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# Introduction

1. India has registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and maternal mortality over the last few decades. In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and childbirth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many States and regions is in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. India is in the midst of an epidemiological and demographic transition - the chronic disease burden and also a decline in mortality and fertility rates and consequent ageing of the population. An estimated 5 million people in the country are living with HIV/AIDS which has the real potential to undermine the health and developmental gains India has made since its independence. Non-communicable diseases such as cardio-vascular diseases, cancer, blindness, mental illness and tobacco use related illnesses have imposed the chronic diseases burden on the already over-stretched healthcare system in the country. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on the poor, women, scheduled castes and tribes especially those who live in the rural areas of the country. The inequity is also reflected in the availability of public resources between the advanced and less developed States.

2. During the last 50 years of independence, the rural primary public health infrastructure has recorded an impressive increase. The network consists of 1,45,000 Sub-centres, 23,109 Primary

Health Centres and 3222 Community Health Centres, catering to a population of 5,000, 30,000 and 1,00,000 respectively (and 3000, 20,000 and 80,000 population in tribal and desert areas). In fact, the country has achieved impressive demographic transition through the decline of Crude Birth Rate, Crude Death Rate, Total Fertility Rate and Infant Mortality Rate. However, the existence of sharp disparities in key public health indicators and inequities, even among the better performing States, pose challenges to the development of India's health sector.

2.1 Despite the impressive public health infrastructure, it is a cause of concern that only about 20% services are being provided by the public health sector, while the private sector provides almost 80% of the healthcare services. Studies demonstrate that curative services largely favour the rich over the poor. Only 1/10<sup>th</sup> of the population is covered by any form of Health Insurance. It is estimated that health related expenditure is the major cause for rural indebtedness and out of pocket expenditure on hospital care causes almost 25% of hospitalized Indians to fall below poverty line.

2.2 The National Common Minimum Programme (NCMP) of the United Progressive Alliance (UPA) Government identifies Health as an important thrust area. At 0.9% of GDP, which translates into Rs.200/- per capita, the total investment on Health in India is among the lowest in the family of nations. In fact, the allocations for Health have decreased from the level of 1.3% of GDP in 1990 to 0.9% in 1999. Even this Outlay is not being effectively utilized and access to healthcare services is not uniform due to inefficiencies of the public health system, poor maintenance of public health infrastructure, manpower problems, lack of accountability, unregulated private sector health

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costs and multiplicity of vertical programmes, which dissipate energies at the operational levels.

2.3 Major initiatives were undertaken in the health sector during the current year by the Government to increase public spending on health and to effectively translate the objective of providing effective, affordable and accessible healthcare to the rural poor. The Government is committed to raise public spending on health from the current 0.9% to 2-3% GDP over the next five years with focus on primary healthcare. In line with this objective, the plan allocation for 2005-06 was Rs.2908 crore as against the budgeted estimates of Rs.2208 crore for 2004-05. A further step up is visualized in the allocation budgeted for 2006-07 at Rs.3328 crore.

3. During the Tenth Five Year plan (2002-2007) the main approach of the family welfare programme is to assess the needs for reproductive and child health and provide need based client centered and demand driven RCH care. This is being supplemented with strengthening of infrastructure for service delivery and bridging the gap in essential infrastructure and manpower.

4. Govt. of India brought out the National Population Policy, 2000 which provides a policy framework for advancing goals and prioritization strategies during the next decade to meet the reproductive and child health need of the people of India and to achieve required replacement levels of Total Fertility Rate (TFR) by 2010. The expected levels of achievement by the year 2010 include :-

- a) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure;
- b) Reduce IMR to below 30 per 1000 live births.
- c) Reduce MMR to below 100 per 100000 live births.
- d) Achieve universal immunization of children against all vaccine preventable diseases.
- e) Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons.

- f) Achieve counseling and services for fertility regulation and contraception with a wide basket of choices
- g) Integrate Indian System of Medicine (ISM) in the provision of RCH services and in reaching out to households; and
- h) Promote vigorously the small family norms to achieve replacement level of TFR.

## 5. NATIONAL RURAL HEALTH MISSION (NRHM)

5.1 The National Rural Health Mission (NRHM) has been launched on 12.4.05 by Hon'ble Prime Minister and is being operationalized from the current financial year 2005-06 throughout the country, with special focus on 18 states which includes 8 Empowered Action Group States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttaranchal, Orissa and Rajasthan), 8 North-East States, Himachal Pradesh and Jammu & Kashmir.

5.2 The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care facilities, especially, to the poor and vulnerable sections of the population. It also aims at bridging the gap in Rural Health care services through creation of a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources. The NRHM further aims to provide overarching umbrella to the existing programmes of Health and Family Welfare including RCH-II, Malaria, Blindness, Iodine deficiency, Filariasis, Kala Azar, T.B., Leprosy and Integrated Disease Surveillance. Further, it addresses the issue of health in the context of sector-wide approach addressing sanitation and hygiene, nutrition and safe drinking water as basic determinants of good health in order to have greater convergence among the related social sector Departments i.e. AYUSH, Women & Child Development, Sanitation, Elementary Education, Panchayati Raj and Rural

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Development. At the district and village level, the institutional framework of the Total Sanitation Campaign will be integrated with the District Health Mission and Village Health & Sanitation Committee.

**5.3** The Mission further seeks to build greater ownership of the programme among the community through involvement of Panchayati Raj Institutions, NGOs and other stakeholders at National, State, District and Sub-District levels to achieve the goals of National Population Policy 2000 and National Health Policy. For better management of the mandate of NRHM, the existing two Departments namely Health and Family Welfare of the Ministry have been merged and the same is being emulated in all the states. To assess the impact of increased investment in health on poverty reduction and overall economic development, a National Commission on Macroeconomics and Health had been set up in March, 2004. The Commission has since submitted its report, which is presently under examination in the Ministry.

**5.4** The Outlay of the National Rural Health Mission for 2005-06 is Rs.6731.00 crore. The Departments of Health and Family Welfare have been merged into a single Department at Government of India level to implement the Mission. The strategy of the Mission has been painstakingly drawn up after several rounds of Stakeholder consultations. Task Forces have been set up to advise on strategic inputs and operational modalities. While sharing the Mission Guidelines, the States have been advised to adapt these strategies as per their State specific needs, within the overall framework suggested by the Mission.

**5.5** The year 2005-06 was the preparatory year for the Mission and the institutional framework of the Mission has been set up in the Centre as well as in the various States. The Mission Steering Group (MSG) at the Centre is chaired by the Union Minister of Health & Family Welfare with Deputy Chairman of the Planning Commission, Ministers of the Panchayati Raj, Rural Development, Human Resource Development, Secretary (Expenditure)

and other senior officials from the Central as well as the State Governments and ten health professionals as members. The Empowered Programme Committee of the Mission is chaired by the Secretary (H&FW) and is envisaged to be the executive arm of the MSG. The Departments of Health and Family Welfare have been merged at the national level and the same is being emulated by the States. There is an Advisory Group on Community Action to guide the process of community participation. At the State level, the State Health Mission which is chaired by the Chief Minister has been set up in most of the States. Integrated Health Society has been set up at the State level in most of the States to operate as the executive arm of the State Health Mission. A parallel set up has been created at the District level under the chairmanship of Zilla Parishad. Integrated District Society is the executive arm of the District Health Mission. The process of communitization of the Mission has been institutionalized through the Hospital Management Society, which fosters community participation in the management of hospitals.

**5.6** The National Rural Health Mission is a statement of hope and conviction. The Government is committed to achieving the goals laid down in National Population Policy and National Health Policy. For the underserved poor in the village level, the Mission spells hope in the form of a voluntary trained community health activist (ASHA) equipped with a drug kit; improved hospital facility at CHC level measurable as per the Indian Public Health Standards (IPHS); availability of drugs for generic common ailments at Health Centres; access to universal immunization; referral and escort services for institutional delivery; nutrition and medical care at Anganwadi level on a monthly basis on the Health Day, and through mobile medical unit at district level and availability of household toilets.

**5.7** It is clearly understood that for the success of the Mission, all round capacity building is a must. Several strategies have been operationalized to

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achieve this objective. The capacity for planning at the State and the District levels have been supplemented with Programme Management Units which include professionals including MBAs, Chartered Accountants and MIS consultants etc. For the EAG States, these Management Units have already been set up with over 700 contractual resource persons being engaged. Adequate provision has also been made out of the Mission funds for training of the members of the Village Health & Sanitation Committee, Zilla Parishad, Hospital Management Committee etc. to equip them with the skills to take up planning, implementation and monitoring of the Mission activities. Procurement of health goods has been a weak area. An Empowered Procurement Wing set up in the Ministry to enhance capacity of the Gol as well as to take up capacity building of the State Governments.

**5.8** The Mission attempts a major paradigm shift by relating Health Outcomes to determinants of good health; empowering Panchayati Raj Institutions, upscaling and optimizing resources, decentralizing powers and planning process, reviving sound local health traditions and enforcing accountability of public health system to the community. We need dynamic political leadership, administrative commitment and buoyant community participation to fulfill the ambitious agenda of the Mission.

## **6. REPRODUCTIVE & CHILD HEALTH II (RCH II)**

**6.1** The RCH II is the flagship programme of the Government of India on Reproductive, child and maternal health under National Health Rural Mission. This programme has been re-oriented and revitalized to give it a pro outcome and pro poor focus. A paradigm shift is envisaged in the manner in which the RCH Programme has been conceptualized and implemented based upon key learning from the first phase of the program to make to consistent with the requirements of the National Rural Health Mission.

**6.2** The key characteristics of the RCH II programme includes:

### **6.3 Adoption of Sectorwide approach:**

This programme is envisaged as an umbrella program of the Family Welfare, which integrates all the related and inter-linked stand alone schemes of the Department into a single composite programme.

### **6.4 Rationalization of existing budget heads and creation of a flexible funding pool**

With a view to adopting a sector-wide approach and transforming RCH-II into an umbrella National Family Welfare Programme, the budget heads of the Department have been rationalized and compressed into 4 omnibus sections:

- A.1 Operational Support to the States-
- A.2 Operational Costs of Institutions supported by the DoFW and other committed expenditures.
- B.1 Activities Centrally implemented by MoHFW
- B.2 Activities in the State Program Implementation Plans (PIPs)

### **6.5 Donor Convergence**

As a part of the sector wide approach, all the externally aided projects of the sector have been merged with RCH II. This includes both Central as well as State projects supported by the development partners. All the development partners have agreed in principle to move towards a sector-wide approach. The development partners, however, have sought a transition period to allow them time to complete their existing commitments and to re-align their current programme with the paradigm shift.

### **6.6 State Ownership and Decentralized Planning and Programme Implementation**

The RCH II programme design and implementation strategy is accordingly wedded to adopting a

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decentralized process under which extensive consultations were held with each States/ Union Territory on the program design. The programme invited each state/ union territory to prepare its own Program Implementation Plan (PIP) based upon a situational analysis of ground realities and requirements. The States have been encouraged to evolve district plans with the clear objective of each district having its own plan as per a schedule (within the RCH II duration) to be laid down by the States/UTs themselves.

### **6.7 Institutional strengthening at District, State and Central levels for effective program implementation**

Institutional capacity has been the major constraint for translation of policy intentions into action at State and District levels. The decentralization and macro management approach places the onus of planning, implementation, monitoring and evaluation more squarely on the states than ever before. The new approach requires a change of mind set as well as a different skill set at the Central level, to this end State and District level Programme Management Units (PMUs) comprising of skilled personnel are being established under RCH II.

### **6.8 Results Framework and Monitoring**

“Results Orientation” is an important indicator envisaged in the RCH II Program. The RCH II vision articulates, “Improving access, use and quality of RCH services, especially for the poor and under served populations”, as an important outcome of the program. The logical framework is being used as a tool to define outcomes at the planning stage and subsequently for monitoring.

### **6.9 Public Private Partnership**

It is recognized that besides the Govt. of India, the State Governments and the development Partners, the private sector is also an important stakeholder in the program. The program accordingly solicits the involvement of the private sector participants. To this end, based upon consultation with the private sector a

comprehensive public- private partnership framework has been developed.

### **6.10 Programme Funding**

The programme would receive funding from three sources: The Government of India; pooled funding from DFID/ World Bank/ UNFPA and funding from other development partners (including EC, USAID, UNICEF and UNFPA).

### **6.11 Current status of RCH-II**

The RCH-II Programme has been launched w.e.f. 1<sup>st</sup> April 2005. During the current financial year 2005-06, the Ministry obtained from all the States and UTs their Project Implementation Plans (PIPs) for RCH II Programme. These PIPs have been appraised and approved by the Ministry.

### **6.12 Monitoring and Evaluation under RCH-II**

The Family Welfare Programme was being implemented earlier under the ‘Target Free Approach (TFA)’ since 1<sup>st</sup> April 1996 all over India. Under the system of decentralized participatory planning. TFA has been renamed as Community Needs Assessment Approach (CNAA) since 1997. The preparation of the Annual Action Plans (Forms 4 and 5) at district and state levels based on the assessed needs of the people for Family Welfare services by the State/UT Governments is one of the most essential and vital activities in the programme and, therefore, the formulation of district and state action plan for a particular year is to be based on the previous year’s achievement and assessed needs for the following year on the basis of guidelines stipulated and contained in the CNAA Manual and supplement thereof, brought out by the Department of Health and Family Welfare and circulated to various districts in the states.

## **7. National Commission on Population (NCP)**

7.1 The Report made available by the Technical Group on Population Projections, 1996 revealed that if the current trends continue, the country as a

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whole would achieve replacement level of TFR of 2.1 by the year 2026. However, the most populous states, which constitute about 40% of the total population of the country, would achieve replacement level of fertility long after that. This is also to be kept in Nevertheless, even after reaching replacement level of fertility, a factor called population momentum will contribute to a substantial increase in the number of births for another generation in which the number of women in the reproductive age (15-49), who were born in a high fertility regime of the past will swell into the rank of potential mothers. The long-term objective of the family welfare programme is to achieve population stabilization by 2045 at a level consistent with requirement of sustained economic growth, social development and environmental protection.

**7.2** The National Commission on Population (NCP), constituted under the chairmanship of the Hon'ble Prime Minister in May 2000, to promote inter-sectoral co-ordination across agencies of the Central and State Governments for achieving the goals set out in the National Population Policy, has been re-located from Planning Commission to the Ministry of Health & Family Welfare. This would ensure comprehensive and multisectoral coordination of Planning and implementation between health & family welfare on one hand and the schemes of the related Departments on the other. The Commission has since been reconstituted with 40 members, the first meeting of which was held on 23<sup>rd</sup> July 2005. Five Expert Groups have been constituted for studying the population profile of the States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh and Orissa in order to identify weaknesses in the health delivery systems and to suggest measures to improve the health and demographic status of these States.

## **8. DISEASE CONTROL PROGRAMMES**

### **8.1 National Vector Borne Disease Control Programme (NVBDCP)**

National Vector Borne Disease Control Programme (NVBDCP) is an umbrella programme for prevention

and control of vector borne diseases viz., Malaria, Filariasis, Kala-azar, Dengue/Dengue Haemorrhagic Fever (DF/DHF) and Japanese Encephalitis since 2003. Under the programme, comprehensive and multi-faceted public health activities are being implemented in the country. The vector borne diseases are complex, determined by multiple determinants and are major impediments in the path of socio-economic development. The high risk areas are generally rural, tribal and urban slums inhabited by the poor, marginalized and vulnerable sections. Remoteness and inaccessibility, socio-economic conditions, inappropriate health seeking behaviour, migration of population as well as emerging drug and insecticide resistance are the contributing factors to the problem. The vision of NVBDCP envisages a well-informed and self-sustained, healthy India free from vector borne diseases with equitable access to quality health care. The Mission of the Programme is integrated and accelerated action towards reducing mortality on account of malaria, dengue, Japanese encephalitis by half and elimination of Kala-azar by 2010 and elimination of Lymphatic Filariasis by 2015. The vision and mission of NVBDCP is in tandem with the National Health Policy goals for VBD. These goals are also in consonance with the overall Millennium Development Goals for reduction of Vector Borne Diseases (VBD) burden and poverty.

The NVBDCP strategies comprise early case detection, prompt and complete treatment; integrated vector management including promotion of personal protection like insecticide treated bed nets, biological control measures like larvivorous fish and minor environmental engineering; Communication for Behavioural Impact, capacity building through integrated training at all tiers of the health care service delivery system, operational research, monitoring and evaluation through regular field visits and Management Information System. Partnership with other National Health Programmes, non-health sector departments, civil society organizations (Non-Governmental Organizations/Faith Based Organizations/Community Based Organizations/ Panchayati Raj Institutions/Self-Help Groups), corporate sector,

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medical academia, professional bodies, are also an integral component of the programme. The objective is to provide uniformity in diagnosis, treatment, and monitoring through a wider base to maximize access to treatment and appropriate and locally applicable vector control measures.

## 8.2 National Leprosy Eradication Programme

The National Health Policy 2002 has kept the goal of leprosy elimination (P.R. of less than 1 case / 10,000 population) by December 2005. NLEP has achieved noteworthy success in its efforts towards achieving elimination. The Prevalence Rate declined from 57.6 in 1981 to 1.34 in March 2005. The number of States / UTs having achieved elimination now stands at 24 with another 4 states being very near this goal. India has achieved the important goal of Leprosy elimination (i.e. PR<1 case/10000 population) as a Public Health Problem in December 2005, as per National Health Policy 2002 Leprosy cases on record has come down to 1.07 lakhs giving PR of 0.95 case/10000 population as on 31<sup>st</sup> December 2005.

On the event of Leprosy elimination by India, a press conference was held by Hon'ble Union Minister of Health & Family Welfare on Anti Leprosy Day i.e. 30<sup>th</sup> January 2006 for declaring elimination of Leprosy by India at National level.

## 8.3 Revised National TB Control Programme (RNTCP)

The Revised National TB Control Programme (RNTCP) using Directly Observed Treatment Shortcourse (DOTS) strategy is being implemented in the country in a phased manner since 1997, with assistance from World Bank, DANIDA, DFID, USAID, GDF and GFATM. By October 2005, 1065 million (95%) of the country's population in 607 districts have been covered under the programme and the entire country is expected to be fully covered during this current year 2005. Till date, the RNTCP has placed more than 49 lakh patients on DOTS treatment thus saving about 8.8 lakhs additional lives, averting more than 8 lakh deaths.

## 8.4 National Programme for Control of Blindness

The Plan of Action to implement National Programme for Control of Blindness during the 10<sup>th</sup> Plan has been prepared in the line with Global initiative "Vision 2020: The Right to Sight". Revised scheme approved for the 10<sup>th</sup> Plan focuses on development of comprehensive eye care services targeting common blinding disorders including cataract, refractive errors, glaucoma and corneal blindness. Prevention and control of childhood blindness is being given high priority during the 10<sup>th</sup> Plan by developing pediatric ophthalmology units, setting up low vision clinics and strengthening school eye screening programme.

## 8.5 National Cancer Control Programme (NCCP)

National Cancer Control Programme (NCCP) has been revamped and the geographical imbalance in the availability of cancer treatment facilities is being reduced by recognition of new Regional Cancer centers, strengthening of existing ones and development of Oncology Wings in Government Medical Colleges and Government Hospitals.

## 8.6 National Mental Health Programme

In order to improve the Mental Health services in the country, new scheme for National Mental Health Programme was launched by the Government during the 10<sup>th</sup> Five Year Plan. During the 10<sup>th</sup> Plan, so far 50 new districts have been inducted in to the District Mental Health Programme during 2004-05 and at present this programme covers 94 districts in total.

## 8.7 Integrated Disease Surveillance Project

The Ministry has launched the Integrated Disease Surveillance Project in November 2004 to develop capacity for early identification of outbreak of important communicable diseases such as Cholera, Typhoid, Polio, Measles, Malaria, Tuberculosis, HIV/AIDS. Surveillance of risk factors for common non-communicable diseases and road traffic accidents would also be covered under this project. This 5

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year project, supported by the World Bank aims at improving laboratory services for confirmation of target diseases and use of modern information technology for data transmission and analysis to trigger warning signals for impending outbreaks. Training of personnel in disease surveillance and rapid response to outbreaks, would also be undertaken. The Project will cover all States and UTs in phased manner.

### 8.8 National AIDS Control Programme

The National AIDS Control Programme, which was started in 1992, has evolved into a holistic and dynamic response to HIV/AIDS. The programme is implemented by the National AIDS Control Organization at the national level and State AIDS Control Societies at state level. In April 2002, the Government of India adopted the National AIDS Prevention and Control Policy. The budget provision for 2004-05 was Rs.259 crore. An additional Rs. 167 crore was provided during the year by the UPA Government by making a quantum jump in mid year as envisaged in the NCMP. The budget for 2005-06 is Rs.533 crore. The total project cost of NACP Phase-II is Rs. 2064.65 crore.

The main components within the programme include Interventions with the Vulnerable Groups (Targeted Interventions, STD Control and Management, Condom Promotion, etc), Preventive interventions with the General Community (IEC, School AIDS Programme, Blood Safety, Voluntary Counselling and Testing), Low Cost AIDS Care (For people infected and affected), Institutional Strengthening (Training, Research, Capacity Building, etc) and Inter Sectoral Collaboration and Mainstreaming HIV through various other departments.

A Scheme to upgrade and strengthen Emergency care in State Hospitals located on National Highways has been under implementation with a view to provide treatment to road accident victims in hospital as near the site of accident as possible. For this purpose, financial assistance is being provided to the several Government Hospitals,

which fall in most accident-prone areas, or National Highways, through the State Governments, to augment and upgrade the Accident and Emergency services for developing necessary emergency facilities.

## 9. OTHER ISSUES

9.1 During 2005, heavy rains and severe floods occurred in the States of Gujarat, Maharashtra, Karnataka, Andhra Pradesh, Tamil Nadu, Madhya Pradesh, Jammu & Kashmir were affected by avalanche and by severe earthquake. Central health teams were deputed to the affected States to assist the State Government in instituting public health measures. Medical relief in the form of manpower, critical essential drugs, disinfectants insecticides etc were provided as per the request of the states. Central Govt. provided all necessary assistance to the Government of Uttar Pradesh during Japanese Encephalitis outbreak.

9.2 World Health Organization (WHO) issued an alert that Bird Flu could spread to India and other countries from the time that the current outbreak of Avian Influenza Virus (H5N1) was first detected in the Republic of Korea in December 2003. Subsequently, cases in poultry and birds were reported in fifteen countries namely Republic of Korea, China, Thailand, Vietnam, Japan, Cambodia, Indonesia, Laos, Malaysia, Russia, Kazakhstan, Turkey, Croatia, Romania and Mongolia. No case of Bird Flu (Avian Influenza) has been reported in India till date either in humans or birds in the current outbreak.

9.3 However, Government of India took adequate measures to prevent entry of Avian Influenza in to India and to contain the disease if it has to occur in poultry or humans. Important measures undertaken during 2005 is preparation of National Influenza Pandemic Preparedness Plan and contingency plan for managing human cases of avian influenza. An inter-ministerial Task Force has been constituted to ensure availability of drugs, vaccine and all other aspects for management of Avian Influenza in the country.

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**9.4** In the light of several studies and compelling evidence which showed a conclusive link between smoking scenes in films and increase in tobacco consumption, more so by youth, the Ministry has notified Rules on 31<sup>st</sup> May 2005 under the Tobacco Control Act, 2003, to provide for ban on sale of tobacco products through vending machine & by minors; ban on display of scenes in films / TV serials depicting tobacco products etc. These rules will come into effect from 1<sup>st</sup> March 2006.

**9.5** Other initiatives taken includes, the decision to establish six AIIMS-like institutions in the underserved areas of the country under the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) and to upgrade eleven institutions in 11 States to that level by grant of one-time assistance with a view to removing regional imbalances in availability of tertiary health care facilities and quality medical education. These are proposed to be set up in the states of Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneswar) Rajasthan (Jodhpur) and Uttaranchal (Rishikesh).

Each of these Institutions will consist of 850 bedded hospital providing medical treatment in 39 disciplines out of which 350 beds are exclusively for super-speciality streams and for ICU beds. The details of operationalising the proposal are under preparation.

**9.6** The revised Scheme of Development of Nursing Services was approved by the Expenditure Finance Committee. According to the revised Scheme, enhanced quantum of assistance for training of nurses and strengthening of nursing schools is being provided to the Nursing Institutions. These steps will result in better availability of trained nurses throughout of the country.

**9.7** Considering the ever increasing responsibilities and larger roles of the personnel engaged in healthcare activities, Government has exempted the health sector from the operation of downsizing exercise in respect of the technical categories of posts to be filled up by direct recruitments.

**24th February 2006**  
**New Delhi**

**PRASANNA HOTA**  
**Secretary (H&FW)**  
**Ministry of Health & Family Welfare**