UNIT 3 HEALTH SCENARIO OF INDIA AND NATIONAL HEALTH PROGRAMMES

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3.0 INTRODUCTION

In unit 1 of this module you have learnt about national health planning and health financing in India and in unit 2 you learnt about health care delivery system in India at Centre, State and District level, national health mission and national health policy. It is known to you that a healthy nation can contribute to economic growth and development of a country. Governments are largely responsible to provide healthcare at the door step through various health programs. Similarly, Government of India tries to provide healthcare at doorstep through health programs by health workforce. Therefore, it is important for you to learn about types, categories and services under each health program in India. Thus, in this unit you will learn about health Scenario and programs in India. You will be able to describe the health problems in country and various national health programmes. Let us first go through the objectives of the unit.

3.1 OBJECTIVES

After completion of this unit you will be able to:

1. critically analyse the health status and health problems of people in India;
2. enlist the national health programmes;

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3. plan to participate in implementing activities under various national health programmes; and
4. describe the programmes for health systems strengthening.

3.2 HEALTH STSTUS AND HEALTH PROBLEMS IN INDIA

Let us briefly review the indicators highlighted in world health statistics report 2019; it stated that recent years have seen improvements in 24 (56%) of the 43 health-related SDG indicators. But, at a global level, five of the 43 indicators: i.e. road traffic mortality, children overweight, malaria incidence, alcohol consumption, water sector are still concern areas. It is estimated that on current trends 51 countries will miss the target for under-5 mortality, and more than 60 countries will miss the target for neonatal mortality in 2030.

Populations in low-income countries have less access to essential health services and these countries experience shortages of health care professionals and government health expenditure is less for health sector. The proportion of the population that suffer catastrophic health expenditures (>10% or >25% of total household expenditures or income) is higher in middle-income countries even in high-income countries out-of-pocket health spending is due to medicines.

Catastrophic health expenditure – WHO

When people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education.

World over 44 million house hold face catastrophic expenditure

World over 25 million house holds are pushed into poverty

Many people decide not to use health care services due to direct or indirect cost

As per SDG India Index-Dashboard 2019, document, there is remarkable change and improvement in India's healthcare system; there have been significant shifts in health strategies adopted to achieve the SDG Goals. The emphasis on water and sanitation, through the Swachh Bharat Mission, has

had a considerable impact on the spread of communicable diseases. The malnutrition among adolescents and women has been taken care off through increasing the entitlement to food under the National Food Security Act and National Nutrition Mission and Poshan Abhiyaan. Health management system is improved through – eVIN (electronic vaccine intelligence network) to track and improve immunisation coverage, ANMOL (ANM online) to extend better maternal and newborn care services, and use of Artificial Intelligence to improve diagnostics and treatment. There are significant efforts and initiatives to improve government accountability on health i.e. government has committed to enhancing public health expenditure to 2.5 per cent of GDP by 2025; the National Health Policy, 2017 recommends State governments' health budget to be more than 8 per cent of their total budget by 2020. The government is committed to establishing 1.5 lakh health and wellness centres by 2022 to ensure access to health services.

As per NITI Aayog, Health Systems for New India Building Blocks 2019, document, India have eliminated polio, guinea worm disease, yaws and maternal and neonatal tetanus. Total Fertility 1 2 Rate (TFR) has reduced sharply from 3.4 in 1992-93 to 2.2 in 2015-16; Maternal Mortality Ratio (MMR level of 130 against a target of 139) and almost succeeded in meeting the Under-5 child mortality target (U5 MR level of 43 against a target of 42). There are significant inter-state and intra-state differentials in health outcomes with socio-economically disadvantaged groups being particularly vulnerable to gaps in access as well as quality of healthcare available to them; the double burden of disease i.e. with a rising burden of non-communicable diseases in addition to the persistence of communicable diseases. India's epidemiological profile and burden of disease still shows that India is in the midst of an epidemiological transition. There is a marked burden of communicable diseases as well as Maternal, Newborn and Child Health (MNCH) related morbidity and mortality, particularly among the poor.

A healthy nation may be described where the rural and urban divide is least, access to clean energy and safe water, accessible and affordable health care is available to all, no poverty, illiteracy and crimes against women and children. Therefore, you may understand that the health scenario of a country is based on the various parameters like birth and death rate, availability of safe water and sanitary latrine, population growth rate and economic status of the country. Healthcare system in India made significant progress attributed to the combined efforts of the public and the private sector. India has made considerable progress in many health indicators.

As per National Health Report, 2019, MOH&FW, GOI, non-communicable diseases dominate over communicable in the total disease burden of the country. In a report of India Council of Medical Research (ICMR), titled India: Health of the Nation's States: The India State-Level Disease Burden Initiative (2017), it is observed that the disease burden due to communicable, maternal, neonatal, and nutritional diseases, as measured using Disability-adjusted life years (DALYs), dropped from 61 per cent to 33 per cent between 1990 and 2016. In the same period, disease burden from non-communicable diseases increased from 30 per cent to 55 per cent. The epidemiological

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transition, however, varies widely among Indian states: 48% to 75% for non-communicable diseases, 14% to 43% for infectious and associated diseases, and 9% to 14% for injuries.

In recent years India has made ground-breaking progress in reducing the maternal mortality ratio (MMR) by 77% from 556 per 100000 live births in 1990 to 130 per 100000 live births in 2016 and MMR has significantly declined to 97 per 100,000 live births in 2018-20. The Urban-Rural divide traditionally seen in institutional births has been largely closed. Overall, 75% of rural births are now supervised as compared to 89% in urban areas. Significant increase from 78.9% in 2015-16 to 88.6% in 2019-21.

India has attained significant progress in achieving immunization coverage through Universal Immunization Programme (UIP) which provides prevention against six vaccine preventable diseases. In 2013, India along with South East Asia Region, declared commitment towards measles elimination and rubella/ congenital rubella syndrome (CRS) control by 2020. MR vaccine campaign is targeted towards 410 million children across the country. 'Mission Indradhanush' aimed to fully immunize more than 90% of newborns by 2020 through innovative and planned approaches. A total of 528 districts were covered during the various phases of this Mission. India has come a long way in immunisation but has to traverse far before achieving its targets.

Demographic Indicators

Demographic indicators of a country reveal its population size, decadal growth rate of population, territorial distribution, gender composition, changes therein and the components of changes such as nativity, mortality and social morbidity.

Demographic indicators can be divided in two parts

Vital Statistics deals with birth rate, death rate, and natural growth rate, life expectancy at birth, mortality and fertility rates

Population Statistics deals with size and growth of population, sex ratio, density of population etc.

State/UT wise performance of these indicators helps government to identify areas that need policy and programme interventions, setting short- and long-term goals, and decide priorities.

India's population, as per census 2011 is 12108.5 lakhs (6232.7 lakhs males and 5875.8 lakhs females). The population of India in 2021, as per the Census of India, is estimated to be around 1.35 billion people. The sex ratio of India during 1901 was 972 females per 1000 males. Since then, it has continued to decline decade over decade to 926 females against 1000 male in 1991 (except in 1981). The sex ratio has further improved from 1991 it was 933 and 943 female against 1000 female in 2001 and 2011 respectively

in the country. The sex ratio in India, as estimated by the NFHS-5 survey conducted between 2019-2021, is 1020 females per 1000 males The highest sex ratio of 1084 females per 1000 males was reported by State of Kerala followed by Puducherry (1037/1000), Tamil Nadu (996/1000), Andhra Pradesh (993/1000), Chhattisgarh (991/1000) and Meghalaya (989/1000). The lowest sex ratio of 618 females per 1000 males was reported by the UT of Daman & Diu followed by Chandigarh (818/1000), NCT of Delhi (868/1000), Andaman & Nicobar Islands (876/1000), Haryana (879/1000), Jammu & Kashmir (889/1000), Sikkim (890/1000) and Punjab (895/1000).

The highest population density of 11320 populations per square kilometre was reported by NCT of Delhi whereas Arunachal Pradesh has reported the lowest population density of 17. Age group-wise distribution of population of the country projected for 2015 and 2016 i.e. 27% of the total estimated population of 2016 were below the age of 14 years and majority (64.7%) of the population were in the age group of 15-59 years i.e. economically active population and 8.5% population were in the age group of 60 to 85+ years.

There has been consistent decrease in the Birth Rate, Death Rate and Natural Growth Rate in India since 1991 to 2017. As on 2017 India has registered Birth Rate of 20.2 per 1000 populations and Death Rate of 6.3 per 1000 populations while the Natural Growth Rate was 13.9 per 1000 population in India. The Birth Rate in Rural was higher than in the Urban. Similarly, the Death Rate and Natural Growth Rate were also higher in rural as compared to the Urban. In 2021, India's crude birth rate was approximately 17.377 births per 1,000 people, and the crude death rate was around 7.30 deaths per 1,000 people. The sex ratio at birth was 937 female births for every 1,000 male births. Additionally, the total fertility rate (TFR) had decreased to 2, falling below the replacement threshold of 2.1.

The population, however, continues to grow, as the decline in the birth rate is not as rapid as the decline in the death rate. The Life Expectancy of Life at Birth has increased from 49.7 years in 1970-75 to 68.7 years in 2012-16. For the same period, the Life Expectancy for Females is 70.2 years and 67.4 years for Males. Infant Mortality Rate has declined considerably (33 i.e. Per 1000 Live Births in 2016), however differentials of rural (37) & urban (23) are still high. As per the latest data available, Maternal Mortality Ratio is highest in Assam & lowest in Kerala. The Total Fertility Rate (TFR) for the country was 2.3 whereas in rural areas it has been 2.5 and it has been 1.8 in urban areas during 2016.

https://hmis.nhp.gov.in/downloadfile?filepath=publications/Rural-Health-Statistics/RHS%202020-21.pdf

https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1332&lid=713

https://main.mohfw.gov.in/sites/default/files/FinalforNetEnglishMoHFW040222.pdf

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Check Your Progress 1

1. Critically analyse health problems in India as per New India Building Block 2019 Niti Ayog document.

2. List the demographic indicators.

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3.3 NATIONAL HEALTH PROGRAMMES

National Health Programmes, launched by the Government of India, have been playing crucial roles in tackling several serious health concerns, communicable and non-communicable diseases, over the last two decades. Health is a state subject and since there is triple burden of disease, that is not limited to geographical boundaries, national health programmes are imperative because they incorporate evidence based strategies for prevention and control. In national programs adequate infrastructure is in place and also resources for programme implementation are available.

As you have learnt in Unit 2 of this module regarding National Health Mission i.e. combine the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) and the main programme components are Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The objective of NHM is to envisage achievement

of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs. Let us now list the national health programmes.

You can read in detail about all national health programmes at the link https://www.nhp.gov.in/healthprogramme/national-health-programmes

3.3.1 Reproductive, Maternal, Neonatal, Child and Adolescent Health Programme

A. **Janani Shishu Suraksha Karyakaram (JSSK) -** Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The scheme is estimated to benefit of pregnant women who access Government health facilities for their delivery.

Following are the Free Entitlements for pregnant women:

- Free and cashless delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay

Following are the Free Entitlements for Sick newborns till 30 days after birth. This has now been expanded to cover sick infants:

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Free drop Back from Institutions to home

B. **Rashtriya Bal SwasthyaKaryakram (RBSK) -** Rashtriya Bal Swasthya Karyakram (RBSK), an innovative initiative, which includes Child Health Screening and Early Intervention Services, a systemic approach of early identification of medical conditions and link to care, support and treatment. This programme replaces the existing school health programme.

Objective - Early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Diseases in children, Deficiency conditions and Developmental delays including Disabilities.

C. Universal Immunisation Programme

Immunization is the process whereby a person is made immune or resistant to an infectious disease, by the administration of a vaccine. Vaccines are substances that stimulate the body's own immune system to protect the person against subsequent infection or disease.

Immunization Programme in India was introduced in 1978 as 'Expanded Programme of Immunization' (EPI) by the Ministry of Health and Family Welfare, Government of India. In 1985, the programme was modified as 'Universal Immunization Programme' (UIP) implemented in phased manner to cover all districts in the country by 1989-90 with the one of largest health programme in the world. Despite being operational for many years, UIP has been able to fully immunize only 65% children in the first year of their life. Government of India is providing vaccination free of cost against vaccine preventable diseases include diphtheria, pertussis, tetanus, polio, measles, severe form of childhood tuberculosis, hepatitis B, meningitis and pneumonia (Hemophilus influenza type B infections), Japanese encephalitis (JE) in JE endemic districts with introduction of newer vaccines such as rotavirus vaccine, IPV, adult JE vaccine, pneumococcal conjugate vaccine (PCV) and measles-rubella (MR) vaccine.

Mission Indradhanush / Intensified Misson Indradhanush

To strengthen and re-energize the programme and achieve full immunization coverage for all children and pregnant women at a rapid pace, the Government of India launched "**Mission Indradhanush"** in December 2014.

The ultimate goal of Mission Indradhanush is to ensure full immunization with all available vaccines for children up to two years of age and pregnant women. The Government has identified 201 high focus districts across 28 states in the country that have the highest number of partially immunized and unimmunized children.

Intensified Mission Indradhanush (IMI)

To further intensify the immunization programme, Prime Minister launched the **Intensified Mission Indradhanush (IMI)** on October 8, 2017. Through this programme, Government of India aims to reach each and every child up to two years of age and all those pregnant women who have been left uncovered under the routine immunisation programme/UIP.

Intensified Mission Indradhanush has covered low performing areas in the selected districts (high priority districts) and urban areas. Special attention was given to unserved/low coverage pockets in sub-centre and urban slums with migratory population. The focus was also on the urban settlements and cities identified under National Urban Health Mission (NUHM).

Intensified Mission Indradhanush (IMI) 2.0

To boost the routine immunization coverage in the country, Government of India has introduced Intensified Mission Indradhanush 2.0 to ensure reaching the unreached with all available vaccines and accelerate the coverage of children and pregnant women in the identified districts and blocks. The IMI 2.0 aims to achieve targets of full immunization coverage in 272 districts in 27 States and at block level (652 blocks) in Uttar Pradesh and Bihar among hard-to-reach and tribal populations.

Several ministries, including the Ministry of Women and Child Development, Panchayati Raj, Ministry of Urban Development, Ministry of Youth Affairs and others have come together to make the mission a resounding success and support the central government in ensuring the benefits of vaccines.

D. Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states. JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.

ASHA (Accredited Social Health Activist) are effective link between the Government and the pregnant women in l0 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other states and UTs, wherever, AWW ((Anganwadi workers) and TBAs or ASHA like activist has been engaged.

E. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

As India strives towards achieving the Sustainable Development Goals (SDGs) and looks ahead to the post-2015 era, progress in reducing maternal mortality becomes an important goal. In 2007-08, India had 47% institutional deliveries (DLHS 3). However as per latest data of the Rapid Survey on Children (2013- 14), the institutional deliveries in India are 78.7%. In spite of this massive increase in the number of pregnant women coming to institutions for delivery, till date only 61.8% women receive first ANC in first trimester and the coverage of full ANC (provision of 100 IFA tablets, 2 tetanus toxoid injections and minimum 3 ANC visits) is as low as 19.7%. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) was launched in the year 2016 under National Health Mission. The program aims to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women on the 9th of every month. A fixed day ANC is given every month across the country. If the 9th day of the month is a Sunday/ a holiday, then the Clinic is to be organized on the next working day. This service is given in addition to the routine ANC at the health facility. This will improve the quality and coverage of Antenatal Care (ANC) including

diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy.

F. Navjaat Shishu Suraksha Karyakram (NSSK)

NSSK is a programme aimed to train health personnel in basic newborn care and resuscitation, has been launched to address care at birth issues i.e. Prevention of Hypothermia, Prevention of Infection, Early initiation of Breast feeding and Basic Newborn Resuscitation. **Objective i**s to have a trained health personal in basic newborn care and resuscitation at every delivery point. The training is for 2 days and is expected to reduce neonatal mortality significantly in the country.

G. National Programme for Family planning

India was the first country in the world to have launched a National Programme for Family Planning in 1952.

Over the decades, the programme has undergone transformation in terms of policy and actual programme implementation and currently aimed to achieve **population stabilization** goal, promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity.** Under the programme public health sector provides various family planning services at various levels of health system.

"**Mission Pariwar Vikas**" - For improved access to contraceptives and family planning services in high fertility districts spreading over seven high focus states, the Ministry of Health and Family Welfare launched "**Mission Pariwar Vikas**" in 2016. Special focus has been given to 146 high fertility Districts of *Bihar, Uttar Pradesh, Assam, Chhattisgarh, Madhya Pradesh, Rajasthan & Jharkhand,* with an aim to ensure availability of contraceptive methods at all the levels of Health Systems.

1.1.2 Programmes for Communicable Diseases

The diseases, which may spread from one person to another through many routes including vectors, contact, air, water and sexually transmitted, are called communicable diseases. The programs for these diseases are launched on the basis of population affected at National level. The microorganisms that cause these are dynamic, resilient, and well adapted to exploit opportunities for change and spread. Their public health significance in terms of human suffering, deaths, and disability is compounded by the considerable toll they take on economic growth and development.

For many important diseases, either control is not possible because of the lack of effective vaccines and therapeutic drugs, or because of existing drugs are becoming ineffective as antimicrobial resistance increasing.

Following programs were launched to control communicable diseases in India:

A. Integrated Disease Surveillance Programme (IDSP)

GOI launched IDSP with World Bank assistance in 2004 to detect and respond to disease outbreaks. It is intended to identify prevalence of "communicable

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diseases”, detect early warning signals of impending outbreaks, and help initiate an effective response in a timely manner.

IDSP focus on Surveillance of outbreaks and Rapid Response to tackle the problem and action taken on further incidence. Under this surveillance units have been established with Central Surveillance Unit (CSU) at National Centre for Disease Control, Delhi. Surveillance Teams and Rapid Response Teams (RRT) created and trained. Under the project weekly disease surveillance data on epidemic prone disease are being collected from reporting units such as sub centres, PHC/ CHC/DH including government and private sector hospitals and medical colleges. The data are being collected on ‘S’ syndromic; ‘P’ probable; and ‘L’ laboratory formats using standard case definitions.

Media scanning and verification cell was established under IDSP in 2008. It detects and shares media alerts with the concerned states/districts for verification and response. A 24X7-call centre was established in 2008 to receive disease alerts on a Toll-Free telephone number (1075). District laboratories are being strengthened for diagnosis of epidemic prone diseases. Program dealing with surveillance for malaria, acute diarrhoeal diseases, TB, measles, polio, plague, and new emerging diseases like Seasonal Influenza H1N1, Zika Virus, Nipah Virus and Ebola etc.

B. Revised National Tuberculosis Control Programme (RNTCP)

Indian government started RNTCP in 1997 that later covered entire nation by 2006. RNTCP uses the WHO recommended Directly Observed Treatment Short Course (DOTS) strategy and initiated services to address TB/HIV, MDR-TB and to extend RNTCP to the private sector. The Central TB Division developed a case based and web based system called “Nikshay”. This helped with the reporting of all TB cases. GOI set up more than 600 CB-NAAT laboratories, and enhanced their capacity with highly sensitive diagnostic services. CB-NAAT is the name given in India to Cartridge Based Nucleic Acid Amplification tests.

GOI introduced National Strategic Plan 2017-2025 to eliminate TB in India. There are four strategic areas of Detect, Treat, Prevent & Build and five-thrust areas as private sector engagement; plugging the “leak” from the TB care cascade, active case finding among key populations; preventing the development of active TB in people with latent TB, and programmatic management of drug-resistant TB (PMDT).

C. National Leprosy Eradication Programme (NLEP)

The National Leprosy Eradication Programme is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India. The Programme is headed by the Deputy Director of Health Services (Leprosy) under the administrative control of the Directorate General Health Services Govt. of India. While the NLEP strategies and plans are formulated centrally, the programme is implemented by the States/UTs. The Programmes also supported as Partners by the World Health Organization, The International Federation of Anti-leprosy Associations (ILEP) and few other Non-Govt. Organizations.

D. National Vector Borne Disease Control Programme

Launched in year 2003-04, major vector borne diseases covered in this are six diseases viz. malaria, filaria, kala-azar, JE, Dengue and Chikungunya. The activities implemented under this program are integrated vector management, Behaviour change communication, integration with national health mission as the program has captured ASHA and village health sanitation committee. The integrated vector management targeted source reduction of vectors, utilization of gambusia fish for larval control, distribution of insecticide treated bed nets (ITNs) and regular spray with DDT.

E. National AIDS Control Programme (NACP)

The National AIDS Control Programme (NACP), launched in 1992, implemented as a comprehensive programme for prevention and control of HIV/ AIDS in India. Over time, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of People living with HIV (PLHIV). The current phase aims to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well-defined integration process with the objective of optimal utilization of existing NRHM/RCH resources for strengthening NACP services. The program is a global success which is achieved through prevention services high risk groups and general population; expanding IEC; promoting comprehensive care, support and treatment and strengthening management information system.

F. National Viral Hepatitis Control Programme

The National Viral Hepatitis Control Program has been launched by Ministry of Health and Family Welfare, Government of India on the occasion of the World Hepatitis Day, 28th July 2018. It is an integrated initiative for the prevention and control of viral hepatitis in India to achieve Sustainable Development Goal (SDG) 3.3 which aims to ending viral hepatitis by 2030. This is a comprehensive plan covering the entire gamut from Hepatitis A, B, C, D & E, and the whole range from prevention, detection and treatment to mapping treatment outcomes.

G. National Programme on Containment of Anti-Microbial Resistance (AMR)

Antimicrobial resistance in pathogens causing important communicable diseases has become a matter of great public health concern globally including our country. Resistance has emerged even to newer and more potent antimicrobial agents like Carbapenems. The rapid spread of multi-resistant bacteria and the lack of new antibiotics to treat infections caused by these organisms pose a rapidly increasing threat to public and animal health and needs to be tackled if we are to contain the problem and prevent untreatable illness becoming a reality. Government of India has launched a "National Programme on Containment of Antimicrobial Resistance" under the 12th five-year plan (2012-2017).

1.1.3 Programmes for Non Communicable Diseases

As you know, the diseases, which don't spread from one person to another but arise because of multiple factors because of our life style including tobacco chewing, alcohol consumption, sedentary life style and stressful life, are called as non-communicable diseases.

Following programs were launched to control non communicable diseases in India

A. National Tobacco Control Programme (NTCP)

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. India is the 2nd largest producer and consumer of tobacco and a variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, bidis and cigars, a plethora of smokeless forms of consumption exist in the country.

The Government of India has enacted the national tobacco-control legislation namely, "The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" in May, 2003. India also ratified the WHO-Framework Convention on Tobacco Control (WHO-FCTC) in February 2004. Further, in order to facilitate the effective implementation of the Tobacco Control Law, to bring about awareness about the harmful effects of tobacco as well as to fulfill the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Programme (NTCP) in 2007- 08.

B. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS)

The country is experiencing a rapid health transition with a rising burden of Non-Communicable Diseases (NCDs) which are emerging as the leading cause of death in India with considerable loss in potentially productive years (aged 35-64 years) of life. Major modifiable risk factors are raised blood pressure, tobacco use, unhealthy diet, physical inactivity, alcohol consumption, and obesity.

Government of India initiated an integrated National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) under the National Health Mission. The focus of the Programme is on health promotion and prevention, strengthening of infrastructure including human resources, early diagnosis and management and integration with the primary health care system through NCD cells at different levels for optimal operational synergies.

The program focuses on following strategies

- Health promotion and health education advocacy
- Early detection of people with high levels of risk factors through 'opportunistic screening'.

- Capacity building of health systems at all levels to tackle NCDs and improve the quality of care.
- District NCD Programmes will include 'District Health Promotion Centres' and the 'District NCD Cells' for creating awareness on lifestyle related diseases with a focus on the adoption of healthy lifestyles at schools, community, work places etc.

C. National Mental Health Programme

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, to ensure the availability and accessibility of minimum mental healthcare for all, encourage the application of mental health knowledge in general healthcare and in social development; and to promote community participation. It has three components treatment of mentally ill, rehabilitation, prevention and promotion of positive mental health.

District Mental Health Programme has thrust areas including to cover the entire country and be more effective with modernization /streamlining of mental hospitals, upgrading Dept of Psychiatry in Medical Colleges and enhancing the psychiatric content, research and training in the field of community mental health, substance abuse and child adolescent psychiatric clinics. In India, the Mental Health Care Act 2017 was passed on 7 April 2017 and came into force from 7 July 2018.

D. National Programme for Control of Blindness & Visual Impairment (NPCB&VI)

Launched in the year 1976, it was a fully centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020. The objective of the program is to reduce the avoidable blindness through identification and treatment of curable blindness, develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment, Strengthening and up-gradation of identified eye care institutions, developing additional human resources for providing high quality comprehensive Eye Care in all districts of the country, enhance community awareness on eye care and lay stress on preventive measures and secure participation of Voluntary Organizations/Private Practitioners in delivering eye Care services.

E. Pradhan Mantri National Dialysis Programme

End Stage Renal Disease continues to be a result of existing and emerging burden of non-communicable disease. Providing for renal transplant facilities for End Stage Renal Disease (ESRD) patients depends upon availability of infrastructure and robust organ donation system coupled with adequate availability of trained qualified manpower. Within the limited choices, dialysis practically remains the first and in majority of cases, the only choice for ESRD patients.

Every year about 2.2 Lakh new patients of End Stage Renal Disease (ESRD) get added in India resulting in additional demand for 3.4 Crore dialysis every year. With approximately 4950 dialysis centres, largely in the private sector in India, the demand is less than half met with existing infrastructure. Since every Dialysis has an additional expenditure tag of about Rs.2000, it results

in a monthly expenditure for patients to the tune of Rs.3-4 Lakhs annually. Besides, most families have to undertake frequent trips, and often over long distances to access dialysis services incurring heavy travel costs and loss of wages for the patient and family members accompanying the patient. Keeping this in mind, strengthening of District Hospitals by providing affordable multispecialty care including dialysis services in district hospitals would be an important step in this direction. It has also been proposed that Dialysis program be undertaken in Public Private Partnership.

F. National Programme for the Health Care for the Elderly (NPHCE)

With a comparatively young population, India is still poised to become home to the second largest number of older persons in the world. Projection studies indicate that the number of 60+ in India will increase from 100 million in 2013 and to 198 million by 2030. Non-communicable diseases requiring large quantum of health and social care are extremely common in old age, irrespective of socio-economic status. Disabilities resulting from these non-communicable diseases are very frequent which affect functionality compromising the ability to pursue the activities of daily living. The treatment/ management of these chronic diseases is also costly, especially for services like joint replacements, heart surgery, neurosurgical procedures etc.

To overcome this out of bound expenses for elderly whose income decreases post retirement and dependent elderly women, Ministry of Health and Family Welfare launched The National Programme for Health Care for the Elderly (NPHCE). It is a attempt to provide a comprehensive health care set up completely dedicated and tuned to the needs of the elderly.

G. National Programme for Prevention and Control of Deafness (NPPCD)

Hearing loss is the most common sensory deficit in humans today. As per WHO estimates in India, there are approximately 63 million people, who are suffering from significant auditory impairment; this places the estimated prevalence at 6.3% in Indian population. As per NSSO survey, currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss (NSSO, 2001). Of these, a large percentage is children between the ages of 0 to 14 years. With such a large number of hearing-impaired young Indians, it amounts to a severe loss of productivity, both physical and economic. An even larger percentage of our population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss.

Objectives of the programme:

1. To prevent avoidable hearing loss on account of disease or injury.
2. Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness.
3. To medically rehabilitate persons of all age groups, suffering with deafness.
4. To strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, for persons with deafness.

5. To develop institutional capacity for ear care services by providing support for equipment, material and training personnel.

   Long term objective: To prevent and control major causes of hearing impairment and deafness, so as to reduce the total disease burden by 25% of the existing burden by the end of 12th Five Year Plan.

Components of programme

1) Manpower training and development – For prevention, early identification and management of hearing impaired and deafness cases, training would be provided from medical college level specialists (ENT and Audiology) to grass root level workers.

2) Capacity building – for the district hospital, community health centres and primary health centre in respect of ENT/ Audiology infrastructure.

3) Service provision–Early detection and management of hearing and speech impaired cases and rehabilitation, at different levels of health care delivery system. 4) Awareness generation through IEC/BCC activities – for early identification of hearing impaired, especially children so that timely management of such cases is possible and to remove the stigma attached to deafness.

Strategies of programme

1. To strengthen the service delivery for ear care.
2. To develop human resource for ear care services.
3. To promote public awareness through appropriate and effective IEC strategies with special emphasis on prevention of deafness.
4. To develop institutional capacity of the district hospitals, community health centres and primary health centres selected under the Programme.

H. National programme for Prevention & Management of Trauma & Burn Injuries (NPPMT&BI)

The programme have two components - Trauma Care & Burn Injury management. The programme on Trauma care was initiated on pilot mode during 9th FYP to strengthen the Emergency Facilities on National Highways in Government Hospitals. Thereafter, the programme was implemented at a national level during 11th & 12th FYP period along with other technical components such a - National injury Surveillance Centre, Pre-Hospital Trauma Technician Course, trainings for Nurses and Doctors in BLS & ATLS respectively, IEC activities on first-aid/good Samaritan etc. The programme on Burn Injury Management was initiated on pilot mode during the 11th FYP and was implemented at a national level during 12th FYP. Both these components merged into NPPMT&BI after 12th FYP i.e. 2017 into one under the umbrella scheme - ‘Territory Care Programmes’ of Ministry of Health & FW.

I. National Programme for Prevention and Control of Fluorosis (NPPCF)

The National Programme for Prevention and Control of Fluorosis (NPPCF) was a new health initiative during 11th Five Year Plan, initiated in 2008-09 and is being expanded in a phased manner. 100 districts of 17 States were covered during 11th Plan, further 11 districts were taken up during 2013-15 (over 19 States) and additional 84 new districts are to be taken up during the remaining period of 12th plan.

Aim of the programme is to prevent and control Fluorosis cases in the country.

Objectives of the programme:

- To collect, assess and use the baseline survey data of fluorosis of Ministry. of Drinking Water and Sanitation for starting the project;
- Comprehensive management of fluorosis in the selected areas;
- Capacity building for prevention, diagnosis and management of fluorosis cases.

Strategies of programme:

- surveillance of fluorosis in the community;
- capacity building (Human Resource) in the form of training and manpower support; · establishment of diagnostic facilities in the medical hospitals;
- management of fluorosis cases including treatment surgery, rehabilitation
- health education for prevention and control of fluorosis cases.

Activities of programme:

- Community Diagnosis of Fluorosis village/block/cluster wise.
- Facility mapping from prevention, health promotion, diagnostic facilities, reconstructive surgery and medical rehabilitation point of view – village/block/district wise.
- Gap analysis in facilities and organization of physical and financial support for bridging the gaps, as per strategies listed above. (a) Diagnosis of individual cases and providing its management. (b) Public health intervention on the basis of community diagnosis.
- Behaviour changes by IEC.
- Training

J. National oral Health Programme

Government of India has initiated a National Oral Health Programme to provide integrated, comprehensive oral health care in the existing health care facilities with the following objectives.

Objective of programme:

- o To improve the determinants of oral health
- o To reduce morbidity from oral diseases
- o To integrate oral health promotion and preventive services with general health care system
- o To encourage Promotion of Public Private Partnerships (PPP) model for achieving better oral health.

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https://notto.gov.in/WriteReadData/Portal/images/THO-Rules-1995-(Original-Rules).pdf
https://notto.gov.in/WriteReadData/Portal/images/THOA-amendment-2011.pdf
https://notto.gov.in/WriteReadData/Portal/images/THOA-Rules-2014.pdf
https://notto.mohfw.gov.in/about-us.htm

Government of India has decided to assist the State Governments in initiating provision of dental care along with other ongoing health programmes implemented at various levels of the primary health care system. Funding has been made available through the State PIPs for establishment of a dental unit [at district level or below]. This dental unit equipped with necessary trained manpower, equipments including dental chair and support for consumables would be provided to the states through the NOHP. **K. National Programme for Palliative Care (NPPC)**

Palliative care is also known as supportive care which is required in the terminal cases of Cancer, AIDS etc. Effective palliative care requires a multidisciplinary approach that includes the family and makes use of available community resources. It can be provided in tertiary care facilities, in community health centres and even in patients' homes. It improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement.

The Ministry of Health & Family Welfare, Government of India constituted an expert group on Palliative care which submitted its report 'Proposal of Strategies for Palliative Care in India' in November, 2012. No separate budget is allocated for the implementation of National Palliative Care Program. However, the Palliative Care is part of the 'Mission Flexipool' under National Health Mission (NHM).

Beneficiaries:

The terminal cases of Cancer, AIDS etc.

Goal: Availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with the community requirements.

Objectives of programme:

- Improve the capacity to provide palliative care service delivery within government health programs such as the National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Rural Health Mission.
- Refine the legal and regulatory systems and support implementation to ensure access and availability of Opioids for medical and scientific use while maintaining measure for preventing diversion and misuse
- Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long-term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).
- Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting health care system.
- Develop national standards for palliative care services and continuously evolve the design and implementation of the National program to ensure progress towards the vision of the programme.

L. National Iodine Deficiency Disorders Control Programme

Iodine is an essential micro nutrient. It is required at 100-150 micrograms daily for normal human growth and development. The disorders caused due to deficiency of nutritional iodine in the food/diet are called iodine deficiency disorders (IDDs).

Objectives of programme:

- Surveys to assess the magnitude of the Iodine Deficiency Disorders.
- Supply of iodated salt in place of common salt.
- Resurvey after every 5 years to assess the extent of Iodine Deficiency Disorders and the impact of iodised salt.
- Laboratory monitoring of iodated salt and urinary iodine excretion.
- Health education & Publicity.

M. National Organ Tissue and Transplant

The Transplantation of Human Organs Act, 1994 - It provides for the regulation of removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs and for matters connected therewith or incidental thereto. Amendments were carried out in 2011 and 2014.

National Organ and Tissue Transplant Organization (NOTTO) is a national level organization set up under Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. It has following two divisions:

- "National Human Organ and Tissue Removal and Storage Network"
- "National Biomaterial Centre"

"National Human Organ and Tissue Removal and Storage Network" The network will be established initially for Delhi and gradually expanded to include other States and Regions of the country. This division of the NOTTO is the nodal networking agency for Delhi and shall network for Procurement Allocation and Distribution of Organs and Tissues in Delhi.

Function/Activities National Network division of NOTTO would function as apex centre for All India activities of coordination and networking for procurement and distribution of Organs and Tissues and registry of Organs and Tissues Donation and Transplantation in the country. Following are the activities at National and Delhi NCR level:

National Level:

- Lay down policy guidelines and protocols for various functions.
- Network with similar regional and state level organizations.
- All registry data from States and Regions would be compiled and published.
- Creating awareness, promotion of organ donation and transplantation activities.
- Co-ordination from procurement of organs and tissues to transplantation when organ is allocated outside the region.
- Dissemination of information to all concerned organizations, hospitals and individuals.
- Monitoring of transplantation activities in the Regions and States and maintaining data-bank in this regard.
- To assist in data management for organ transplant surveillance & organ transplant and Organ Donor registry.
- Consultancy support on the legal and non-legal aspects of donation and transplantation.
- Coordinate and Organize trainings for various cadre of workers.

For Delhi and NCR

- Maintaining the waiting list of terminally ill patients requiring transplants.
- Networking with transplant centres, retrieval centres and tissue banks.
- Co-ordination for all activities required for procurement of organs and tissues including medico legal aspects.
- Matching of recipients with donors.
- Allocation, Transportation, Storage and Distribution of Organs and Tissues within Delhi and National Capital Territory region.
- Post-transplant patients & living donor follow-up for assessment of graft rejection, survival rates etc.

- Awareness, Advocacy and Training workshops and other activities for promotion of organ donation.

National Biomaterial Centre (National Tissue Bank

The Transplantation of Human Organs (Amendment) Act 2011 has included the component of tissue donation and registration of tissue Banks. It becomes imperative under the changed circumstances to establish National level Tissue Bank to fulfil the demands of tissue transplantation including activities for procurement, storage and fulfil distribution of biomaterials. The main objective is to fill up the gap between 'Demand' and 'Supply' as well as 'Quality Assurance' in the availability of various tissues. Following are the functions of the centre:

- Bone and bone products e.g. deep frozen bone allograft, freeze dried bone allograft, dowel allograft, AAA Bone, Durometer, facialata, fresh frozen human amniotic membrane, high temperature treated board cadaveric joints like knees, hips and shoulders, cadaveric cranium bone graft, loose bone fragment, different types of bovine allograft, used in orthodontics
- Skin graft
- Cornea
- Heart valves and vessels

Other tissues shall be gradually included.

Activities

- Coordination for tissue procurement and distribution
- Donor Tissue Screening
- Removal of Tissues and Storage
- Preservations of Tissue
- Laboratory screening of Tissues
- Tissue Tracking
- Sterilization
- Records maintenance, Data Protection and Confidentiality
- Quality Management in tissues
- Patient Information on tissues
- Development of Guidelines, Protocols and Standard Operating Procedures
- Trainings
- Assisting as per requirement in registration of other Tissue Banks

3.3.4 National Nutritional Programs

Malnutrition has been identified as a major problem in India for which GOI has launched many nutritional programs. These were able to reduce the severity of nutritional problems but not able to eradicate the same.

Following are the important national programs launched by the GOI:

A. National Iodine Deficiency Disorders Control Programme

IDD control programme in India is one of the success stories of public health in the country. The current 91 per cent household level coverage of iodized salt in India, of which 71 per cent is adequately iodized salt, is a big achievement. The components of a national IDD program are use of iodized salt in place of common salt, monitoring and surveillance, manpower training and mass communication. Each state has a IDD control cell which is responsible for checking iodine levels which is expected to be 30 ppm at the production level and 15 ppm at the consumer level. The iodisation of salt is now the most widely used prophylactic public health measure against endemic goitre. Iodised salt is most economical, conventional and effective means of mass prophylaxis in endemic areas.

B. MAA (Mothers' Absolute Affection) Programme for Infant and Young Child Feeding

MAA - "Mother's Absolute Affection" is a nationwide programme of the Ministry of Health and Family Welfare in an attempt to bring undiluted focus on promotion of breastfeeding and provision of counselling services for supporting breastfeeding through health systems. The programme has been named 'MAA' to signify the support a lactating mother requires from family members and at health facilities to breastfeed successfully.

The *goal* is to revitalize efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates.

C. Integrated Child Development Services (ICDS)

Largest nutritional program implemented by Government of India through network of around 2 lac Anganwadi's. Six services as a package with the help of Anganwadi were offered i.e. supplementary nutrition, preschool education, immunization, health checkup, referral services, nutrition, and health education. Supplementary nutrition is provided for 300 days a year. On the spot feeding is done as far as possible at the Anganwadi. All children eligible beneficiaries receive daily ration of 300 calories with 8 to 10 g protein. Severely malnourished children, pregnant and lactating mothers receive daily supplementary nutrition providing 600 calories and 18-20 g protein.

ICDS now consists of six sub-schemes: Anganwadi Services (in place of ICDS), Scheme for Adolescent Girls (earlier known as SABLA), Child Protection Services (earlier known as the Integrated Child Protection Scheme), National Crèche Scheme (earlier called the Rajiv Gandhi National Crèche Scheme), National Nutrition Mission and, Pradhan Mantri Matru Vandana Yojana (PMMVY).

D. Mid-Day Meal Programme

Tamil Nadu was the first to initiate a massive noon meal programme to children. Neither a child that is hungry, nor a child that is ill can be expected to learn.

Realizing this need the Mid-Day Meal (MDM) Scheme was launched in primary schools during 1962-63. Mid-Day Meal improves three areas: 1. School attendance 2. Reduced dropouts 3. A beneficial impact on children's nutrition.

The Central Government supplies the full requirement of food grains for the programme free of cost. For its implementation in rural areas, Panchayats and Nagarpalikas are also involved or setting up of necessary infrastructure for preparing cooked food. For this purpose, NGOs, women's group and parent-teacher councils can be utilized. The total charges for cooking, supervision and kitchen are eligible for assistance under Poverty Alleviation Programme. In several states, supplementary feeding was assisted by food supplies from Cooperation for American Relief Everywhere (CARE) and World Food Programme (WFP). There are problems of administration and quality of food that have affected the programme outcomes.

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Check Your Progress 2

1. Describe national programme for elderly.

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2. Briefly describe the ICDS and Midday meal programmes.

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3.4 PROGRAMMES FOR HEALTH SYSTEMS STRENGTHENING AND QUALITY

Let us learn about programmes which are launched by the government to strengthen the health system to provide universal health coverage to the people of the country. Review the Ayushman Bharat Scheme in Unit 1 of this Block.

A. Ayushman Bharat Yojana

Ayushman Bharat or "Healthy India" is a national initiative launched by Prime Minister as the part of National Health Policy 2017, in order to achieve the vision of Universal Health Coverage (UHC). This initiative has been designed on the lines as to meet SDG and its underlining commitment, which is "leave no one behind".

Ayushman Bharat is an attempt to move from sectoral and segmented approach of health service delivery to a comprehensive need-based health care service. Ayushman Bharat aims to undertake path breaking interventions to holistically address health (covering prevention, promotion and ambulatory care), at primary, secondary and tertiary level.

Ayushman Bharat adopts a continuum of care approach, comprising of two inter-related components, which are:

1. **Establishment of Health and Wellness Centres**–The first component, pertains to creation of 1,50,000 Health and Wellness Centres which will bring health care closer to the homes of the people. These centres will provide Comprehensive Primary Health Care (CPHC), covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

2. **Pradhan Mantri Jan Arogya Yojana (PM-JAY)** –PM-JAY is one significant step towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3).It aims to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health episodes.

Pradhan Mantri Jan Arogya Yojana (PM-JAY) will provide financial protection (Swasthya Suraksha) to 10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries). It will offer a benefit cover of Rs. 500,000 per family per year (on a family floater basis).

PM-JAY will cover medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures. PM-JAY has defined 1,350 medical packages covering surgery, medical and day care treatments including medicines, diagnostics and transport.

To ensure that nobody is left out (especially girl child, women, children and elderly), there will be no cap on family size and age in the Mission. The scheme will be cashless & paperless at public hospitals and empaneled private hospitals. The beneficiaries will not be required to pay any charges for the hospitalization expenses. The benefit also includes pre and post-hospitalization expenses. The scheme is an entitlement based, the beneficiary is decided on the basis of family being figured in SECC database. When fully implemented, the PM-JAY will become the world's largest government funded health protection mission.

Benefits of PM-JAY

Beneficiary Level

- Government provides health insurance cover of up to Rs. 5,00,000 per family per year.
- More than 10.74 crore poor and vulnerable families (approximately 50 crore beneficiaries) covered across the country.
- All families listed in the SECC database as per defined criteria will be covered. No cap on family size and age of members.
- Priority to girl child, women and senior citizens.
- Free treatment available at all public and empaneled private hospitals in times of need.
- Covers secondary and tertiary care hospitalization.
- 1,350 medical packages covering surgery, medical and day care treatments, cost of medicines and diagnostics.
- All pre-existing diseases covered. Hospitals cannot deny treatment.
- Cashless and paperless access to quality health care services.
- Hospitals will not be allowed to charge any additional money from beneficiaries for the treatment.

- Eligible beneficiaries can avail services across India, offering benefit of national portability. Can reach out for information, assistance, complaints and grievances to a 24X7 helpline number - 14555

Health System Level

- Help India progressively achieve Universal Health Coverage (UHC) and Sustainable Development Goals (SDG).
- Ensure improved access and affordability, of quality secondary and tertiary care services through a combination of public hospitals and well measured strategic purchasing of services in health care deficit areas, from private care providers, especially the not-for profit providers.
- Significantly reduce out of pocket expenditure for hospitalization. Mitigate financial risk arising out of catastrophic health episodes and consequent impoverishment for poor and vulnerable families.
- Acting as a steward, align the growth of private sector with public health goals.
- Enhanced used to of evidence-based health care and cost control for improved health outcomes.
- Strengthen public health care systems through infusion of insurance revenues.
- Enable creation of new health infrastructure in rural, remote and under-served areas.
- Increase health expenditure by Government as a percentage of GDP.
- Enhanced patient satisfaction.
- Improved health outcomes.
- Improvement in population-level productivity and efficiency
- Improved quality of life for the population

B. Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) aims at correcting the imbalances in the availability of affordable healthcare facilities in the different parts of the country in general, and augmenting facilities for quality medical education in the under-served States in particular. The scheme was approved in March 2006.

The first phase in the PMSSY has two components - setting up of six institutions in the line of AIIMS; and upgradation of 13 existing Government medical college institutions.

It has been decided to set up 6 AIIMS-like institutions, one each in the States of Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneswar), Rajasthan (Jodhpur) and Uttaranchal (Rishikesh). Each institution will have a 960 bedded hospital (500 beds for the medical college hospital; 300 beds for Speciality/Super Speciality; 100 beds for ICU/Accident trauma; 30 beds for Physical Medicine & Rehabilitation and 30 beds for Ayush) intended to provide healthcare

facilities in 42 Speciality/Super-Speciality disciplines. Medical College will have 100 UG intake besides facilities for imparting PG/doctoral courses in various disciplines, largely based on Medical Council of India (MCI) norms and also nursing college conforming to Nursing Council norms.

In addition to this, 13 existing medical institutions spread over 10 States will also be upgraded. In the second phase of PMSSY, the Government has approved the setting up of two more AIIMS-like institutions, one each in the States of West Bengal and Uttar Pradesh and upgradation of six medical college institutions. In the third phase of PMSSY, it is proposed to upgrade the few other existing medical college institutions.

C. LaQshya' programme (Labour Room Quality Improvement Initiative)

After launch of the National Health Mission (NHM), there has been substantial increase in the number of institutional deliveries. However, this increase in the numbers has not resulted into improvements in the maternal and new-born health indicators. It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery. A transformational change in the processes related to the care during the delivery, which essentially relates to intrapartum and immediate postpartum care, is required to achieve results. Prerequisite of such approach require the health system's preparedness for prompt identification and management of maternal and newborn complications.

'LaQshya' programme of the Ministry of Health and Family Welfare aims at improving quality of care in labour room and maternity Operation Theatre (OT). The goal is to reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.

Strategies:

1. Reorganizing/aligning Labour room & Maternity Operation Theatre layout and workflow as per 'Labour Room Standardization Guidelines' and 'Maternal & Newborn Health Toolkit' issued by the Ministry of Health & Family Welfare, Government of India.
2. Ensuring that at least all government medical college hospitals and high case-load district hospitals have dedicated obstetric HDUs (High Dependency Units) as per GoI MOHFW Guidelines, for managing complicated pregnancies that require life-saving critical care.
3. Ensuring strict adherence to clinical protocols for management and stabilization of the complications before referral to higher centres.

D. National Health Mission

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups.

The Union Cabinet vide its decision dated 1st May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013. NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out-of-pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

The National Health Mission (NHM) encompasses its two Sub-Missions, **The National Rural Health Mission (NRHM)** and **The National Urban Health Mission (NUHM)**. The main programmatic components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs. Continuation of the National Health Mission - with effect from 1st April 2017 to 31st March 2020 has been approved by Cabinet in its meeting dated 21.03.2018.

National Health Mission (NHM) was launched by the government of India in 2013 subsuming the National Rural Health Mission and National Urban Health Mission. It was further extended in March 2018, to continue till March 2020.

The main programme components include Health System Strengthening in rural and urban areas for - Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs.

Six financing components:

(i) NRHM-RCH Flexipool,

(ii) NUHM Flexipool,

(iii) Flexible pool for Communicable disease,

(iv) Flexible pool for non-communicable disease including Injury and Trauma,

(v) Infrastructure Maintenance and

(vi) Family Welfare Central Sector component.

Within the broad national parameters and priorities, states have the flexibility to plan and implement state specific action plans. The state PIP spells out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes. The State PIPs is a combination of the district/city health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district/city plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state. The fund flow from the Central Government to the states/UTs as per the procedure prescribed by the Government of India.

The National Health Mission seeks to ensure the achievement of the following indicators: -

- Reduce MMR to 1/1000 live births
- Reduce IMR to 25/1000 live births
- Reduce TFR to 2.1
- Prevention and reduction of anemia in women aged 15–49 years
- Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
- Reduce household out-of-pocket expenditure on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half
- Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000
- Less than 1 per cent microfilaria prevalence in all districts
- Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Indian Public Health Standards (IPHS)

IPHS are the standards gives guidelines for manpower, services to be provided, equipment and supplies to ensure quality of services to be provided by Sub-Centres/ HWCs, PHC, CHC, District hospital.

Indian Public Health Standards (IPHS) for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals were published in January/ February, 2007. These are used as the reference point for public health care infrastructure planning and up-gradation in the States and UTs. IPHS are a set of uniform standards to improve the quality of health care delivery in the country. The IPHS documents have been revised in 2012 keeping in view the changing protocols of the existing programmes and introduction of new programmes especially for Non-Communicable Diseases. Flexibility is allowed to suit the diverse

needs of the States. IPHS guidelines act as the bench mark for assessing the functional status of health facilities.

IPHS guidelines has been further revised in 2022 and released on 16th April 2022 for District/Sub-District Hospital, Community Health Centres, Health and Wellness Centre-Primary Health Centres and Health and Wellness Centre-Sub Health Centres.

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Standards for Quality

Guidelines and protocols are given for Reproductive and Child Health Care and various other services and clinical protocols, management processes e.g. few guidelines are given below. You can read all the guidelines at the link given below.

Maternal Health Guidelines:

- Training Manual for Medical Method of Abortion (MMA) in early Gestation
- Scope of Practice of Midwifery Educator and Nurse Practitioner Midwife
- Standard Operating Procedures for HIV and Syphilis Screening of Pregnant Women at VHNSD site
- SUMAN - Surakshit Matritva Asshwasan
- JSSK Dietary Guidelines
- Guidelines for Midwifery Services in India

Child Health Guidelines

- Operational Guidelines for establishing hospital-based birth defect sentinel surveillance system
- Guidelines for home-based care of young children
- National Guidelines on Lactation Management centres in public health facilities
- Operational Guidelines on family participatory care for improving newborn health
- Operational Guidelines on strengthening facility based pediatric care
- India Newborn Action Plan
- Operational Guidelines Kangaroo Mother Care 9KMC) and optimal feeding of Low-Birth-Weight Infants
- Operational Guidelines Child Death Review

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https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1182&lid=364

Standard Treatment Protocols and Skill Gaps

Standard treatment and skill protocols and guidelines are provided for RCH services, training etc i.e. Skill Birth Attendance training, Navjat Shishu Suraksha Karyakram (NSSK) and the IMNCI package, the Home-Based Newborn Care (HBNC), and the Emergency Obstetric Care (EmOC) package. These training packages also introduced the standard treatment protocols.

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https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=822&lid=218

https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=819&lid=219

Rogi Kalyan Samiti (RKS) - (Hospital Management Society)

Rogi Kalyan Samities (RKSs) / Hospital Management Committees were introduced in 2005 under the National Rural Health Mission (NRHM) as a forum to improve the functioning and service provision in public health facilities, increase participation and enhance accountability. The National Health Mission (NHM), recognizing the challenges in making RKS effective, reinforces and stresses on the need to strengthen the RKS to oversee governance and serve as an effective Grievance Redressal mechanism at the facility level, with active engagement of Panchayati Raj Institutions (PRIs)/ Urban Local Bodies (ULBs).

Experiences of RKS functioning across the country were mixed. Some States have experience of effective RKS functioning, overall findings from Common Review Missions, monitoring visits, and evaluations indicate that strengthening of RKS is an important area of focus. The findings also show that changes are needed in the governance structures, mandate, functions, revenue models, and above all a better understanding of members of their roles and responsibilities in enabling improved service quality and public accountability.

Objectives of the RKS:

1. Serve as a consultative body to enable active citizen participation for the improvement of patient care and welfare in health facilities.

2. Ensure that essentially no user fees or charges are levied for treatment related to care in pregnancy, delivery, family planning, postpartum period, newborn and care during infancy, or related to childhood malnutrition, national disease control programmes such as Tuberculosis, Malaria, HIV/AIDS, etc. and other government funded programmes which are provided as assurance or service guarantees to those accessing public sector health facilities.

3. Decide on the user fee structure for outpatient and inpatient treatment, which should be displayed in a public place and be set at rates which are minimal and do not become financial barrier to accessing healthcare.

4. Ensure that those patients who are Below Poverty Line, vulnerable and marginalized groups and other groups as may be decided by the state government, do not incur any financial hardship for their treatment, and create mechanisms to cover part/full costs related to transport, diet, and stay of attendant.

5. Develop mechanisms to guard against denial of care to any patient who does not have the ability to pay, especially for services that are being provided at the government's expense.

6. Ensure provision of all non-clinical services and processes such as provisioning of safe drinking water, diet, litter free premises, clean toilets, clean linen, help desks, support for navigation, comfortable, patient waiting halls, security, clear signage systems, and prominent display of Citizens' Charter.

7. Ensure availability of essential drugs and diagnostics, and use of standard treatment protocols/standard operating procedures, patient safety, effective mechanisms for maintaining patient records, periodic review of medical care/deaths.

8. Enable assured health services to all who seek services in the government health facility will allow the hospital in charge to procure essential drugs/ diagnostics not available in the health facility out of the RKS funds. Such local purchases must be made only as a short-term interim measure. The Executive Committee will review such purchases in each meeting and ensure that the rationale for the purchase is justified and that this is not undertaken repeatedly.

9. Promote a culture of user-friendly behaviour amongst service providers and hospital staff for improved patient welfare, responsiveness and satisfaction through inter-alia organizing training/ orientation/ sensitisation workshops periodically.

10. Operationalize a Grievance Redressal Mechanism including a prominent display of the "Charter of Patient Rights" (Annexure I) in the health facility and address complaints promptly thus building confidence of people in the public health facilities.

11. Create mechanisms for enabling feedback from patients, at least at the time of discharge and take timely and appropriate action on such feedback.

12. Undertake special measures to reach the unreached / disadvantaged groups e.g. Campaigns to increase awareness about services available in the facility.

13. Ensure overall facility maintenance to ensure that the facility conforms/ aspires to conform to the Indian Public Health Standards (IPHS).

14. Supervise, maintain, and enable expansion of hospital building for efficient and rational use and management of hospital land and buildings.

15. Facilitate the operationalization of National and State Health programmes as appropriate for the level of the facility.

16. Proactively seek out participation from charitable and religious institutions, community organisations, corporates for cleanliness and upkeep of the facility.
17. Facilitate participation and contribution from the community in cash/ kind (drugs/ equipment/diet), labour including free professional services.

Composition of Governing Body (GB) of RKS at District Hospital

- Chairperson: In-charge Minister/ local MP/ President Zila Panchayat/ District Magistrate
- Member Secretary: Medical Superintendent/Civil Surgeon/Hospital- in-charge
- Members (Ex-officio)

1. District Magistrate, (if not chairperson)
2. Local MLA, in whose jurisdiction the health facility is located
3. Chairperson-Zilla Panchayat
4. Mayor/Chairperson of the Urban Local Body at the District Hospital headquarters
5. Chief Executive Officer, District Panchayat
6. Commissioner/Chief Municipal Officer, Municipal Corporation/ Council.
7. Chief Medical and Health Officer
8. Medical Superintendent In-charge of DH Member Secretary
9. District AYUSH Officer
10. District Officer of Departments of Women and Child Development, Water and Sanitation, Education, Social Welfare, Public Health Engineering Department, Public Works Department, (including Electrical and Mechanical), Electricity Board
11. Individuals/ institutional donors as associate membership

    Nominated Members (names to be recommended by Member Secretary/ District Magistrate)

    - Three eminent citizens, of whom one must be a female, nominated by the Chairperson from the names recommended by Member Secretary/ District Magistrate
    - Two Civil society representatives
    - One Representative of local medical college, if any. The senior specialists in-charge of different wards and DPHN/Nurse Matron should be invited as permanent special invitees

https://nhm.gov.in/New_Updates_2018/communization/RKS/Guidelines_for_Rogi_Kalyan_Samiti https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1078&lid=145#:~:text=2.1%20Rogi%20Kalyan%20Samiti%20(Patient,the%20affairs%20of%20the%20hospital.es_in_Public_Health_Facilities.pdf

Programmes for Quality Improvement

Quality of health care is people's right, though under NHM there has been considerable improvement in an infrastructure, human resource and increased budgetary allocation; quality of services but still there are many issues and challenges.

Quality Assurance (QA) refers to the planned and systematic activities implemented in a quality system, so that quality requirements for facility's service will be fulfilled.

Quality Standard refers to set of requirements, which are essential to ensure that the service delivered, leads to desired outcomes, as well as ensures users' safety, comfort and satisfaction.

The need for improving quality of care in health institutions there is a need to provide support to those concerned with quality assurance in the institutions to ensure efficiency and effectiveness of the services rendered. The improvements in service quality will help in achieving programme objectives, also lead to patient satisfaction and therefore increased utilization of services being offered.

The Quality Improvement and Quality Assurance Cell, the reorganized and modified version of Hospital Development Team was established in 2013 as per the Operational Guidelines for Quality Assurance in Public Health Facilities of Government of India. The primary role of the Quality Improvement and Quality Assurance Cell is to facilitate implementation of Quality Standards at all Public Health Facilities leading to improvement of Quality Health Care with emphasis on RMNCH+A services. NABH and ISO 9001 guidelines and NHM also support quality management system. Details of guidelines and NQAS checklist under National Health Mission can be referred through link provided below.

Ministry of Health & Family Welfare, Government of India in collaboration with state health departments has developed and implementing a comprehensive quality assurance framework for public health facilities and Programs. This Framework comprises of four interrelated approach and activities to achieve patient centric quality system

- Instituting Organizational Framework for Quality
- Defining Standards of Service Delivery and Patient Care
- Continuous Assessment of services against set standards
- Improving Quality through closing gaps and implementing opportunities for Improvement.

The main pillars of Quality Measurement Systems are Quality Standards. These standards have been defined for various level of facilities. The Standards have been grouped within the eight **Areas of Concern** i.e. service provision, patient rights, inputs, support services, clinical services, infection control, quality management and outcomes. Each Standard further has specific **Measurable Elements**. These standards and measurable elements are checked in each department of a health facility through department specific **Checkpoints**. All Checkpoints for a department are collated, and together they form assessment tool called '**Checklist**'. Scored/filled-in Checklists would generate scorecards.

http://www.nrhmorissa.gov.in/frmqaqi.aspx

https://qps.nhsrcindia.org/quality-assurance-framework/operational-guidelines

https://qps.nhsrcindia.org/national-quality-assurance-standards/quality-RNQAS

https://qps.nhsrcindia.org/national-quality-assurance-standards/nqas-Guidelines

https://qps.nhsrcindia.org/national-quality-assurance-standards/nqas-tools

National Digital Health Mission

In a follow-up of the NHP's specific goals for adopting digital technologies, the Ministry of Health and Family Welfare constituted a committee headed by Shri J. Satyanarayana to develop an implementation framework for the National Health Stack. This committee produced the National Digital Health Blueprint (NDHB), laying out the building blocks and an action plan to comprehensively and holistically implement digital health. 1.1.3. Taking forward the NDHB, this document describes the broad context, rationale, scope, and implementation arrangements for a digital ecosystem for healthcare services across the country. Since the implementation is envisioned to be in a mission mode, the initiative is referred to as the National Digital Health Mission (NDHM). 1.2. Vision of National Digital Health Mission 1.2.1. To create a national digital health ecosystem that supports universal health coverage in an efficient, accessible, inclusive, affordable, timely and safe manner, that provides a wide-range of data, information and infrastructure services, duly leveraging open, interoperable, standards based digital systems, and ensures the security, confidentiality and privacy of health-related personal information. 1.3. Objectives of National Digital Health Mission 1.3.1. To strengthen the accessibility and equity of health services, including continuum of care with citizen as the owner of data, in a holistic healthcare programme approach leveraging IT & associated technologies and support the existing health systems in a 'citizen-centric' approach, the NDHM envisages the following specific objectives: 1. To establish state-of-the-art digital health systems, to manage the core digital health data, and the infrastructure required for its seamless exchange; 2. To establish registries at appropriate level to create single source of truth in respect of clinical establishments, healthcare professionals, health workers, drugs and pharmacies; 3. To enforce adoption

of open standards by all national digital health stakeholders; 4. To create a system of personal health records, based on international standards, easily accessible to individuals and healthcare professionals and services providers, based on individual's informed consent; 5. To promote development of enterprise-class health application systems with a special focus on achieving the Sustainable Development Goals for health; 6. To adopt the best principles of cooperative federalism while working with the States and Union Territories for the realization of the vision; 7. To ensure that the healthcare institutions and professionals in the private sector participate actively with public health authorities in the building of the NDHM, through a combination of prescription and promotion; 8. To ensure national portability in the provision of health services; 9. To promote the use of clinical decision support (CDS) systems by health professionals and practitioners; 10. To promote a better management of the health sector leveraging health data analytics and medical research; 11. To provide for enhancing the efficiency and effectiveness of governance at all levels; 12. To support effective steps being taken for ensuring quality of healthcare; and 13. To strengthen existing health information systems, by ensuring their conformity with the defined standards and integration with the proposed NDHM. 1.4. Opportunity for the National Digital Health Mission 1.4.1. The current strong public digital infrastructure—including that related to Aadhaar, Unified Payments Interface and wide reach of the Internet and mobile phones (JAM trinity) —provides a strong platform for establishing the building blocks of NDHM. The existing ability to digitally identify people, doctors, and health facilities, facilitate electronic signatures, ensure non-repudiable contracts, make paperless payments, securely store digital records, and contact people provide opportunities to streamline healthcare information through digital management

https://www.nhp.gov.in/national-digital-health-mission-(ndhm)_pg

Check Your Progress 3

1. Describe AYUSHMAN BHARAT Scheme.

2. Describe LaQshay programme.

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3.5 LET US SUM UP

In this unit you have learnt about health status and health problems in India. Various national health programmes for communicable and non-communicable diseases. National health mission and various guidelines for quality of health care services and National Digital Health Mission.

3.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. As per NITI Aayog, Health Systems for New India Building Blocks 2019, document, India have eliminated polio, guinea worm disease, yaws and maternal and neonatal tetanus. Total Fertility 1 2 Rate (TFR) has reduced sharply from 3.4 in 1992-93 to 2.2 in 2015-16; Maternal Mortality Ratio (MMR level of 130 against a target of 139) and almost succeeded in meeting the Under-5 child mortality target (U5 MR level of 43 against a target of 42). There are significant inter-state and intra-state differentials in health outcomes with socio-economically disadvantaged groups being particularly vulnerable to gaps in access as well as quality of healthcare available to them; the double burden of disease i.e. with a rising burden of non-communicable diseases in addition to the persistence of communicable diseases. India's epidemiological profile and burden of disease still shows that India is in the midst of an epidemiological transition. There is a marked burden of communicable diseases as well as Maternal, Newborn and Child Health (MNCH) related morbidity and mortality, particularly among the poor.

2. Demographic Indicators

Demographic indicators can be divided in two parts

Vital Statistics deals with birth rate, death rate, and natural growth rate, life expectancy at birth, mortality and fertility rates

Population Statistics deals with size and growth of population, sex ratio, density of population etc.

Check Your Progress 2

1. With a comparatively young population, India is still poised to become home to the second largest number of older persons in the world. Projection studies indicate that the number of 60+ in India will increase from 100 million in 2013 and to 198 million by 2030. Non-communicable diseases requiring large quantum of health and social care are extremely common in old age, irrespective of socio-economic status. Disabilities resulting from these non-communicable diseases are very frequent which affect functionality compromising the ability to pursue the activities of daily living. The treatment/management of these chronic diseases is also costly, especially for services like joint replacements, heart surgery, neurosurgical procedures etc.

   To overcome this out of bound expenses for elderly whose income decreases post retirement and dependent elderly women, Ministry of Health and Family Welfare launched The National Programme for Health Care for the Elderly (NPHCE). It is a attempt to provide a comprehensive health care set up completely dedicated and tuned to the needs of the elderly.

2. Tamil Nadu was the first to initiate a massive noon meal programme to children. Neither a child that is hungry, nor a child that is ill can be expected to learn. Realizing this need the Mid-Day Meal (MDM) Scheme was launched in primary schools during 1962-63. Mid-Day Meal improves three areas: 1. School attendance 2. Reduced dropouts 3. A beneficial impact on children's nutrition.

   The Central Government supplies the full requirement of food grains for the programme free of cost. For its implementation in rural areas, Panchayats and Nagarpalikas are also involved or setting up of necessary infrastructure for preparing cooked food. For this purpose NGOs, women's group and parent-teacher councils can be utilized. The total charges for cooking, supervision and kitchen are eligible for assistance under Poverty Alleviation Programme. In several states, supplementary feeding was assisted by food supplies from Cooperation for American Relief Everywhere (CARE) and World Food Programme (WFP). There are problems of administration and quality of food that have affected the programme outcomes.

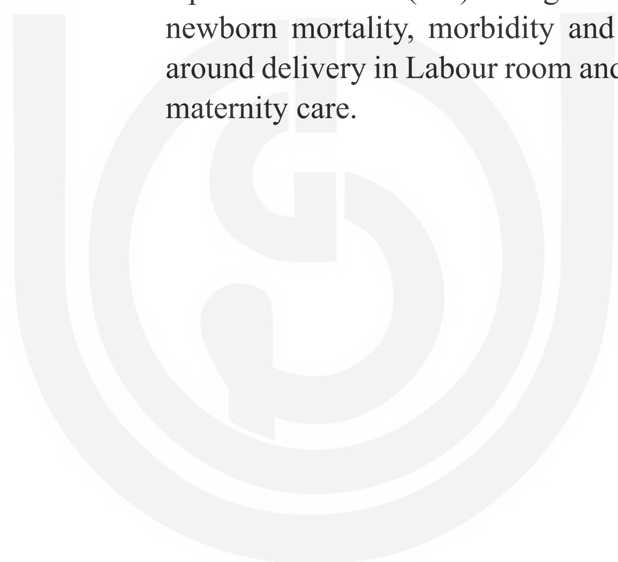
Check Your Progress 3

1. Ayushman Bharat adopts a continuum of care approach, comprising of two inter-related components, which are:

   Establishment of Health and Wellness Centres–The first component, pertains to creation of 1,50,000 Health and Wellness Centres which will bring health care closer to the homes of the people. These centres will provide Comprehensive Primary Health Care (CPHC), covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

   Pradhan Mantri Jan Arogya Yojana (PM-JAY) –PM-JAY is one significant step towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3).It aims to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health episodes.

2. 'LaQshya' programme of the Ministry of Health and Family Welfare aims at improving quality of care in labour room and maternity Operation Theatre (OT). The goal is to reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.



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