2 Chapter

NATIONAL HEALTH MISSION (NHM)

2.1 INTRODUCTION

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 in rural and urban areas, 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 healthcare services that are accountable and responsive to people's needs.

National Rural Health Mission (NRHM): NRHM seeks to provide quality healthcare to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu & Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission is on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality.

National Urban Health Mission (NUHM): NUHM seeks to improve the health status of the urban population particularly urban poor and other vulnerable sections by facilitating their access to quality primary healthcare. NUHM covers all State capitals, district headquarters and other cities/ towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will continue be covered under NRHM.

2.2 MAJOR INITIATIVES UNDER NRHM/NHM

2.2.1 ASHA: More than 9.15 lakh Accredited Social Health Activists (ASHAs) are in place across the country and serve as facilitators, mobilizers and providers of community level care. ASHA is the first port of call in the community especially for marginalized sections of the population, with a focus on women and children. Since 2013, when the National Urban Health Mission was launched, ASHAs are being selected in urban areas as well. Several evaluations and successive Common Review Missions show that the ASHA has been a key figure in contributing to the positive outcomes of increases in institutional delivery, immunization, active role in disease control programmes (Malaria, Kala-azar and Lymphatic filariasis, in particular) and improved breastfeeding and nutrition practices. The majority of States have in place an active training and support system for the ASHA to ensure continuing training, on site field mentoring and performance monitoring.

2.2.2 Rogi Kalyan Samiti/Hospital Management Society is a simple yet effective management structure. This committee is a registered society

whose members act as trustees to manage the affairs of the hospital and is responsible for upkeep of the facilities and ensure provision of better facilities to the patients in the hospital. Financial assistance is provided to these committees through untied fund to undertake activities for patient welfare. 31,763 Rogi Kalyan Samitis (RKS) have been set up involving the community members in almost all District Hospitals (DHs), Sub-District Hospitals (SDHs), Community Health Centres (CHCs) and Primary Health Centres (PHCs) till date.

2.2.3 The Untied Grants to Sub-Centres (SCs) has given a new confidence to our ANMs in the field. The SCs are far better equipped now with blood pressure measuring equipment, haemoglobin (Hb) measuring equipment, stethoscope, weighing machine etc. This has facilitated provision of quality antenatal care and other healthcare services.

2.2.4 The Village Health Sanitation and Nutrition Committee (VHSNC) is an important tool of community empowerment and participation at the grassroots level to address issues of environmental and social determinants. VHSNC membership includes Panchayati Raj representatives, ASHA & other frontline workers and also representatives of the marginalized communities. Untied grants of Rs. 10,000 are provided annually to each VHSNC. Till date, 5.01 lakh VHSNCs have been set up across the country. Capacity building of the VHSNC members with regards to their roles and responsibilities including public service monitoring and planning is being initiated in states.

2.2.5 Healthcare service delivery requires intensive human resource inputs. NHM has attempted to fill the gaps in human resources by providing nearly 1.88 lakh additional health human resources to States including 7,263 GDMOs, 3,355 Specialists, 73,154 ANMs, 40,847 Staff Nurses on contractual basis. NHM has also focused on multi skilling of doctors at strategically located facilities identified by the States e.g. MBBS doctors are trained in Emergency Obstetric Care (EmOC), Life Saving Anaesthesia Skills (LSAS) and Laparoscopic Surgery. Due importance is also being given to capacity building of nursing staff and auxiliary workers such as ANMs. NRHM also supports co-location of AYUSH services in health facilities such as PHCs, CHCs and DHs. A total of 24,890 AYUSH doctors have been deployed in the States with NRHM funding support.

2.2.6 Janani Suraksha Yojana (JSY) aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health facilities. Under the scheme, cash assistance is provided to eligible pregnant women for giving birth in a government health facility. Since the inception of NRHM, 8.55 crore women have benefited under this scheme.

2.2.7 Janani Shishu Suraksha Karyakram (JSSK): Launched on 1st June, 2011, JSSK entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. This marks a shift to an entitlement based approach. The free entitlements include free drugs and consumables, free diagnostics, free diet during stay in the health institutions, free provision of blood, free transport from home to health institution, between health institutions in case of referrals and drop back home and exemption from all kinds of user charges. Similar entitlements are available for all sick infants (up to 1 year of age) accessing public health institutions. All States and Union Territories are implementing this scheme. As per the latest reports received from the States /UTs, 89% pregnant women availed free drugs, 82% free diagnostics, 75% free diet, 49% free home to facility transport and 56.03% free drop back home. For sick infants, 73% sick infants availed free drugs, 40% free diagnostics, 10% sick infants free home to facility transport and 28% free drop back home.

2.2.8 Facility Based Newborn Care: A continuum of newborn care has been established with the launch of home based and facility based newborn care components ensuring that every newborn receives essential care right from the time of birth and first 48 hours at the health facility and then at home during the first 42 days of life. Newborn Care Corners (NBCCs) are established at delivery points to provide essential newborn care at birth, while Special Newborn Care Units (SNCUs) at District Hospital/Medical College and Newborn Stabilization Units (NBSUs) at FRUs provide care for sick newborns. As on June 2015, a total of 14,441 NBCCs, 2,020 NBSUs and 575 SNCUs have been made operational across the country.

2.2.9 National Mobile Medical Units (NMMUs): Support has been provided in 333 out of 672 districts for 1107 Mobile Medical Units (MMUs) under NHM in the country. To increase visibility, awareness and accountability, all Mobile Medical Units (MMUs) have been repositioned as "National Mobile Medical Unit Service" with universal colour and design.

2.2.10 National Ambulance Services (NAS): As on date, 31 States/UTs have the facility where people can dial 108 or 102 telephone number for calling an ambulance. Dial 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims etc. Dial 102 services essentially consist of basic patient transport aimed at the needs of pregnant women and children though other categories are also taking benefit and are not excluded. JSSK entitlements e.g. free transport from home to facility, inter facility transfer in case of referral and drop back for mother and children are the key focus of 102 service. This service can be accessed through a toll free call to a Call Centre.

Presently, 7358 Dial-108, 400 Dial-104 and 7836 Dial-102 Emergency Response Service Vehicles are operational under NHM, besides 6290 empaneled vehicles for transportation of patients, particularly pregnant women and sick infants from home to public health facilities and back.

2.2.11 Upto 33% of NHM funds in High Focus States can be used for infrastructure development. Details of new construction and renovation/ upgradation works undertaken across the country under NHM are as follows:

Facility	New Construction		Renovation/Upgradation	
	Sanctioned	Completed	Sanctioned	Completed
SC	26116	16051	17475	12992
PHC	2148	1362	9280	8196
CHC	637	356	3536	2480
SDH	101	50	671	613
DH	102	69	947	730
Other*	1646	762	938	690
Total	**30750**	**18650**	**32847**	**25701**

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

2.2.12 In order to ensure that enhanced fund allocations to States/UTs and other institutions under the NHM are fully coordinated, managed and utilized, Financial Management Group for NHM (FMG-NHM) has been set up at the State level.

2.2.13 Mainstreaming of AYUSH: Mainstreaming of AYUSH has been taken up by allocating AYUSH facilities in 10042 PHCs, 2732 CHCs, 501 DHs, 5714 health facilities above SC but below block level and 421 health facilities other than CHC at or above block level but below district level.

2.2.14 Launch of National Quality Assurance Framework for Health facilities: To improve quality of healthcare in over 31000 public facilities and provide a clear roadmap to States, Quality Standards for District Hospitals (DHs), CHCs and PHCs under National Quality Assurance Framework were rolled out in November, 2014.

2.2.15 Launch of Kayakalp - an initiative for Award to Public Health facilities: Kayakalp-initiative has been launched to promote cleanliness, hygiene and infection control practices in public health facilities. Under this initiative public healthcare facilities shall be appraised and such public healthcare facilities that show exemplary performance meeting standards of protocols of cleanliness, hygiene and infection control will receive awards and commendation. Further, Swachhta Guidelines to promote Cleanliness, Hygiene and Infection Control Practices in public health facilities were released on 15th May, 2015. The Guidelines provide details on the planning, frequency, methods, monitoring etc. with regard to Swachhta in public health facilities.

2.2.16 Free Drugs Service Initiative: An incentive of up to 5% additional funding (over and above the normal allocation of the state) under the NHM is provided to those States that introduce free medicines scheme. Under the NHM-Free Drug Service Initiative, substantial funding is available to States for provision of free drugs subject to States/UTs meeting certain specified conditions. Detailed Operational Guidelines for NHM- Free Drugs Service Initiative was released to the States on 2nd July 2015 and is available on NHM website.

2.2.17 Free Diagnostics Service Initiative: The NHM- Free Diagnostics Service Initiative was launched in 2013 to provide free essential diagnostic services at public health facilities under which substantial funding was provided to States within their resource envelope. The Operational Guidelines on Free Diagnostics Service Initiative have been developed by the Central Government and shared on 2nd July, 2015 with the States various mechanisms adopted for providing free essential diagnostic services which include:-

- Strengthening of the existing systems in public health facilities such as Lab infrastructure, provision of Lab Technician, equipment, etc.;
- Out Sourcing of High Cost -low frequency diagnostic services and
- Contracting in of services of essential Human Resources (e.g. Radiologist, Lab Technician) on a need basis.

2.2.18 Bio Medical Equipment Maintenance: States have been asked to plan interventions for comprehensive equipment maintenance for all functional medical equipment/machinery. The Ministry has circulated model contract documents for guidance. Support for comprehensive equipment maintenance for all functional medical equipment/machinery is intended to ensure optimum utilisation of medical equipment.

2.2.19 Comprehensive Primary Healthcare: Primary healthcare including preventive and promotive healthcare enables early detection

and prompt treatment and serves a gate-keeping function to secondary and tertiary care and also reduces the cost of care. In December 2014, the Ministry of Health and Family Welfare constituted a Task Force to provide a report on roll out of comprehensive Primary Healthcare. The Committee was charged with identifying current challenges to rolling out comprehensive primary health care, finalizing components of service delivery, clarifying the institutional structures and service organizations, developing guidelines for the PHC team and coordinating with other Task Forces set up by the Ministry of Health and Family Welfare working on Human Resources for Health and Developing Standard Treatment Guidelines. Nine areas for action to make primary healthcare comprehensive and universal are proposed. They include:

- Strengthen Institutional Structures and Organization of Primary Healthcare Services;
- Improve access to technologies, drugs and diagnostics for comprehensive Primary Healthcare;
- Increase utilization of Information, Communication and Technology (ICT) - empowering patients and providers;
- Promote Continuity of care - making care patient centric;
- Enhance Quality of Care;
- Focus on Social Determinants of Health;
- Emphasize Community Participation and Address Equity Concerns in Health;
- Develop a Human Resource Policy to support primary healthcare;
- Strengthen Governance including financing, partnerships and accountability and
- States are also offered support through the PIPs of the NHM to strengthen existing sub centers.

2.2.20 Kilkari: To create proper awareness among pregnant women, parents of children and field workers about the importance of Ante-Natal Care (ANC), Institutional Delivery, Post-Natal Care (PNC) and Immunization, it was decided to implement the Kilkari and Mobile Academy services across India in phased manner. In the first phase Kilkari would be launched in 6 States viz. Uttarakhand, Jharkhand, Uttar Pradesh, Odisha, Rajasthan High Priority Districts (HPDs) & Madhya Pradesh High Priority Districts (HPDs). The Mobile Academy would be launched in 4 States viz. Uttarakhand, Jharkhand, Rajasthan & Madhya Pradesh.

Kilkari is an Interactive Voice Response (IVR) based mobile service that delivers time-sensitive audio messages (Voice Call) about pregnancy and child health directly to the mobile phones of pregnant women, mothers of young children and their families. The service covers the critical time period–where the most maternal/infant deaths occur from the 4th month of pregnancy until the child is one year old. Families which subscribe to the service receive one pre-recorded system generated call per week. Each call will be 2 minutes in length and serve as reminders for what the family should be doing that week depending on woman's stage of pregnancy or the child's age. Kilkari services will be available to states in regional dialect too.

2.2.21 Mobile Academy is an anytime, anywhere audio training course on interpersonal communication skills that the ASHA can access from her mobile phone. It gives ASHAs tips on how to convince families to adopt priority RMNCH behaviors, while refreshing her existing knowledge. The course is 240 minutes long and consists of 11 chapters with 4 lessons each. At the end of each chapter, there is a quiz for them the ANM/ASHAs who pass the course will be provided with a certificate.

2.2.22 Launch of Nationwide Anti-TB drug resistance survey: Drug resistance survey for 13 anti TB drugs was launched to provide a better estimate on the burden of Multi-Drug Resistant Tuberculosis within the community. This is the biggest ever such survey in the world with a sample size of 5214 patients. Results are expected by 2016.

2.2.23 Kala Azar Elimination Plan: To reduce the annual incidence of Kala-azar to less than one per 10,000 population at block PHC level by the end of 2015, Kala-azar elimination Plan was rolled out, which inter-alia includes:

- o New thrust areas for UP, Bihar, West Bengal and Jharkhand;
- o New Action Plan to include active search, new drug regimen, coordinated Indoor Residual Spray (IRS) etc. and
- o Use of new non-invasive diagnostic kit.

2.2.24 Criteria for incentives to States under the NHM were revised. States that show improved progress made on key Outcomes/Outputs such as IMR, MMR, Immunization, number and proportion of quality certified health facilities etc. will be able to receive additional funds as incentives.

2.3 NATIONAL URBAN HEALTH MISSION (NUHM)

2.3.1 National Urban Health Mission (NUHM) was approved by the Union Cabinet on 1st May, 2013 as a sub-mission under an overarching National Health Mission (NHM) for providing equitable and quality primary healthcare services to the urban population with special focus on slum and vulnerable sections of the society. NUHM seeks to improve the health status by facilitating their access to quality primary healthcare.

The Centre-State funding pattern is 60:40 for all the States w.e.f. FY 2015-16, except the North-Eastern States and other hilly States viz. Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for which the Centre-State funding pattern is 90:10. In the case of UTs the entire NUHM programme is fully funded by Central Government.

Under NUHM, support is provided to the States/ UTs for strengthening and upgradation of existing infrastructure including Urban Family Welfare Centres (UFWCs), Urban Health Posts and Primary Health Centres and HR augmentation for providing comprehensive primary healthcare services.

Urban Health programme is being implemented through Urban Local Bodies (ULBs), in seven metropolitan cities, viz., Mumbai, New Delhi, Chennai, Kolkata, Hyderabad, Bengaluru and Ahmedabad. For the remaining cities, the State Health department decides whether the Urban Health Programme is to be implemented through health department or any other urban local body.

Under the Programme the support is being provided by the Asian Development Bank (ADB) based on progress related to certain indicators.

2.3.2 Service Delivery Infrastructure

NUHM envisages setting up of service delivery infrastructure which is largely absent in cities/ towns to specially address the healthcare needs of urban poor and provides:-

- **Urban–Primary Health Centre (U-PHC):** New U-PHCs are established as per gap analysis, as per norm of one U-PHC for approximately 50,000 urban populations. The new U-PHCs are preferably located within or near a slum for providing preventive, promotive and OPD (consultation), basic lab diagnosis, drug/contraceptive dispensing services, apart from counseling for all communicable and non- communicable diseases.

- **Urban-Community Health Centre (U-CHC) and Referral Hospitals:** 30-50 bedded U-CHCs are established for providing inpatient care. U-CHCs are set up in cities with a population of above 5 lakhs.
- **Outreach services:** NUHM also support engagement of ANMs for conducting outreach services for targeted groups particularly slum dwellers and the vulnerable population for providing preventive and promotive healthcare services at the household and community level.

2.3.3 Community Process

Mahila Arogya Samiti (MAS): One Mahila Arogya Samiti will covers 250-1,000 beneficiaries and between 50-100 households and act as community based peer education group in slums. So far 40132 MAS have been formed to facilitate community mobilization, monitoring and referral with focus on preventive and promotive care, facilitating access to identified facilities and management of grants received.

ASHA/Link Worker: One frontline community worker ASHA serves as an effective and demand–generating link between the health facility and the urban slum population. Each link worker/ASHA will have a well-defined service area of about 1000-2,500 beneficiaries/between 200-500 households based on spatial consideration. However, the states would have the flexibility to either engage ASHA or entrust her responsibilities to MAS. So far 31899 ASHAs have been identified.

2.3.4 Progress so far

An outlay of Rs.1924.43 crore had been allocated for financial year 2014-15, out of which Rs.1345.82 crore was released to 34 States/UTs and in FY 2015-16, an amount of Rs.1386 crore was allocated for NUHM, out of which Rs.570.44 crore has been released to 22 States/UTs till the end of 3rd Quarter. The statement of fund allocated and released in FY 2014-15 and FY 2015-16 is at **Appendix - I**.

Since the launch of the Programme in Financial Year 2013-14, support has been provided for strengthening of 4325 facilities in urban areas, construction of 762 new UPHCs and 51 new UCHCs. The Human resources under the programme includes 2,763 Medical Officers, 262 Specialists, 18,562 ANMs, 7,597 Staff Nurses, 3,503 Pharmacists and 3,875 Lab Technicians, 62,803 ASHAs and 98,128 MAS which have been approved under the programme.

So far the following guidelines have been shared with the States/UTs viz. NUHM Implementation Framework, Community Process Guidelines in the Urban context, Induction Module for Mahila Arogya Samiti (MAS), Induction Module for ASHAs in Urban areas, ToR for engagement of Public Health Manager, Outreach Guidelines and Quality Standards for U-PHC.

2.4 FUNDING PATTERN FOR THE PROGRAMMES UNDER NATIONAL HEALTH MISSION (NHM)

The National Health Mission (NHM) is a major instrument of financing and support to the States to strengthen public health systems and healthcare delivery. This financing to the States are based on the State's Programme Implementation Plan (PIP). The State PIPs comprises of following major pools:

Part I NRHM RCH Flexi pool

Part II NUHM Flexi pool

Part III Flexible pool for Communicable Disease

Part IV Flexible pool for Non communicable Disease, Injury and Trauma

Part V Infrastructure Maintenance

The Budgetary Outlays & Expenditure of NHM for the Financial Years 2012-13, 2013-14, 2014-15 and 2015-16 are as follows:

Year	Approved Plan Budgetary Outlay (BE) (Rs. in crore)	Revised estimate (R. E.) (Rs. in crore)	Plan Expenditure (Rs. in crore)
2012-13	20,542.00	17,000.00	16,762.77
2013-14	20,999.00	18,100.00	18,211.45
2014-15	21,912.00	17,627.82	18,037.99
2015-16*	18,295.00	-	14,810.28
Total	**81,748.00**	**52,727.82**	**67,822.49**

** The Plan Expenditure for the 2015-16 is up to 31/12/2015 and is provisional.*

2.5 IMPROVEMENT IN THE QUALITY OF HEALTHCARE

The improvement in the status of healthcare over the years in respect of some of the basic demographic indicators is given in Table-1. The Crude Birth Rate (CBR) has declined from 40.8 in 1951 to 29.5 in 1991 and further to 21.4 in 2013. Similarly there has been a sharp decline in Crude Death Rate (CDR) which has decreased from 25.1 in 1951 to 9.8 in 1991 and further to 7.0 in 2013. Also, the Total Fertility Rate (average number of children likely to be born to a woman aged 15-49 years) has decreased from 6.0 in 1951 to 2.3 in the year 2013 as per the estimates from the Sample Registration System (SRS) of Registrar General & Census Commissioner, India (RGI), Ministry of Home Affairs.

The Maternal Mortality Ratio has also declined from 437 per one lakh live births in 1992–93 to 167 in 2011-13 according to the SRS Report brought out by RGI. Infant Mortality Rate, which was 110 in 1981, has declined to 40 per 1000 live births in 2013.

Table-1: Achievements of Health & Family Welfare Programme

Sl. No.	Parameter	1951	1981	1991	2001	2013 (latest available)
1	Crude Birth Rate (Per 1000 Population)	40.8	33.9	29.5	25.4	21.4
2	Crude Death Rate (Per 1000 Population)	25.1	12.5	9.8	8.4	7.0
3	Total Fertility Rate (Per women)	6.0	4.5	3.6	3.1	2.3 (2013)
4	Maternal Mortality Ratio (Per 100,000 live births)	NA	NA	437 (1992-93) NFHS	301 (2001-03) S.R.S.	167 (2011-13) S.R.S.
5	Infant Mortality Rate (Per 1000 live births)	146 (1951-61)	110	80	66	40
6	Expectation of life at Birth	-	55.4 (1981-85) Mid-year 1983	59.4 (1989-93) Mid-year 1991	63.4 (1999-03) Mid-year-2001	67.5 (2009-13) Mid-year 2011

Source: Office of Registrar General & Census Commissioner, India, Ministry of Home Affairs.

2.6 HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS)

Health Management Information System (HMIS) is a web-based monitoring system that has been put in place by the Ministry to monitor health programmes under National Health Mission and provide key inputs for policy formulation and interventions.

It was launched in October 2008 with district wise data uploading on HMIS portal. To make HMIS more robust and effective and in order to facilitate local level monitoring, all States/UTs were requested to shift to "facility based reporting" from April, 2011. At present, 672 districts are reporting facility wise data while Brihan Mumbai and Kolkata are uploading district consolidated figure on the HMIS web portal. The data is being made available to various stakeholders in the form of standard & customized reports, factsheets, score-cards etc. HMIS data is widely used by the Central/State Government officials for monitoring and supervision purposes.

Periodic review meetings, workshops and trainings are conducted to discuss data quality issues and latest developments including new reports, features available on the portal etc. To enhance the analytical capabilities of National and State level users, they have been provided SAS WRS and SAS-VDD software. GIS enabled HMIS application is also ready to be launched soon.

2.7 SURVEYS AND EVALUATION ACTIVITIES

2.7.1 Large Scale Surveys: The Ministry has been conducting large scale surveys periodically to assess the level and impact of health interventions. These surveys include National Family Health Survey (NFHS), District Level Household Survey (DLHS), Annual Health Survey (AHS) etc. The main aim of these surveys is to assess the impact of the health programmes and to generate various health related indicators at the District, State and National level.

2.7.2 District Level Household Survey (DLHS): The District Level Household and Facility Surveys were initiated with a view to assess the utilization of services provided by health facilities and people's perception about the quality of services. DLHS is designed to provide district level estimates on important indicators on maternal and child health, family planning and other reproductive health services and also important interventions of National Rural Health Mission (NRHM). DLHS-4 (2012-13), the fourth in the series of the district surveys was preceded by DLHS-1 in 1998-99, DLHS- 2 in 2002-04 and DLHS -3 in 2007-08.

The fourth round of DLHS was taken up (household and facility survey in non- AHS States and facility survey in AHS States) with the objective of estimating reliable indicators of population, maternal & child health and family planning at District and State level. As a part of the Survey, a number of Clinical Anthropometric and Biochemical (CAB) tests are carried out to produce district level estimates for nutritional status and prevalence of certain life style disorders. The major constituents of the CAB component are height, weight and blood pressure, estimation of haemoglobin (Hb), blood sugar and test for iodine content in the salt used by households. The District/State Reports for 18 States and Facility Survey reports for 9 AHS States were disseminated in 2015.

2.7.3 Annual Health Survey (AHS): Three rounds of Annual Health Survey (AHS) were conducted for providing district level estimates on major programme indicators, besides estimates of impact indicators like Total Fertility Rate (TFR), Infant Mortality Rate (IMR), Under Five Mortality Rate (U5MR), Maternal Mortality Ratio (MMR- at Commissionerate level), etc. Office of RGI was the nodal organization for conducting AHS.

Under the AHS, 284 districts in the 8 EAG States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Rajasthan, Odisha, Uttar Pradesh and Uttarakhand) and Assam were covered. The AHS was conducted during 2010-11, 2011-12 and 2012-13 and the results were published earlier. Further, under the AHS, the component on Clinical, Anthropometric and Bio-chemical (CAB) tests were conducted in 2014 to collect data on height & weight measurement, blood test for anaemia and sugar, blood pressure measurement and testing of iodine in the salt used by households. The results of CAB survey were published in 2015 in the form of factsheets.

2.7.4 National Family Health Survey (NFHS): Three rounds of National Family Health Surveys were carried out in 1992-93 (NFHS-1), 1998-99 (NFHS-2) and 2005-06 (NFHS-3) under the stewardship of the Ministry of Health and Family Welfare, Government of India, with the International Institute for Population Sciences (IIPS), Mumbai, serving as the nodal agency for conducting the survey. The Ministry has decided to integrate all surveys and to conduct one survey (i.e. National Family Health Survey) to provide district and above level data with a periodicity of three years. Accordingly the Ministry has initiated the activities related to the fourth round of the Survey (NFHS-4) which will provide essential data on Health and Family Welfare.

The field work of NFHS-4 is being taken up in two phases covering 17 States/Regions in Phase-1 and 15 States/Regions in Phase-2. The main survey field work in 16 States/Regions covered in first phase has been completed and in the case of remaining one State viz. Assam, the main survey field work is under progress. The field work (mapping and listing of households) is in progress in 15 States/Regions covered in second phase.

2.7.5 Regional Evaluation Teams (RETs): There are 8 Regional Evaluation Teams (RETs) located in the Regional Offices of the Ministry. Out of them, RET Pune is defunct at present due to lack of staff. The RETs undertake evaluation of the NHM activities including Reproductive and Child Health Programme (RCH) on a sample basis by visiting the selected districts and interviewing the beneficiaries. These teams generally visit two adjoining districts in a State every month and see the functioning of health facilities and carry out sample check of the beneficiaries to ascertain whether they have actually received the services. Reports of the RETs are sent to the States/UTs for taking corrective measures on issues highlighted in the reports. As on October, 2015, 46 districts have been visited by the RETs during 2015-16.

2.8 POPULATION RESEARCH CENTRES (PRCs)

The Ministry has established 18 Population Research Centres (PRCs) in various institutions in the country with a view to carry out research on various topics pertaining to Population Stabilization, Demographic and other Health related programmes. While 12 of these PRCs are located in Universities, the remaining six are located in the Institutes of national repute. The Ministry of Health and Family Welfare provide 100% financial grant-in-aid to all PRCs on year to year basis for incurring expenditure towards salaries of staff, books and journals, TA/DA, data processing/stationary/contingency etc., and other infrastructure requirement.

Annual Reports of all the 18 PRCs along with the audited statement of accounts are laid on the tables of both the Houses of Parliament. During 2014-15, the PRCs have completed 100 research studies and monitoring of Programme Implementation Plan of National Health Mission (NHM) in respect of 213 districts. During 2015-16, till 15, November 2015,

the PRCs have completed 22 research studies and monitoring of NHM Programme Implementation Plan in 102 districts.

2.9 NATIONAL HEALTH SYSTEM RESOURCE CENTRE (NHSRC)

The National Health System Resource Centre (NHSRC) was set up in 2007, as a technical support and knowledge management agency for the National Rural Health Mission (NRHM). The Regional Resource Centre, North East (RRC-NE) a branch of the NHSRC serves as the technical support organization for the States of the North East.

2.10 SUPPORT TO NGO

Under the National Health Mission, the NGO guidelines have been revised with effect from 01.04.2014. As per these revised guidelines, the Central Government will support the NGOs only as per the proposals of States through their Programme Implementation Plans (PIPs).

Appendix - I

Financial statement showing Allocation and Release of FY 2014-15 and FY 2015-16 [NUHM]

(Rs. in crore)

Sl. No.	Name of State/UT	2014-15		2015-16	
		Allocation	Released	Allocation	Released upto 3rd quarter
1	Andhra Pradesh	89.96	57.55	92.16	43.14
2	Bihar	40.86	16.93	32.28	16.14
3	Chhattisgarh	32.13	24.30	27.98	13.99
4	Goa	2.70	1.47	0.98	--
5	Gujarat	110.58	77.30	65.31	48.98
6	Haryana	51.07	38.63	32.04	24.03
7	Himachal Pradesh	1.43	1.08	1.08	0.81
8	Jammu & Kashmir	12.71	8.42	12.02	11.22
9	Jharkhand	27.97	16.50	17.34	13.01
10	Karnataka	90.52	64.68	74.80	--
11	Kerala	30.50	23.07	35.55	26.66
12	Madhya Pradesh	104.06	78.71	88.17	63.98
13	Maharashtra	318.52	240.92	214.24	--
14	Odisha	31.37	23.73	26.41	24.59
15	Punjab	51.65	39.07	31.96	--
16	Rajasthan	74.91	56.66	48.70	48.70
17	Tamil Nadu	156.38	118.28	111.99	111.99
18	Telangana	64.29	48.63	65.87	49.40
19	Uttar Pradesh	200.97	152.01	136.55	--
20	Uttarakhand	12.84	9.71	9.79	4.90
21	West Bengal	160.69	121.55	115.53	--
22	Arunachal Pradesh	5.37	0.94	1.61	--
23	Assam	99.53	33.18	36.34	--
24	Manipur	9.71	2.11	3.77	--

(Rs. in crore)

Sl. No.	Name of State/UT	2014-15		2015-16	
		Allocation	Released	Allocation	Released upto 3rd quarter
25	Meghalaya	17.56	13.17	7.79	--
26	Mizoram	10.55	4.10	8.85	4.20
27	Nagaland	8.19	2.53	8.65	4.07
28	Tripura	10.75	1.84	13.92	1.77
29	Sikkim	1.34	1.00	3.07	--
30	Delhi	82.50	62.41	54.03	54.03
31	Puducherry	3.66	2.21	3.33	1.67
32	A & N Islands	0.74	0.47	0.38	--
33	Chandigarh	6.47	2.19	3.10	3.08
34	Dadra & Nagar Haveli	0.90	0.47	0.21	--
35	Daman & Diu	0.83	0.00	0.20	0.08
36	Lakshadweep	0.22	--	--	--
	Total	**1924.43**	**1345.82**	**1386.00**	**570.44**


unicef
MEDIA LAUNCH OF
WEEKLY IRON & FOLIC ACID SUPPLEMENTATION (WIFS)
AWARENESS CAMPAIGN
Dr. Jagdish Prasad
BHANU PRATAP SHARMA
SHRI J. P. NADDA
PRIYANKA CHOPRA


पोलिओचा समूळ नायनाट करण्यासाठी
असे लुळेपणाचे रुग्ण
डॉक्टरांना कळवून
सहकार्य करा.