC prepared and share them with the States for their use. In the long run, NRHM would like the procurement to take place in a decentralized manner at the district level. It would take up the capacity building exercise for this purpose in right earnest. It supports State led initiatives for capacity building and setting up State Procurement Systems and Distribution Networks for improved supplies and distribution. In order to take informed procurement decisions, market intelligence is of utmost importance. The EPW is getting a market survey done to collect information about the drugs and vaccines which are procured under the RCH-II. This database, which this market survey would generate, would be updated through annual market surveys. These would be shared with the states to help them in taking informed procurement decisions.

L. Monitoring / Accountability Framework

19. The NRHM proposes an intensive accountability framework through a three pronged process of community based monitoring, external surveys and stringent internal monitoring. Facility and Household Survey, NFHS-II, RHS (2002) would act as the baseline for the mission against which the progress would be measured.

20. While the process of communitization of the health institutions itself would bring in accountability, the NRHM would help this process by wide dissemination of the results of the surveys in a language and manner which could be understood by the general population. It would be made compulsory for all the health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, user charges to be paid (if any) etc, as envisaged in the Right to Information Act. The community as well as the Patient Welfare Committee would be expected to monitor the performance of the health facilities on those parameters. Health Monitoring and Planning Committees would be formed at PHC, Block, District and State levels to ensure regular community based monitoring of activities at respective levels, along with facilitating relevant inputs for planning. Organisation of periodic Public hearings or dialogues would strengthen the direct accountability of the Health system to the community and beneficiaries. The Mission Steering Group and the Empowered Programme Committee at the Central and the State level will also monitor progress periodically. The NRHM is committed to publication of Public Reports on Health at the State and the district levels to report to the community at large on progress made. The Planning Commission will also carry out periodic monitoring and concurrent evaluation of NRHM. The Mission will also appoint Special Rapporteurs to carry out field visits and supervision of programmes. The NRHM would involve NGOs, resource institutions and local communities in developing this monitoring arrangement. The Mentoring Group on ASHA, the National Advisory Committee on Community Action (which have been constituted with the leading NGOs as their members) and the Regional Resource Centres would provide valuable inputs to the Mission. A wide network of MNGOs, FNGOs / SNGOs would also be providing feedback to the Mission.

21. The periodic external, household and facility surveys would track the effectiveness of the various activities under the NRHM for providing quality health services. Beside these surveys, Supervision Missions would be conducted twice in every state to help monitor the outcomes. A computer based MIS would be developed using the network being set up by the IDSP for rigorous monitoring of the activities.

22. The requirements of audit will apply to all NRHM activities. The National, State and District Health Missions will be subject to annual audit by the CAG as well as by a Chartered Accountant and any special audit that the Mission Steering Group may deem fit. Special audit by agencies like the Indian Public Auditors of India could also be undertaken. Every State will also be supervised by one or more research and resource institutions who may be contracted for this purpose. All procedures of government regarding financial grants including Utilization Certificates etc. would apply to the State and District Health Societies.

23. For the accountability framework to be truly community owned, the effort will be to ensure that at least 70 percent of the total NRHM expenditures are made by institutions and organizations that are being supervised by an institutional PRI/community group.

Monitoring outcomes of the Mission

- Right to health is recognized as inalienable right of all citizens as brought out by the relevant rulings of the Supreme Court as well as the International Conventions to which India is a signatory. As rights convey entitlement to the citizens, these rights are to be incorporated in the monitoring framework of the Mission. Therefore, providing basic Health services to all the citizens as guaranteed entitlements will be attempted under the NRHHM.
- Preparation of Household specific Health Cards that record information on the following - record of births and deaths, record of illnesses and disease, record any expenditure on health care, food availability and water source, means of livelihood, age profile of family, record of age at marriage, sex ratio of children, available health facility and providers, food habits, alcohol and tobacco consumption, gender relations within family, etc, (by ASHA/AWW/Village Health Team).
- Preparation of Habitation/Village Health Register on the basis of the household Health Cards. (By the Village Health Team)
- Periodic Health Facility Survey at SHC, PHC, CHC, District level to see if service guarantees are being honoured.[By district /Block level Mission Teams/ research and resource institutions].
- Formation of Health Monitoring and Planning Committees at PHC, Block, District and State levels to ensure regular monitoring of activities at respective levels, along with facilitating relevant inputs for planning.
- Sharing of all data and discussion at habitation/ village level to ensure full transparency.
- Display of agreed service guarantees at health facilities, details of human and financial resources available to the facility.

- Sample household and facility surveys by external research organizations/NGOs.
- Public reporting of household and health facility findings and its wider dissemination through public hearings and formal reporting.

M. Convergence within the health department

24. The Ministry of Health & Family Welfare [MOHFW] has a large number of schemes to support states in a range of health sector interventions. Many of these programmes pertain to disease specific control programmes. Many others relate to programmes for Family Welfare. Special programmes have been initiated as per need for diseases like TB, Malaria, Filariasis, HIV/AIDS etc. While the disease specific focus has helped in providing concerted attention to the issue, the weak or absent integration with other health programmes has often led to lack of coordination and convergent action. All central programmes have worked on the assumption that there is a credible and functional public health system at all levels in all parts of the country. In practice, in many parts of the country, the public health system has not been in a satisfactory state. The challenge of NRHM, therefore, is to strengthen the public health institutions like SHC/PHC/CHC/Sub Divisional and District Hospitals. This will have positive consequences for all health programmes. Whether it is HIV/AIDS, TB, Malaria or any other disease, NRHM attempts to bring all of them within the umbrella of a Village/District/State Health Plan so that preventive, promotive and curative aspects are well integrated at all levels. The intention of convergence within the Health Department is also to reorganize human resources in a more effective and efficient way under the umbrella of the common District Health Society. Such an integration within the Health Department would make available more human resources with the same financial allocations. It would also promote more effective interventions for health care. To help the States achieve inter sectoral convergence, appropriate guidelines would be issued to the districts.

25. The pandemic of HIV/AIDS requires convergent action within the health system. By involving health facilities in the programme at all stages, it is likely to help early detection, effective surveillance and timely intervention wherever required. The NACO has presence only from district level upwards. The NRHM would enable the NACO to provide necessary investment and support to the programme at district and sub district levels. While NACO will provide Counsellors at CHCs and PHCs as also testing kits as a part of the NACP – III, it would also help to integrate training on HIV/AIDS to Medical Officers, ANMs, para medicals and lab technicians. Common programmes for condom promotion and IEC are also planned. NRHM seeks to

improve outreach of health services for common people through convergent action involving all health sector interventions.

N. Convergence with other departments

26. The indicators of health depend as much on drinking water, female literacy, nutrition, early childhood development, sanitation, women's empowerment etc. as they do on hospitals and functional health systems. Realizing the importance of wider determinants of health, NRHM seeks to adopt a convergent approach for intervention under the umbrella of the district plan. The Anganwadi Centre under the ICDS at the village level will be the principal hub for health action. Likewise, wherever village committees have been effectively constituted for drinking water, sanitation, ICDS etc. NRHM will attempt to move towards one common Village Health Committee covering all these activities. Panchayati Raj institutions will be fully involved in this convergent approach so that the gains of integrated action can be reflected in District Plans. While substantial spending in each of these sectors will be by the concerned Department, the Village Health Plan/District Plan will provide an opportunity for some catalytic resources for convergent action. NRHM household surveys through ASHA, AWW will target availability of drinking water, firewood, livelihood, sanitation and other issues in order to allow a framework for effective convergent action in the Village Health Plans. The Ministry has constituted an inter Departmental Committee on convergence with the Mission Director as Chairman. This Committee reports to the EPC. Convergence is also envisaged at the level of the MSG which has representation of all the concerned Ministries. Similar mechanisms are available at the State level. Convergence with the Department of Women and Child Development and with AYUSH has been clearly outlined and shared with States. Necessary guidelines on inter sectoral convergence are being issued by the Ministry.

27. The success of convergent action would depend on the quality of the district planning process. The District Health Action Plans will reflect integrated action in all section that determine good health – drinking water, sanitation, women's empowerment, adolescent health, education, female literacy, early child development, nutrition, gender and social equality. At the time of appraisal of District Health Plan, care would be taken to ensure that the entire range of wider determinants of health have been taken care of in the approach to convergent action.

O. Role of Non Governmental Organizations

28. The Non-governmental Organizations are critical for the success of NRHM. The Mission has already established partnerships with NGOs for establishing the rights of households to health care. With the mother NGO programme scheme, 215 MNGOs covering nearly 300 districts have already been appointed. Their services are being utilized under the RCH-II programme. The Disease Control programmes, the RCH-II, the immunization and pulse polio programme, the JSY make use of partnerships of variety of NGOs. Efforts are being made to involve NGOs at all levels of the health delivery system. Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas and aspects, working together with community organizations and Panchayati Raj institutions, and contributing to monitoring the right to health care and service guarantees from the public health institutions. The effort will be to support/ facilitate action by NGO networks of NGOs in the country which would contribute to the sustainability of innovations and people's participation in the NRHM.

29. A Mentoring Group has already been set up at the national level for ASHAs to facilitate the role of NGOs. Grants-in-aid systems for NGOs will be established at the District, State and National levels to ensure their full participation in the Mission.

P. Risk pooling and the poor

30. Household expenditure on Health Care in India was more than Rs.100, 000 crore in 2004-05. Most of it was out of pocket and was incurred during health distress in unregulated private facilities, leading to the vicious circle of indebtedness and poverty. As a matter of fact, in a country of over a billion people, barely 10 million are covered under the private health insurance schemes. Even if we take into account Social Health Insurance Schemes like CGHS, ESIS etc., the coverage increases only to 110 million of which only 30 million are poor. In order to reduce the distress of poor households, there is therefore an imperative need for setting up effective risk pool systems. Involvement of NGOs and community based organizations as insurance providers and as third party administrators can help to generate more confidence in the risk pooling arrangement being pro-people and in the interests of poor households. Innovative and flexible insurance products need to be developed and marketed that provide risk pooling from government and non governmental facilities.

31. While setting up of effective health insurance system is clearly a very important mission goal, it is realized that the introduction of such a system without the back up of a strong preventive health system and curative public health infrastructure would not be cost effective. Such a venture would only end up subsidizing private hospitals and lead to escalation of demand for high cost curative health care. The first priority of the Mission is therefore to put the enabling public health infrastructure in place.

32. While the private insurance companies would be encouraged to bring in innovative insurance products, the Mission would strive to set up a risk pooling system where the Centre, States and the local community would be partners. This could be done by resource sharing, facility mapping, setting standards, establishing standard treatment protocols and costs, and accreditation of facilities in the non-governmental sector.

33. Primary health care would be provided without any charge. However, in the case of need for hospitalization, CHCs would be the first referral unit. Only when the CHC is not in a position to provide specialized treatment, a patient would be referred to an accredited private facility/teaching hospital. The patient would have the choice of selecting any provider out of the list of hospitals accredited by the District Health Mission. Reimbursement for the services would be made to the hospitals based on the standard costs for various interventions decided by the experts from time to time.

34. It is envisaged that the hospital care system would progressively move towards a fully funded universal social health insurance scheme. Under such a system, the government facilities would also be expected to earn their entire requirement of recurring expenditure including the salary support out of the procedures they perform, while taking care that access to those who cannot pay is not compromised. This system would obviously work only when the personnel working in the CHCs are not part of a state cadre but are recruited locally at the district level by the District Health Mission on contract basis. Since evolving such a system is likely to take some time, at the first instance, it is proposed to give control of the budget of the CHC/ Sub Divisional and District Hospitals to the Rogi Kalyan Samitis or equivalent public bodies set up for efficient management of these health institutions. Efforts to develop risk pooling arrangements as partnerships of the Central, State and local Governments along with community organizations, will be attempted. A possibility of two thirds of the resource support coming from government and one third to be collected from those who can afford to run a public health system based risk pool arrangement would also be experimented with, in partnership with states.

Q. Reforms in Medical/Nursing Education

35. The need for trained human resources, medical as well as para medical for rural areas has already been brought out. The medical / para medical education system would require a new orientation to achieve these objectives. While the existing colleges would require strengthening for increased seat capacity, a conscious policy decision would be required to promote new colleges in deficient states. A fresh look also needs to be given on the norms for setting up new medical colleges under the regulations framed under Indian Medical Council Act to see whether any relaxation is necessary for such areas. The viability of using the caseload at district hospital for setting up Govt / private medical colleges would also be examined. Apart from creating teaching infrastructure at the district level, it would also promote much needed investment and improvement in tertiary care in the district hospitals.

36. The curriculum in the Medical Colleges perhaps give undue emphasis on specialization and tertiary care which is available only in large cities. In the syllabus, the primary health care as well as preventive aspects of health are largely ignored. It is therefore natural for the students to aspire for a career in a big hospital in urban setting. In the process the health care in the rural areas suffers. The Mission would look at ways and means to correct the situation.

37. The NRHM also recognizes the need for equipping medical colleges and other suitable tertiary care centres – including select district hospitals, select not for profit hospitals and public sector undertaking run hospitals for a variety of special courses to train medical officers in short term courses to handle a large number of essential specialist functions in those states where medical colleges and postgraduate courses are below recommended norms. This includes courses from multi skilling serving Medical Officers, specially for anaesthesia, emergency obstetrics, emergency pediatrics especially new born care, safe MTP services, mental health, eye care, trauma care etc. Further short term programmes are needed to upgrade skills of nurses and ANMs to that of nurse-practitioners for those centres/regions which potentially have adequate nurses, but a chronic shortage of doctors over at least two decades.

38. The Mission would support strengthening of Nursing Colleges wherever required, as the demand for ANMs and Staff Nurses and their development is likely to increase significantly. This would be done on the basis of need assessment, identification of possible partners for building capacities in the governmental and non governmental sectors in each of the States/UTs, and ways **of financing such support**

in a sustainable way. Special attention would be given to setting up ANM training centres in tribal blocks which are currently para-medically underserved by linking up with higher secondary schools and existing nursing institutions.

39. Efforts to improve skills of Registered Medical Practitioners would also be introduced. The NRHM recognizes the need for universal continuing medical education programmes which are flexible and non threatening to the medical community, but which ensures that they keep abreast of medical advances, and have access to unbiased medical knowledge, and adequate opportunity to refresh and continuously upgrade existing knowledge and skills.

R. Pro-people partnerships with the non-governmental sector

40. The Non-governmental sector accounts for nearly 4/5 of health expenditure in India. In the absence of an effective Public Health System, many households have to seek health care during distress from the Non-governmental sector. A variety of partnerships are being pursued under the existing programmes of the Ministry, especially the RCH-II and independently by the States with their own resources with non governmental partners. Under NRHM, Task Forces are set up with experts, institutional representatives and NGOs. The RCH-II has development partners, including UN agencies. Under this the States are trying contract in, contract out, out sourcing, management of hospital facilities by leading NGOs, hiring staff, service delivery, including family planning services, MTP, treatment of STI/RTI, etc. Franchising and social marketing of contraceptives are already built into the FW programmes. The Immunization and Polio Eradication Programmes effectively make use of partnerships with WHO, UNICEF, the Rotary International, NGOs etc. The Janani Suraksha Yojana (JSY) has also factored in accreditation of private facility for promotion of institutional delivery. The Disease Control programmes make use of NGO partnerships in a big way. The Ministry also has strong relations with FOGSI, IMA, IPHS etc. which are professional Associations for dissemination of information, advocacy, creating awareness, HRD etc.

41. The Non-governmental sector being unregulated, the rural households have to face financial distress in meeting the costs of health care. The NRHM attempts to provide people friendly regulation framework that promotes ethical practice in the non-governmental sector. It also encourages non-governmental health providers to provide quality services in rural areas to meet the shortage of health facilities there. Such efforts will involve systems of accreditation and treatment protocols so that ethical practice becomes the basis for health interventions. NRHM encourages training and up-gradation of skills for non-governmental providers wherever such

efforts are likely to improve quality of services for the poor. Arrangements for demand side financing to meet health care needs of poor people in areas where the Public Health System is not effective will also be attempted under the NRHM. The NRHM recognizes that within the non-governmental service there is a large commercial private sector and a much smaller but significant not for profit sector. The not-for-profit centres which are identified as setting an example of pro-poor, dedicated community service would be encouraged used as role model, benchmark, site of community centered research and training to strengthen the public health system and improve the regulatory frameworks for the non governmental sector as a whole.

CONCURRENT ASSESSMENT AND TECHNICAL SUPPORT TO DISTRICTS IN UTTAR PRADESH

Goal and objectives

The main goal of ongoing Concurrent Assessment and Technical Assistance to districts (CATA), under the European Commission supported Sector Investment Programme (SIP) in the state of Uttar Pradesh, is to assess continuously the system of health care delivery in relation to National Family Welfare Programme and suggest interventions for improving the service delivery, bring about a quantitative improvement by removing weaknesses of the system and build the capacity of state and district level health managers in order to meet the challenges by involving medical and health teaching institutions of the state of Uttar Pradesh.

The activity has following major objectives.

- a) To develop a health intelligence information system at the state and districts' level for National Family welfare Programme and other health programmes.
- b) To use this system for ongoing assessment and mid course correction in the programmes at different level.
- c) Formulation and development of long-term planning and policy, based on information collected under the system.
- d) To make the system available for research and development in the area of public health management.
- e) To get profile of state, districts and large cities, separately.
- f) Technical Assistance to district health & family welfare authorities, which has been reconstituted as District Health Society and District Health Mission under the NRHM .
- g) Capacity building of Medical Colleges and District Health & Family Welfare Authority/ District Health Mission/ District Health Society.

Implementation arrangement

The Programme is being implemented by a network of institutions working in the area of public health, community medicine and programme evaluation. The Directorate General of Family Welfare, Government of Uttar Pradesh has executed a Memorandum of Understanding (MoUs) with King George Medical University Lucknow and a number of participating institutions for organizing and carrying out the study and providing technical support outlined as under.

Coordinating Agency: The CATA is being coordinated by the Upgraded Department of Community Medicine, KG Medical University, Lucknow. Among others, this involves overall coordination and supervision of the programme, strategy formulation, liaison with DG Family Welfare Govt. of UP and all participating institutions, selection of sample of clusters for participating institutions, qualitative monitoring of the work undertaken by the participating institutions, collation of district / city level data / results through partners, preparation of integrated reports for submission to the Government and other agencies, release of funds to the participating institutions, auditing and submission of expenditure reports.

Participating Institutions: The initial list of participating institutions includes all Medical Colleges in the State, Central Universities' Medical College/ institute in the state, Population Research Centre, University of Lucknow and Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow.

Core Technical Team: The Technical, administrative and financial protocols have been developed by a core team headed by an officer from the Directorate General of Family Welfare with the representatives of Coordinating agency (KGMU, Lucknow) and selected participating institutions and SIFPSA. The core technical team is responsible for following functions

- (a) finalizing the survey instruments methodology, including the layout and format for the reports to be generated by the participating institutions
- (b) determine the qualification and selection process for surveyors and supervisors as well as to make arrangements for their training.
- (c) qualitative monitoring, and
- (d) collating the data received from the participating institutions to generate consolidated reports and its comparative analysis vis-à-vis results of the surveys commissioned by GOI and other agencies.

Concurrent Assessment process: Every participating institution is assigned a number of districts. The first choice for surveyors was the students from the participating institutions and/or other teaching institutions and the district and sub-district level staff. However, later on, professional surveyors had to be engaged and trained because the students could not remain available round the year due to their academic schedule and most of the districts have significant shortage of staff. Every participating institution also employs at least one supervisor for each district for local

coordination and ensuring qualitative monitoring. The institution also attempts to develop a network of local supervisors in the districts for hands-on training.

The members of Core Technical Team visit at least 10% of clusters during the survey, for qualitative monitoring. The assessment survey is conducted as per the standard 30-cluster methodology (WHO recommended). However, the core committee recommended some adaptations and modifications with a view to build a database, meeting qualitative monitoring of the RCH programme.

Every participating institution prepares a district wise report and submits to the coordinating institution for validation. After the report has been finalized, the participating institution presents the report in a meeting of departmental officers at the district headquarters, so that they get a first-hand account of their districts. The presentation also dwell into probable interventions to improve the situation.

Study Design and Methodology

Study area: The survey covers the urban and rural areas of all the seventy districts of Uttar Pradesh. The districts are divided into two categories (a) districts with major cities/urban areas (total no. 12), and (b) districts with minor cities/urban areas (total no. 58). In category (a) districts, rural and urban areas are considered as separate units for the survey and report generation, whereas in category (b) districts rural and urban areas combined together will form an unit of study and report generation.

Sampling Technique: The sampling technique of this study is based on the WHO thirty cluster methodology. The thirty clusters are selected from the districts of category (a) described above, separately for rural and urban areas. From districts of category (b), thirty clusters are selected from rural and urban areas combined together. Sampling unit (cluster) for rural area is a revenue village and for urban area, it is a municipal ward. The selection is based on systematic sampling scheme with population proportional to size.

Sampling Procedure: For selecting rural clusters in a district, all revenue villages are listed with their total population according to census 2001. The villages are arranged in the same order as they appear in the census list. A random number, less or equal to sampling interval, is selected. The village, corresponding to cumulative population equalled or exceeded the random number, is selected as the first cluster. The sampling interval is added to the random number and a new number is obtained. Subsequent village corresponding to cumulative population equalled or exceeded to new number is selected as second cluster. Similarly the third, fourth and subsequent clusters are selected by adding the sampling interval to the obtained numbers. For selection of clusters in urban areas of category (a) districts, municipal wards are taken as clusters.

For category (b) districts, revenue villages and urban wards are combined together to form the sampling (list) and thirty clusters are selected using the above procedure.

Sample size: To provide district level estimate of reproductive and child health indicators, RHS-I & II required about 1000 household per district. Considering a design effect of 1.5, the CATA covers about 1,500 households per district. Each sample includes (a) 7 households having at least one mother who had a live-birth or stillbirth during previous 12 months, preceding the date of survey, (b) all married women in the reproductive age in the all households are interviewed, (c) 7 children in the age group 12-23 months and 7 children in the age group 24-35 months.

Termination of survey in a cluster: The visit to subsequent households is terminated after achieving the above numbers. If last selected household has more such member than needed to reach the target, the information on all such members is collected before terminating the survey. It is estimated that the above targets will involve a visit to at least 40-45 households in each cluster. Thus, a minimum of 1200 households are expected to be covered from each district in one round.

Data management and analysis

Data collection is done on pre-designed questionnaires, which are common for all participating institutions. Each participating institution is allotted a unique code for data management. All selected clusters also have a structured location code provided by the apex-coordinating centre. The data are managed by computers, using a common data acquisition software, which has been especially developed for this purpose. This facilitates inbuilt error and inconsistency checks in the data. The district level analysis is carried out at each centre and sent to apex-coordinating centre in hard and soft copies. The apex centre pools the data and undertakes final analysis at regional level. A web based dissemination system is being developed for easy and quick exchange of information.

Survey Tools.

During the survey, the information is collected at sub-centre, village, household and individual levels. The set of instrument developed under the project is described below.

- A. **Sub Centre Profile:** This instrument collects information about infrastructure available at sub-centre, knowledge and skills of the ANM, and information on service delivery at subcentre level. This instrument is administered, if a sub-centre is present in the village, which have been selected as a cluster. If sub-centre is not present in the selected cluster/village, then, this section is skipped.

- B. **Village Profile:** This instrument collects information on indicators of villages facilities like distance from pucca road, availability of post office, bank, local market, health facilities, education, transportation system and presence of village level institutions, if any. This is administered in each selected rural cluster.
- C. **Household Profile:** This schedule is administered in all selected households, starting from the first selected household in the cluster till the completion of the target irrespective of the fact whether the household has an eligible member or not. This collects information about age, gender, marital status, occupation etc. of each member of the household and socio-economic status, current morbidity and mortality in the household.
- D. **Eligible couple profile:** This questionnaire is administered to all currently married females in the reproductive age group, found in the selected/ visited households. The collected information pertains to age, education, age at marriage, complete reproductive history child mortality and current use of family planning methods by the female.
- E. **Recently Delivered Mothers Profile:** This instrument is administered to seven mothers, who have given a live birth or stillbirth during preceding 12 months from the date of survey. Information pertaining to last childbirth is collected, which pertains to antenatal care, delivery practices, postpartum care, newborn care, etc.
- F. **Child immunization Profile:** This instrument is used for children aged 12-23 months and records status of immunization and related information like age at which the immunization was given, the service provider and reason if not immunized.

Indicators being measured

The indicators being measured under the survey include morbidity (in last 15 days), mortality (in last one year), non- Iodised Salt users, fertility (mean number of children ever born to women age 40-44 years, total fertility rate, birth order), current users of family planning methods, unmet family planning need, maternal health care (ANC check-up, TT injection during pregnancy, IFA tablets during pregnancy, full ANC, Safe delivery) and child care (percentage babies bathed immediately after birth, percentage of babies weighed, percentage distribution of baby weight, percentage of infants discontinued breast feeding at age of 1 to 5 months, immunization status).

Annexure-IV

Problems identified (in RCH-I) and mid-course corrections made (in RCH-II)

Problems Identified	Mid course correction made during the 10 th Plan under RCH-II Programme
<p>1. Limited involvement of states and limited ownership by states of RCH Phase I</p>	<p>The design process started with national consultation with all states.</p> <p>The RCH Phase II Program Implementation Plan (PIP) is designed to set out broad strategic direction, define a core minimum service package and estimate national resource requirements.</p> <p>Within this broad evidence-based strategic direction, states will prepare five-year plans linked to clear outcomes after assessing their own priorities, allowing a needs-based state-specific plan to be developed.</p> <p>States will be encouraged to form a multi-disciplinary planning team, involving local stakeholders and resources with a view to <i>prioritizing</i> state needs.</p> <p>States have been offered a wide choice of sector reforms and improvements that they may include in the MoUs to increase accountability and establish linkages between performance benchmarking and fund flow. States themselves will plan and select their outcome and process indicators and reform areas or improvements to achieve the indicators.</p>
<p>2. Pace of implementation to be made faster</p>	<p>The core service package is defined and will be included in all state's plans for implementation.</p> <p>The MoU will be used as a performance benchmarking/ mutual monitoring mechanism and also ensure accountability.</p> <p>Bottlenecks to fund flows will be removed by simplifying processes.</p>
<p>3. Enhancing utilization of public health facilities</p>	<p>This has been diagnosed as being due to perceptions of low quality among the users, frequent service unavailability and low acceptability of some services.</p> <p>This will be addressed through pre-service and in-service training, with a particular focus on provider attitudes and making services more user friendly.</p> <p>Contracted staff will be engaged and their performance monitored to ensure continued availability of services.</p> <p>The core services will include quality standards.</p> <p>Demand side stimulation activities will be an important part of state plans. BCC activities will be focused on improving the image of public health facilities, promoting new services and improving health-seeking behavior.</p> <p>Facility norms will be reviewed and altered using multiple criteria to</p>

Problems Identified	Mid course correction made during the 10th Plan under RCH-II Programme
	effectively match needs of users.
4. Infrastructure to be completed within the project time frame	<p>The core service package will ensure the availability of essential infrastructure.</p> <p>Outsourcing will be undertaken with agreed institutional mechanisms to manage infrastructure and to ensure accountability and delivery of reliable and quality services.</p> <p>The processes of managing construction of infrastructure will be simplified.</p>
5. Management capacity limited	<p>There will be lateral infusion of skilled personnel to improve management capacity structure at national, state and district levels, with clearly defined functional responsibilities and roles.</p> <p>A system will be established to ensure continuity of tenure of key posts and positions. States will review the roles of different cadres and restructure them to strengthen public health and user needs orientation of services as a part of MoU.</p>
6. Need to incorporate the system of smooth flow of funds	<p>A study of financial management had been undertaken to identify and understand the bottlenecks in the current system and design mechanisms to remove them and simplify the flow of funds. The recommendations of the study, after suitable validation, have been examined for improved financial management.</p> <p>The MoUs will clearly define the central government's responsibilities regarding the flow of funds and the state governments' responsibilities on performance and associated expenditure.</p> <p>Accounting procedures for reporting and the process of review will be simplified through an accounting and financial manual which has been prepared by the center.</p> <p>Financial management systems will be built into the program management structure.</p> <p>Professionals/chartered accountants are being inducted in the area of financial management.</p>
7. Need to have a vision and policy guidelines in RCH	<p>A clear vision statement has been developed (section 1.1)</p> <p>A strategic plan has been agreed and strategic direction is laid out in the short, medium and long term (section 1.4).</p> <p>Strategic objectives and policy options are well articulated (section 1.3).</p> <p>Outcome indicators have been identified from various policy documents and commitments at international summits (section 1.2)</p>
8. RCH Phase I was implemented as a project without well-	<p>RCH is visualized as a long-term program oriented towards achieving ambitious but realistic health outcomes and improvements in CPR and TFR. The 5-year period is looked upon as a 'project' within this larger time frame but with definitive outcomes moving towards the long term goals.</p>

Problems Identified	Mid course correction made during the 10th Plan under RCH-II Programme
defined outcome indicators.	<p>The national level program framework is the overview, whilst state level planning will be oriented towards a more limited timescale (5 years) and linked to specific health outcomes relevant to the state that will cumulatively lead towards achieving the goals of national health outcomes.</p> <p>State PIPs will be refined on an ongoing basis as the experience of implementation and results from studies feed in to the state planning process, recognizing that state capacity varies widely.</p> <p>The planning and design will be a dynamic process and the national and state PIPs, Log Frames and MoUs will be live documents.</p>
9. RCH Phase I had a “one size fits all” design	<p>States will have different requirements, levels of performance and capacities and will be able to take these into account when designing their state PIPs.</p> <p>Such a differential approach may be extended to district level depending upon the performance of districts.</p> <p>The BCC, though centrally designed, will also be state-specific.</p> <p>The state PIPs will ensure the equitable availability of quality RCH services designed taking into account the needs of local communities and state capacities.</p> <p>Equity issues especially towards the poor and vulnerable will be addressed through the M&E system and community monitoring.</p>
10. Need to move away from “stand alone” public health approach	<p>RCH Phase II will adopt a program approach, bringing in key elements of sector management and reform and systems strengthening.</p> <p>Partnerships with PRIs, ULBs, the private sector, the NACP and the ICDS program will be built during RCH Phase II.</p>
11. RCH Phase I focused almost exclusively on the supply side	<p>Whilst RCH Phase II necessarily includes supply side strategies, these will be complimented by an integrated and robust strategy to stimulate demand for services.</p> <p>One part of the demand side strategy will be a comprehensive and coordinated BCC plan which specifically addresses issues such as the perceived low quality of services, the availability of services and promoting health seeking behavior.</p> <p>A study specially commissioned on the demand supply nexus has been taken into account in the design.</p> <p>The family planning initiatives will also be integrated in RCH.</p>
12. RCH Phase I was centrally designed with little consultation	<p>RCH Phase II has been designed after wider consultation.</p> <p>EAG states will be assisted in formulating their PIPs.</p> <p>MoH&FW accepts that the national PIP is an operational framework.</p>

RCH II TECHNICAL STRATEGIES FOR WOMEN AND CHILD HEALTH

1.1.1 GUIDING PRINCIPLES FOR MATERNAL HEALTH

The following principles will guide the planning and implementation of maternal health strategies in RCH II:

- **Equity.** The focus would be on the poor and the vulnerable sections of the society.
- **Evidence-base.** Interventions included in the program would be evidence-based.
- **Continuum of care.** The maternal health strategy would be a complementary mix of community and facility-based interventions.
- **Health system approach.** Strengthening of health system will be at the core of maternal health strategy.
- **Integrated services.** Maternal health interventions will be integrated with other components of the RCH program, including newborn and child health and family planning.

1.1.2 OBJECTIVES

- **Improve access to skilled care and emergency obstetric care**
- Improve coverage and quality of antenatal care
- Increase coverage of post-partum care

1.1.3 STRATEGIES

- a) **Enhance Coverage of Facilities for Institutional Deliveries and Emergency Obstetric Care (EmOC)**

Expansion and strengthening of facilities for institutional deliveries and EmOC will be given the highest priority in RCH II. Two levels of institutions will be targeted, namely, i) PHCs & CHCs for *basic* EmOC and ii) FRUs for *comprehensive* EmOC.

b) **Operationalize All CHCs and at Least 50% PHCs for Providing 24 Hour Delivery Services And Basic EmOC**

By 2010, all CHCs and at least 50% of PHCs will be providing 24 hour delivery services and basic EmOC.

These facilities would also provide services for newborns and children, family planning, safe MTP and RTIs/STIs as described in relevant sections.

- c) In RCH I, the strategy of instituting 24 hour delivery services in PHCs was mooted, but only a few states, such as Tamilnadu and Andhra Pradesh, were able to implement the scheme at a limited number of PHCs. A UNFPA project in 7 districts in Rajasthan has demonstrated a rise in met need for EmOC from 8.8% in 2000 to 14.3% in 2003 (increase of 62%). These experiences will be built on, replicated and scaled-up nationwide.
- d) Suitable PHCs and non – FRU CHCs will be identified by the state government. Those with good access, transportation link and some existing infrastructure would be chosen. Equity consideration will be addressed by ensuring that underserved areas including the backward, tribal, difficult-to-reach ones are well covered.
- e) Infrastructure will be strengthened to an optimum level. Basic equipment for labor/delivery room and for newborn care will be provided. A newborn care corner will be developed. Enough supplies of essential drugs would be ensured. An ambulance (outsourced or otherwise) would be available round-the-clock for transportation of sick mothers and children to and from community and referral centers as needed.
- f) Norms and guidelines for these PHCs will be developed. These would pertain not only to infrastructure, staff, drugs and supplies, but also to functional standards. A certification system would be instituted. This will include criteria for criteria for no third delay, gender sensitivity, and uninterrupted services. The essential criteria would be the availability of uninterrupted services 24 hours a day, 365 days a year.
- g) The team at PHCs would consist preferably of 2 MOs, who would be assisted by LHV and nurses for round-the-clock services. Nurses would be the key functionaries who would provide 24 hour midwifery cover under the

supervision of MOs. The CHCs may have specialists in addition. Group D staff (nurse aid / helper) would also be engaged to provide support for asepsis, housekeeping and waste disposal. Wherever necessary, staff including doctors, nurses etc. could be hired on contractual basis. If nurses are not available, ANMs could be deployed. A laboratory attendant would be provided for hemoglobin testing, urine examination, blood grouping and making etiological diagnosis of RTIs/STIs. Training will be provided for selected skills to each category of the staff as per the training needs assessment.

- h) Patient care guidelines for care of women, newborn, and children would be provided. Evidence-based interventions such as use of partogram and active management of the third stage will be implemented. Suitable job-aids and manuals will be provided.

[A group will prepare detailed guidelines by October 2004].

1.1.4 Operationalize Comprehensive Emergency Obstetric Services at 2000 First Referral Units

- a) By 2010, a total 2000 FRUs will be made operational to provide comprehensive EmOC services 24 hours a day, 365 days a year.
- b) In RCH II, the unfinished agenda of providing comprehensive emergency obstetric care services at the sub-district level will be completed. This would meet the UN norm of one such unit for 5,00,000 population taking also into account the difficult-to-reach and backward areas. The FRUs will complement facilities in the private sector.
- c) Recently the DoFW has prepared guidelines for Operationalization of FRUs. States are being approached to develop FRUs accordingly. A certification process would be instituted to accredit the FURs on the basis of infrastructure, staff, drugs, supplies, as well as quality of services.

1.1.5 Ensure access to blood bank at all district hospitals and blood storage facility at FRUs

Blood transfusion is a life saving measure for a woman with hemorrhage and anemia. Provision of blood transfusion is an essential component of comprehensive EmOC. Hence, it is essential that all FRUs and district hospitals, have access to blood round the clock. Recently, the DoFW has developed guidelines for blood storage facilities. This has paved way for establishing blood storage facilities at FRUs. In addition, it is recommended that each district hospital has a blood bank or access to one from where blood could be procured in less than half hour.

1.1.6 Train MBBS medical officers in anesthesia for EmOC

DoFW has developed a 14-weeks course an anaesthesia training for MBBS doctors. The first batch has completed training at AIIMS last year. Administrative formalities have nearly been completed. It is recommended that by 2010, a total of 4000 MBBS doctors be trained in this course to meet the acute shortage of anesthetists that has hitherto seriously hampered Operationalization of FRUs.

1.1.7 Train MBBS doctors in conducting cesarean sections

In view of the non-availability of obstetricians for manning the FRUs, the FOGSI (Federation of Obstetrics and Gynecological Societies of India) has developed a course on basic obstetric care including cesarean deliveries for MBBS doctors. This important step in capacity building in comprehensive EmOC and operationalisation of FRUs will be implemented in a step-wise manner. A pilot phase would be followed by evaluation before scaling up.

1.1.8 Provide emergency obstetric care services to BPL families at recognized private facilities

There is an urgent need to devise mechanisms for BPL families to avail of EmOC in the private sector. This is extremely important because presently, and for some more time to come, EmOC in the government sector would not be fully operational. Yet, in many parts of the country, in cities and towns, a vibrant private sector is well established. Ways need to be found to provide the poor access to these facilities. This could be on the basis of a voucher or insurance system, or by any other innovative method. This issue pertains also to the broader

theme of public-private partnership in RCH II dealt with in other sections of the PIP.

1.1.9 Other strategies

- Shift specialists (obstetricians/ anaesthetists/ pediatricians) from dispensaries and PHCs to FRUs and CHCs where they can contribute to emergency care of women and children.
- Involve general surgeons in providing EmOC, wherever possible.
- Use telecommunication means (call phones/ emails) for making referral system efficient.
- Provide ambulances at PHCs/CHCs/FRUs (outsourced or otherwise)
- Provide incentive to doctors and other staff to work at PHCs/CHCs/FRUs providing round the clock services. Improve living quarters and working conditions; recognize good work.
- Provide imprest money to ANMs and MOs to run SCs/PHCs/CHCs/FRUs smoothly (to undertake minor repairs, ensure upkeep of premises at, purchase drugs/ supplies from market in emergency, hire transport to shift a sick mother etc.)
- Encourage establishment of maternity hospitals / nursing homes in small towns in private sector.

1.1.10 Behaviour Change Communication and Community Mobilization Strategies

1. Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana is the modified version of the National Maternity Benefit Scheme. Its twin objectives are : a) reduce maternal and infant mortality through promotion of institutional deliveries, and b) protecting the female fetus and child. Pregnant women belonging to BPL (below poverty line) would be eligible. Some of the draft provisions of the JSY include the following :

- a) Pregnant woman who opts for institutional delivery would receive financial assistance that would be more for the girl child.
- b) An assistance of Rs. 1500/- will be provided in the event of a cesarean delivery.

- c) A transport assistance of Rs. 150/- will be provided to a rural woman for travel to a health centre for delivery.
 - d) The TBA who mobilizes and assists women in antenatal care, institutional delivery and post-natal care will be provided a financial compensation.
2. Provisions have been made to widely disseminate the information regarding the scheme in the community. The scheme would help mobilize poor families for skilled care at birth and other reproductive health services available at government facilities.
 3. Equally importantly, the scheme is also an attempt to reorient the role of TBAs as agents of change for positive community behaviors that save pregnant women from morbidity and death.
 4. In RCH II, this demand-side strategy will be vigorously implemented to enhance utilization of RCH services at PHCs/CHHs/FRUs.

1.1.11 Other measures

- Educate communities about danger signs of pregnancy, labor and post-partum period. Use media and other IEC/IPC strategies to enable individuals, families and communities to recognize signs of obstetric emergencies.
- Launch a sustained social mobilization effort for institutional deliveries with the help of panchayati raj institutions, opinion leaders, NGOs, self help groups as well as AWWs, link volunteers, ANMs and other stakeholders; reward villages that achieve high rates of institutional deliveries, and save mothers with obstetric emergencies through timely action.
- Promote referral transport for routine deliveries and emergency obstetric care. Make referral transport funds available with AWW/ANM. Map facilities; plan transport options; encourage innovative solutions by communities.

Provide Skilled Care To Pregnant Women At The Community Level

- Promote deliveries by skilled births attendants at Sub-centres and in the community

- In some states, many ANMs conduct deliveries at sub-centres and at homes. In RCH II, efforts will be made to enable more ANMs to provide skilled care in these settings. States would be encouraged to include sub-centre strengthening for deliveries as a priority for their PIPs.
- A new cadre of Community Skilled Birth Attendants (C-SBAs) is proposed to be introduced. After a training of one-year, a C-SBA would provide midwifery care as a ‘practitioner’ in the community. The training of the first batch of C-SBA is on the anvil. The scheme is, thus, in early stage of pilot implementation. For the RCH II period, the initiative should be seen as an experiment – the results of which would decide its future scaling-up.

1.1.12 Permit ANMs to administer obstetric first-aid

ANMs are the front-line workers of the health system in India. Many of them conduct deliveries in the sub-centre and home settings. All of them are likely to come across situations when a woman with obstetric emergency such as post-partum bleeding, eclampsia, or puerperal sepsis would be brought to her for advice and treatment.

At present, ANM is not permitted to administer injection oxytocin or misoprestol (for post-partum bleeding), injection magnesium sulphate (for eclampsia) or an antibiotics (for puerperal sepsis) that may be life saving even as she arranges referral of the patient. Lack of mandate to the ANM to provide obstetric first aid using these drugs is a serious missed opportunity and a lacuna in the system.

It is therefore strategised that in order to save lives of women with obstetric emergencies in the community, the ANM is permitted to use the following drugs:

- Inj. Oxytocin
- Inj. Magnesium sulphate
- Misoprestol oral
- Inj. Ampicillin

It is important to ensure that a systematic training is provided to ANMs prior to granting permission to use these drugs. Safeguards need to be provided to ensure that the drugs are administered only after ascertaining the clinical need. Once the decision is taken to grant right to ANMs to use there drugs appropriate supplies should be ensured.

1.1.13 Improve Coverage and Quality of Antenatal Care (ANC)

Antenatal care is important for not only the mothers but also the newborn. There is a need to enhance coverage and quality of ANC in the program. The aim would be to raise the proportion of pregnant women receiving 3 ANC checks to 80% from the present level of 44% (NFHS II).

1.1.14 Improve equity-driven coverage of ANC

- Make special efforts to reach women of BPL, SC/ST and other marginalized groups.
- Target primigravida and adolescent mothers.
- Ensure fixed – day ANC activity/clinic in the community and the facilities.
- Involve AWWs, women’s groups, TBAs and other community partners to reach out to each pregnant woman, especially the above mentioned groups.

1.1.15 Improve quality of ANC

- Ensure:
 - first check up in first trimester
 - total 3 check ups or more
 - two doses of TT
 - ingestion of 100 tablets of IFA
- Ensure that antenatal check includes all the recommended elements (history, abdominal palpation, BP, looking for edema, urine examination etc.) at all levels; and, in addition, blood grouping at facility level).
- Improve counseling at ANC sessions focusing on:
 - Promotion of institutional deliveries.
 - Danger signs of obstetric emergency.
 - Birth preparedness: deciding about place and attendant at delivery, where to go if emergency arises, how would transportation be arranged, arranging money for emergency situation.
 - Early care of the baby, including initiation of breastfeeding, drying and wrapping, delaying bath etc.

Strengthen skills of ANMs in improving quality of ANC, especially for counseling.

- Introduce sticks-based rapid estimation of hemoglobin and urine examination.

- Provide mother-baby linked card to all, depicting key messages apart from clinical information.

1.1.16 Strengthen Post-partum Care at the Community Level

- Post-partum care will be improved significantly in RCH II. It would be combined with newborn care. The emphasis would be in the home setting. A large proportion of births, especially among the poor, may continue to occur at homes. But even the institutionally- delivered mothers and babies are likely to discharged within a day or so after the delivery.
- Home-based newborn care will be combined with home-based post-partum care.*
- The **IMNCI** protocols are being modified to include algorithms and advice on post-partum care. AWWs would visit neonates and mothers on days 1,2,7,14 and 28 with particular emphasis on the first two visits. They would use the modified IMNCI charts to identify problems (serious problems such as puerperal sepsis, and minor problems such a breast conditions), counsel and refer, if necessary.
- Provide mother-baby linked card to all, depicting key messages apart from clinical information.
The *key messages* for the mothers would be on:
 - Danger signs
 - Nutrition
 - Iron-folic acid supplementation
 - Birth spacing
 - Newborn care

1.1.17 STRATEGIES FOR NEWBORN AND CHILD HEALTH IN RCH II

In RCH II, a comprehensive newborn and child health package of interventions will be implemented in the country with the aim of achieving a decisive breakthrough in neonatal, infant and child mortality. The knowledge about what saves the lives of children in a cost-effective manner is available to the nation and the world at large. The mission in RCHI II is to translate this knowledge into action and usher in the second child survival revolution in the country.

a) **Guiding principles**

The following principles will govern the planning and implementation of newborn and child health strategies:

- Evidence-based interventions
- Integrated approach in sync with family planning and maternal health components of the program
- Equity-driven implementation and monitoring
- Rational mix of family-centered (home level), population centered (outreach) and individual-centered (clinical) interventions
- Decentralized priority setting and phasing at the state and district levels
- Participation of the private sector

b) **Newborn and Child Health Strategy: The IMNCI Plus**

Objectives of the newborn and child health strategy are:

1. Increase coverage of **skilled care at birth** for newborns in conjunction with maternal care
2. Implement, by 2010, a newborn and child health package of preventive, promotive and curative interventions using a **comprehensive IMNCI** approach
 - 2.1 At the level of all
 - Sub-centres
 - Primary health centres
 - Community health centres
 - First referral units
 - 2.2 At the household level in rural and poor periurban settings in at least 250 districts (through AWWs / LVs)
3. Implement the **Medium-term Strategic Plan for the UIP** (Universal Immunization Program)

- Increase coverage of skilled care at birth for newborns in conjunction with maternal care
- Implement by 2010, a newborn and child health package of preventive, promotive and curative interventions using a comprehensive IMNCI approach at the level of all Sub-centres, Primary Health Centres, Community Health Centres and First

Referral Units as well as at household level in rural and poor periurban settings in atleast 125 districts (through AWWs/LVs/ASHAs).

- Implement the medium-term strategic plan for the UIP (Universal Immunisation Programme)
- Strengthen and augment existing services in areas where IMNCI is yet to be implemented

c) **Why IMNCI 'Plus'**

IMNCI adapted and under early implementation in India takes the generic IMCI approach much further - by including 0-6 days of age group, by having a health worker module, and by incorporating the home-based approach for newborn care. But there is a need to add the inpatient care component for facilities to ensure effective care of sick neonates and children who require hospitalization. This will be done by adapting WHO and local guidelines and tools. Even in this comprehensive form, IMNCI package would still not cover the vital care of the neonates at birth in home and facility settings. Further, the IMNCI approach includes counseling for immunization, but the implementation of immunization in India is largely a periodic outreach activity and that cannot be adequately captured by the IMNCI contacts alone. Therefore, a comprehensive immunization plan will be an additional pillar of the newborn and child health strategy. Health system inputs and community level activities are germane to the effectiveness of not only IMNCI, but also that of care at birth, as well as successful immunization strategies.

It is in the light of the above reasons that the newborn and child health strategy for RCH It is named as 'The IMNCI Plus' strategy to connote the wider, comprehensive range of interlinked interventions that form the newborn and child health component of RCH II program.

d) **Skilled care at birth**

This component is linked intimately to maternal care intervention of the program, and thereby a continuum of antenatal and intrapartum interventions.

The underlying principle of effective care at birth is that wherever an infant is born, home or facility, she is provided clean care, warmth, resuscitation, and exclusive breastfeeding. She is weighed and examined, and if her clinical needs are not manageable at the place of delivery, she is referred and managed at an appropriate facility. RCH II program aims at promoting institutional deliveries. Newborn care is

relatively easy to implement in facilities because of the presence of skilled birth attendants (doctor/ nurse/ ANM/LHV), and an enabling/ supporting environment. However, a large proportion of deliveries would continue to occur at homes by the TBAs for some more years to come, especially in the EAG states. It is therefore, considered desirable to continue to impart newborn care skills to TBAs in areas with high rates of home deliveries, in order to enable them to contribute, as much as possible, towards newborn survival and health in partnership with the families and the AWWs/ ANMs/LVs. They will also be provided clean delivery kits. At the same time, overall effort would be to promote childbirth by skilled attendants and in institutions, both in the public and private sector.

Skilled care at birth everywhere

Level	Provider	Key input
Institutions* 24 hour functioning PHCs / CHCs	MOs, ANMs, LHVs, nurses	Delivery room Resuscitation equipment Newborn Care Corner/Unit
FRUs, District hospitals	MOs, specialists, nurses	Maternity OT & delivery room Resuscitation equipment Newborn Care Corner/Unit
Home (wherever institutional deliveries not possible)	<i>Skilled birth attendants</i> ANMs, nurse practitioners, Community-SBAs	Clean delivery kit Resuscitation equipment
	<i>Trained TBAs</i> (if access to skilled attendants is not possible)	Clean delivery kit

Private institutions should have the same or better norms

e) IMNCI

The IMNCI approach will be the centre-piece of newborn and child health strategy in RCHI II. A comprehensive model of IMNCI will be implemented (Fig.4). It would include the home and community-based component (through ANMs and AWWs/LVs) and the facility-based outpatient care component, as is being piloted in UNICEF's border district project. In addition, a component on management of sick neonates and children in the inpatient setting at PHCs/ CHCs/ FRUs, and in private facilities will be added. Health system strengthening and community components will be addressed effectively to ensure effective implementation.

IMNCI implementation at different levels

Level	Approach	Sites / strategy	IMNCI module	Provider(s)	Key inputs
Home and Community	Home-based newborn care	Home visits on day 1,2, 7,14 & 28; more visits for LBW and sick babies	Basic Health Worker (AWW/LV) module	AWW/ LV Supervised by ANM. Assisted by TBA	IMNCI medications Referral funds
	Community management of newborn and childhood illness	Neonates and children brought to AWW or sub-centre; and those seen at field/home visits and at immunization sessions	Basic Health Worker (ANM) module	AWW / LV ANM	IMNCI drugs as per norms Referral funds
Facility*	Outpatient care at PHCs, CHCs, FRUs, DHs	Outpatient care of neonates and children reporting with illness	Physicians' module	MO; ANM , LV, nurses under supervision	IMNCI drugs Educational materials Observation area Referral transport
	Inpatient care at 24-hour functioning PHCs, CHCs, FRUs, DHs	Inpatient care of sick neonates and children	Care of sick neonates and children+	MO with nurses/ ANMs/ LHV's	Newborn care corner/unit Inpatient area for sick children Requisite drugs and supplies Referral transport

*To be replicated also at private facilities of corresponding levels / developed +Module to be adapted

It is emphasized that the above strategies will be built on the existing skills of the care providers, and the existing structures and systems. Several activities and approaches of RCH I would be continued with enhanced quality and coverage. There will, however, be significant additionalities to encompass unattended interventions such as home-based newborn care.

The proposed phasing for coverage of IMNCI is shown in the Table below:

Cumulative operationalization of IMNCI (Suggestive)

Level	Providers	By 2006	By 2007	By 2008	By 2009	By 2010
Sub-centres /	ANMs	10%	30%	50%	75%	100%
PHCs / CHCs / FRUs	MOs, LHV's	10%	30%	50%	75%	100%
Village	AWW LV	25 districts	50 districts	100 districts	175 districts	250 districts

f) **Training for IMNCI**

Training load

The tentative number of providers at different levels to be trained are shown in Table below:

Training for IMNCI: Levels and providers to be targeted (2005-2010)

Level	Providers	
	Cadre	Number (approx.)
Health System		
All sub centres	ANMs	1,30,000
All PHCs	MOs	30,000
All FRUs	MOs	
50% PHCs / allFRUs	Nurses	To be determined
ICDS System		
Villages in 250 districts	AWWs	250,000
Private Sector		
Small towns and villages	Private physicians	To be determined in consultation with states and professional bodies.

g) *In-service training*

Table below shows outline of in-service training program for different workers.

In-service training for IMNCI and Skilled Care at Birth

Provider	Content & duration (tentative)	By whom (suggested)
Health system		
ANMs/ LHV's	IMNCI* (8 days)	NIHFW network
Nurses	Care of inborn neonates Lactation skills Outpatient and inpatient care of sick neonates and children (6 days)	Medical and nursing colleges/NNF/TNAI (AIIMS module on neonatal nursing recommended)
MOs	IMNCI (Newborn & young infant module only) and Inpatient care of sick neonates Newborn resuscitation Inpatient care of sick <u>children</u> Lactation/IYCF skills (4+1+1+1=7 days)	IMNCI training network (to be established) NNF district training system program with improvements
ICDS system		
AWWs	IMNCI* & lactation and young infant feeding counseling (8 days)	ICDS/ NIPCCD network
Private sector		
Private physicians	As for the MO	IGNOU (Distance education)
TBAs		
TBAs	Clean and safe delivery, home care of neonates including care at birth, breastfeeding, warmth, small baby care, detection of danger signs (3 days)	NGOs/district centres

* Will include post-partum care of mothers

As far as possible, the training of different providers will be done in such a manner that a district develops the team at all levels simultaneously. This would ensure simultaneous operationalization of the entire district health and ICDS system.

The RCH II training workplan is being developed by a core group. The available training materials and modules are being reviewed. The above outline including the duration of courses is suggestive, and would be finalized by this group. There will be an overarching organization/group/ institution to ensure that the quality of training is ensured for all cadres. The guidelines for this and other organizational issues are being developed.

h) **Pre-service training**

The IMNCI Plus training packages as outlined above for different categories of workers will be incorporated into the pre-service curricula of physicians, nurses, ANMs, LHV,s, community skilled birth attendants, AWWs and link volunteers, after suitable adaptations. The experience gained from the ongoing WHO project on IMNCI in MBBS curriculum in 5 medical colleges will be built on while planning this initiative.

Lactation and feeding counseling is also an important area for skills strengthening among all cadres of health workers/professionals.

The Common Minimum Program calls for expansion of ICDS through out the country. It is a unique opportunity to train all the new AWWs in the IMNCI skills as a part of the pre-service training. Likewise, many new ANMs will be trained and deployed in many states. Hence, IMNCI should become a part of the ANM curriculum nationally.

1.1.18 **Health System Issues**

Strengthening facilities for care of newborn infants and children

All PHCs will provide the outpatient level IMNCI. A minimum of 50% PHCs countrywide (that are being developed into 24 hour delivery institutions) will provide, in addition: (i) care of inborn neonates, (ii) inpatient care of sick neonates brought from outside, and (iii) inpatient care of sick infants and children. Suitable norms, standards and guidelines will be developed, and integrated with those for reproductive

and maternal health services at this level. The norms for the facilities will pertain to: infrastructure, equipment, human resources, drugs/ supplies, referral system, etc.

CHCs and FRUs will be strengthened. Draft guidelines for newborn and child health services at the CHCs/FRUs have been developed alongwith those for reproductive and maternal health services. Based on these norms, 2000 FRUs will be operationalized for providing integrated maternal, child and family planning services in RCH II.

A system of certifying and monitoring the operationlization of facilities will be implemented. While operationalizing the facilities geographical equity will be borne in mind to ensure that underserved areas get adequate coverage.

1.1.19 Ensuring referral of sick neonates and children

Referral funds made available with AWW/ANM would be utilized for transport of sick neonates and children. PHCs, CHCs and FRUs will have ambulances (outsourced or otherwise) to cater to the referral transport of sick neonates and children. Communities would be educated about the availability of referral funds/ transport, and BPL/SC/ST families would, in particular be encouraged to avail of these resources. Community based organizations (PRIs, women's groups, youth groups etc.) will be mobilized to innovate local solutions and mechanisms to ensure transport of sick neonates and children.

1.1.20 Permitting ANMs and AWWs to administer selected antibiotics

To ensure that the life-threatening conditions of sick neonates and children are managed quickly and effectively, it is of fundamental importance that the providers closest to the communities have the necessary skills and the mandate to mangle these killer diseases. This is particularly critical for the poorest who cannot seek care away from homes due to lack of resources.

At present ANMs cannot manage newborn babies with sepsis because they are not permitted to administer gentamicin injection. And AWWs cannot treat diarrhea or pneumonia with ORS and co-trimoxazole.

Therefore, the ministry will take steps to ensure that:

- ANMs be permitted to administer injection gentamicin to neonates. The same would apply to community-SBAs.

- AWWs be permitted to administer ORS and cotrimoxazole as per the IMNCI algorithms. This strategy, would go a long way in improving access to treatment by critically sick neonates and children, especially those of the poorest families.

Skills-based training and supportive supervision will be instituted to ensure acquisition and retention of skills by the workers to administer the specified drugs. Injection safety norms will be followed strictly for gentamycin injections. Disposable or AD syringes will be provided.

1.1.21 Other health system issues

The success of IMNCI Plus strategy will depend on the strength and efficiency of the following ingredients of the health system in addition to those covered above:

Deployment of providers with the desired motivation, commitment and competence

- Strengthening of health infrastructure
- Uninterrupted availability of drugs and supplies
- High quality supervision and monitoring
- Ownership of the state and district level program managers.
- Efficiency of administrative/ financial system

Strengthening neonatal care services and education infrastructure at medical/ nursing teaching institutions.

Newborn services are often inadequately developed at government teaching institutions. This hampers training of the medical/ nursing students, and limits the potential of these institutions to play the desired range or role in training, research and referral care in the program. Therefore, it is proposed to strengthen newborn and child health services of medical colleges. Likewise, nursing and ANM schools will be strengthened to improve their training expertise, capacity and quality.

1.1.22 Community-based Interventions

- **BCC and community mobilization are cross-cutting areas in RCH II.** Inputs for ensuring effective demand for and utilization of services for newborn and child health gains will be systematically woven into the overall BCC and community mobilization strategy. Following is the outline of key

themes that would be promoted through all possible channels and mechanisms:

- **Mobilize families for institutional deliveries in government/ private facilities.** Launch a sustained social mobilization effort with the help of panchayati raj institutions, opinion leaders, NGOs, self help groups and other stakeholders; mobilize communities for Janani Suraksha Yojana.
- **Promote healthy home care practices for newborn care.** Promote warmth, early and exclusive breastfeeding, cord care and hygiene; avoid harmful practices including early bathing, colostrum discarding, pre-lacteals and cord applications etc.
- **Promote healthy home practices in diarrhea:** Educate families and communities in: use of home fluids, continuing breast feeding and solid feeds in diarrhea, for early introduction of ORS to prevent dehydration.
- **Make ORS readily/ freely available.** Make ORS packets available with all primary care providers (AWWs, ANMs, male workers, link volunteers, teachers etc.) and at all anganwaris, sub centres and facilities (PHCs, FRUs, CHCs, hospital); use alternative approaches for making ORS readily available (public distribution system, social marketing).
- **Widen the net of persons who can treat diarrhea.** Involve male workers, community volunteers, and village practitioners among others to treat diarrhea with ORS.
- **Promote early recognition of neonatal and childhood illness.** Educate, families regarding of signs of sickness ('danger signs') among neonates and children, enable families to seek care early and from trained providers.
- **Improve referral of sick neonates and children who cannot be managed at home.** Educate families, facilitate transport, make referral funds available with AWWs & ANMs, focus particularly on BPL/SC/ST families.

1.1.23 Other strategies

- Promote use of the more effective low osmolality ORS as recommended by WHO

- Ensure 100% registration of births as envisaged in the National Population Policy (2004)

1.1.24 Newborn and child health in urban areas

The principles of newborn and child health services in urban areas would be the same as outlined above. Because of the unique features of urban setting and the multiplicity of the actors and agencies, adaptation of the above approaches would be necessary. While developing the urban RCH component the states are being encouraged to build on the existing systems to plan most suitable delivery models to take interventions to the poorest neonates and children.

1.1.25 Promoting care for sick neonates and children of BPL families in private sector

Private-public participation is being addressed in RCH II design. Options and mechanisms are being examined to explore how families of BPL families can access life-saving care for obstetric or pediatric emergency in the private sector. States are being encouraged to develop innovative approaches towards this objective. The issues of quality standards and accreditation of facilities that would be compensated from public funds in lieu of care of BPL mothers/ children are also being examined.

1.1.26 Operations Research

- Develop system to monitor cause-specific burden for neonatal and childhood mortality on population basis.
- Develop models of primary care newborn service delivery in rural and periurban settings.
- Assess role micronutrient supplementation in reducing morbidity and mortality among LBW neonates.
- Track burden of low birth weight neonates, and epidemiology thereof.
- Undertake surveillance of pneumonia and dysentery-causing bacteria and their antimicrobial sensitivity.
- Assess effectiveness of Rotavirus, H. influenzae and Pneumococcal vaccines.

1.1.27 Work in progress

- A detailed *action plan for IMNCI Plus strategy* is being developed (including organizational schema, phasing and indicators etc.)

- A core group on Training for RCH is engaged in formulating the training action plan for RCH II.

1.1.28 Infant and young child feeding (IYCF)

Child nutrition is a wide and cross-sectoral issue. RCH II program activities will complement activities of ICDS and other departments in regard to promotion of breastfeeding and appropriate complementary feeding practices.

Objective

The objective of RCH II strategy on IYCF will be to contribute towards attainment of the national goals in nutrition in partnership with the Department of Women and Child Development and other departments

A National Breastfeeding Partnership has been announced recently in recognition of the importance of breastfeeding as the crucial child survival intervention.

Following strategies will be implemented:

Implement a nation-wide behavior change effort to promote breastfeeding. Involve all grassroots workers: TBAs, AWWs, ANMs, village practitioners, male workers, link volunteers etc.; involve panchayats, self help groups, agents of change, opinion leaders, NGOs ; employ mass media; use all health-related contacts to promote improved feeding ; give standard unambiguous messages (‘ exclusive breast feeding for six months’).

Augment AWW’s contacts with mothers. Promote home visiting by AWWs in the antenatal, and post-natal periods as a part of IMNCI Plus activities.

Use all ANM / male health worker contacts for IYCF counseling. Use immunization sessions, field visits of ANMs and male health workers for IYCF counseling.

Strengthen breastfeeding promotion efforts at facilities. Promote ten steps of successful breastfeeding at facilities including PHCs, CHCs, FRUs and district hospitals.

Improve IYCF counseling skills of providers. Train TBAs, AWWs, ANMs, LHVs, male workers, link volunteers, as well as physicians (government, private; general, specialist; modern, ISM) and nurses in lactation and feeding counseling techniques through pre-service and in-service training and education.

Implement the IMS (Infant Milk Substitutes, Feeding Bottles and Infant Food: regulation, supply and distribution) Act more effectively by educating providers at all levels about the key provisions of the Act.

Promote appropriate and adequate complementary feeding. Strengthen AWW's role through supportive supervision and monitoring, use all health related contacts to counsel regarding solid foods; emphasize portion size and calorie density; promote culturally acceptable, low cost, balanced, locally available infant foods (prepare local lists for counseling).

Launch a National Breastfeeding Partnership with clear mandate, resources, networking mechanisms and roadmap. The aim is to bring all stakeholders together to raise the profile of this key agenda in the country and, not only converge their own programs, but to run a sustained high profile breastfeeding movement in the country jointly.

Annexure VI

Comparative statement on statewide information on the institutional delivery rates as per the NFHS-III (2005-06) and NFHS-II (1998-99)

Name of the state	Institutional delivery Rate	
	NFHS-III (2005-06)	NFHS-II (1998-99)
Uttar Pradesh	22.0	15.2
Chhattisgarh	15.7	13.8
Gujarat	54.6	46.3
Maharashtra	66.1	52.6
Punjab	52.5	37.5
Orissa	38.7	22.6
Andhra Pradesh	68.6	49.8
Assam	22.7	17.6
Delhi	60.7	59.1
Rajasthan	32.2	21.5
Meghalaya	29.7	17.3
West Bengal	43.1	40.1

Annexure – VII

**UNIVERSAL IMMUNIZATION PROGRAMME
ESTIMATED TARGETS AND REPORTED COVERAGE IN PERCENT
1990-91 TO 2005-06**

Year	Target (in lakhs)		Coverage levels (%)				
	Infants	P. Women	DPT	OPV	BCG	MSL	TT(PW)
1990-91	223.39	252.66	100.72	101.50	103.00	90.90	79.70
1991-92	233.34	261.31	90.90	91.30	92.90	85.00	77.60
1992-93	242.90	270.08	90.60	91.00	96.60	85.90	79.40
1993-94	247.89	275.55	93.20	93.60	97.20	88.50	82.60
1994-95	247.65	275.25	94.50	95.20	99.80	87.20	83.80
1995-96	248.61	275.30	90.70	91.60	97.10	82.60	80.40
1996-97	254.01	281.08	91.50	92.70	98.10	83.20	81.80
1997-98	255.45	282.87	92.90	93.90	99.50	85.80	82.60
1998-99	251.17	277.47	93.70	95.30	97.70	88.10	83.90
1999-00	247.22	292.41	95.30	95.90	101.60	89.80	81.30
2000-01	240.53	284.92	102.70	104.10	108.20	97.00	86.00
2001-02	245.24	272.06	100.80	100.40	106.10	93.70	86.80
2002-03	249.31	294.46	96.60	97.00	102.50	91.80	82.90
2003-04	256.79	302.83	91.20	92.50	100.20	85.60	77.90
2004-05	256.26	301.79	93.60	94.20	99.90	90.30	78.60
2005-06*	257.93	303.08	96.90	95.60	103.60	92.90	80.20

Coverage Evaluation Surveys by UNICEF for all
antigens -1998-20005 at All India Level

Year	DPT-3	OPV-3	BCG	Measles	Full Immunization
1998-99	68.6	68.6	73.2	55.2	51.0
1999-2000	46.4	58.8	67.5	50.2	37.8
2000-01	63.6	70.7	72.8	55.6	52.8
2004-05	67.3	61.3	83.4	68.1	54.5

Annexure VIII

District Level Household Survey 2002-04

S. No.	State	BCG	DPT 3	POLIO 3	Measles	Full Immunization	Two or more TT (preg)
1	Andaman & Nicobar Islands *	98.4	86.3	51.5	90.4	47.7	86.4
2	Andhra Pradesh	92.5	78.7	82.2	74.4	62.9	84.5
3	Arunachal Pradesh	56.1	36.0	32.1	39.3	22.5	43.6
4	Assam	62.7	39.5	30.0	39.1	19.3	57.6
5	Bihar	46.8	35.0	34.3	28.2	24.4	71.0
6	Chandigarh	89.9	78.6	62.8	79.0	53.3	64.0
7	Chhatisgarh	87.8	70.5	70.6	70.2	60.9	67.8
8	Dadra & Nagar Haveli *	95.7	92.1	92.1	87.0	85.2	84.1
9	Daman & Diu *	94.0	77.7	67.6	78.6	57.3	81.1
10	Delhi	90.9	71.1	71.9	76.4	61.0	75.0
11	Goa	96.6	87.7	87.9	93.1	81.5	76.2
12	Gujarat	86.6	68.9	71.2	69.4	57.7	73.2
13	Haryana	83.3	75.7	75.0	69.2	62.9	77.5
14	Himachal Pradesh	96.1	91.2	86.5	89.7	79.4	58.1
15	Jammu & Kashmir	94.6	48.1	55.9	83.0	38.6	73.6
16	Jharkhand	52.0	39.3	38.4	34.5	29.3	64.2
17	Karnataka	92.5	84.5	83.7	80.4	74.1	79.5
18	Kerala	98.0	90.7	89.6	90.0	81.2	87.5
19	Lakshadweep *	99.7	86.9	74.5	91.8	67.6	89.3
20	Madhya Pradesh	72.6	43.9	47.2	50.1	32.5	64.5
21	Maharashtra	95.9	88.5	82.3	88.0	74.3	79.4
22	Manipur	83.4	48.8	50.6	55.6	37.0	67.6
23	Meghalaya	64.9	31.2	26.1	30.3	14.1	30.3
24	Mizoram	79.0	48.7	46.1	61.6	35.3	47.8
25	Nagaland	67.7	32.5	26.7	40.2	14.4	43.5
26	Orissa	88.5	70.0	69.3	69.9	55.1	76.6
27	Pondicherry *	99.3	93.8	94.8	95.8	89.4	97.2
28	Punjab	88.0	82.8	82.7	79.1	75.3	84.4
29	Rajasthan	60.6	36.4	36.8	36.8	25.4	59.1
30	Sikkim	91.4	74.0	60.0	82.6	50.2	77.5
31	Tamil Nadu	99.0	96.8	95.5	95.7	92.1	86.3
32	Tripura	75.0	47.9	35.2	44.7	26.7	68.3
33	Uttar Pradesh	57.8	37.9	36.9	37.7	28.1	61.5
34	Uttaranchal	72.8	57.7	57.3	56.9	47.2	64.4
35	West Bengal	86.4	69.8	67.0	67.6	54.4	86.2
	INDIA	74.7	59.0	58.2	58.0	47.6	71.8

Annex-IX (a)

Distribution and annual intake in the MBBS course in medical colleges

S.No.	State	No. of colleges			Annual Intake
		Govt.	Other	Total	
1.	Andhra Pradesh	9	5	14	1975
2.	Assam	3	-	3	391
3.	Bihar	6	2	8	510
4.	Chandigarh	1	-	1	50
5.	Chhattisgarh	1			100
6.	Delhi	4	-	4	460
7.	Goa	1	-	1	100
8.	Gujarat	8	2	10	1405
9.	Haryana	1	-	1	150
10.	Himachal Pradesh	2	-	2	115
11.	Jammu & Kashmir	2	2	4	350
12.	Jharkhand	3	-	3	190
13.	Karnataka	4	18	22	2955
14.	Kerala	5	1	6	800
15.	Madhya Pradesh	5	-	5	620
16.	Maharashtra	18	17	35	4010
17.	Manipur	-	1	1	100
18.	Orissa	3	-	3	364
19.	Pondicherry	1	2	3	275
20.	Punjab	3	3	6	520
21.	Rajasthan	6	-	6	650
22.	Tamil Nadu	11	5	16	1865
23.	Uttar Pradesh	9	2	11	1212
24.	Uttaranchal	-	1	1	100
25.	West Bengal	7	-		905
	Total	113	61	174	20172

Annexure -IX (b)

Annual Intake in the specialties related to maternal care

S. No.	State	MD (OBG)	MS(Gen. Surgery)	MD (Anesthesiology)	Diploma in Anesthesia
1.	Andhra Pradesh	55	76	49	51
2.	Assam	16	20	7	12
3.	Bihar	9	30	11	8
4.	Chandigarh	1	7	3	-
5.	Delhi	24	28	23	10
6.	Goa	4	4	3	4
7.	Gujarat	68	78	81	25
8.	Haryana	9	-	5	8
9.	Himachal Pradesh	5	4	2	3
10.	Jammu & Kashmir	-	28	19	6
11.	Jharkhand	9	12	-	2
12.	Karnataka	86	141	71	110
13.	Kerala	17	42	18	22
14.	Madhya Pradesh	16	53	18	19
15.	Maharashtra	102	137	93	70
16.	Manipur	6	8	3	4
17.	Orissa	22	26	6	4
18.	Pondicherry	10	8	6	-
19.	Punjab	39	40	61	23
20.	Rajasthan	24	-	1	6
21.	Tamilnadu	33	-	-	62
22.	Uttar Pradesh	-	-	-	17
23.	Uttaranchal	-	-	-	3
24.	West Bengal	-	-	-	24
	Total	555	742	480	493

Annexure-X (a)

Number of Nursing Education Institutions as on 31st March, 2004

Sl. NO.	States and Union Territory	Total No. of Nursing Educational Institutions in India recognized by INC									Registered nurses in respective State Nursing Registered Council		
		A.N.M.	G.N.M.	DNEA	B.SC. (N)	P.B. B.SC(N)	M.Sc(N)	Short Term	M. Phil	PhD	A.N.M.	G.N.M.	HV/FHA
1	Andhra Pradesh	22	91		39	1					94395	84306	2480
2	Assam	9	12		2			1			12589	10321	
3	Bihar	23	13								7501	8883	511
4	Chattisgarh		2		2						93	179	
5	Delhi	1	12	1	5	2	1				355	2594	
6	Gujarat	2	18			1					35840	85796	1352
7	Haryana	9	12		1						13112	15821	694
8	Himachal Pradesh	1	5								9087	7920	411
9	Jharkhand*							1			15	10	
10	Karnataka	1	154		67	15	15		1		47407	54762	6836
11	Kerala	12	74	1	5	1	1				27612	71589	7797
12	Mahakoshal	7	16	2	7	3	1				25344	92331	998
13	Maharashtra	16	47	1	2	5	1	2			25690	81983	551
14	Mizoram	1	3		1						1441	1301	
15	Orissa	15	4								30213	46090	110
16	Punjab	27	55		11	1					17389	43470	2584
17	Rajasthan	8	38		2						22239	35482	850
18	Tamil Nadu	8	54		36	5	12		1	1	52819	159525	11083
19	Tripura		1								969	641	79
20	UP &Uttarachal	30	24		2	1					26956	17479	2763
21	West Bengal	16	22		2	1		1			55858	44652	11294
22	Chandigarh				1	1	1						
23	MIB	3	4										
24	SIB	3	17		2	1	2						
25	AFMS		6										
	TOTAL	214	684	5	187	38	34	5	2	1	506924	865135	50393

* Registration Started from August 2004

Assam = Assam+Arunachal Pradesh+ Manipur+Meghalaya+Nagaland	ANM: Auxiliary Nurse Midwives
Maharashtra = Maharashtra+Goa	GNM: General Nursing and Midwives
Punjab = Punjab+J & K	DNEA: Diploma in Nursing Education and Administration
Tamil Nadu = Tamil Nadu + Andaman & Nicobar Islands + Pondicherry	B.Sc(N): Bachelor in Nursing,
West Bengal = West Bengal+ Sikkim	M.Sc(N): Master in Nursing
	PBBS(N): Post Basic Bachelor in Nursing

Annexure-X (b)

Distribution of Nursing Educational Institutions Recognized by India Nursing Council [as on 31st March, 2006]

S. No.	States	A.N.M.	G.N.M.	B.Sc.	M.Sc.	P.B. B.Sc.
1	Andaman & Nicobar	1	1	0	0	0
2	Andhra Pradesh	30	182	107	2	1
3	Arunachal Pradesh	1	2	0	0	0
4	Assam	6	11	3	0	0
5	Bihar	27	15	0	0	0
6	Chandigarh	0	0	1	1	1
7	Chattisgarh	1	1	9	1	0
8	Delhi	1	17	5	2	2
9	Goa	1	2	2	0	1
10	Gujarat	3	28	5	1	1
11	Haryana	10	25	3	0	0
12	Himachal Pradesh	2	6	0	0	0
13	Jharkhand	3	2	0	0	0
14	Jammu & Kashmir	1	2	0	0	0
15	Karnataka	4	392	237	25	22
16	Kerala	14	137	59	3	5
17	Madhya Pradesh	13	24	23	3	4
18	Maharashtra	22	71	23	2	6
19	Manipur	3	4	0	0	0
20	Meghalaya	2	5	1	0	0
21	Mizoram	2	4	2	0	0
22	Nagaland	1	1	0	0	0
23	Orissa	16	20	8	0	1
24	Pondicherry	1	1	5	0	0
25	Punjab	34	92	19	2	6
26	Rajasthan	10	74	5	0	0
27	Sikkim	0	0	1	0	0
28	Tamilnadu	11	102	49	33	9
29	Tripura	1	3	0	0	0
30	Uttar Pradesh	30	50	6	0	1
31	Uttaranchal	0	0	2	0	0
32	West Bengal	20	38	5	2	2
	Grand Total	271	1312	580	77	62