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REVIEW OF RESEARCH

REPRODUCTIVE AND CHILD HEALTH PROGRAMME IN INDIA- AN OVERVIEW

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ABSTRACT

The National Rural Health Mission (NRHM) launched in 2005 brought focus on provision of healthcare towards improvement in the quality of life, especially amongst underprivileged and underserved groups amongst Indian citizens. Possibly, the underlying presumption in most of such national and international strategic pronouncements over the quality of life or standards of living could be that improvement in the quality of life through provision of quality healthcare, education, women's empowerment, etc. would motivate people to limit their family size and thus fertility regulation and population stabilization processes would get accelerated. This paper focuses on the study of reproductive and child health rogramme.

KEYWORD : *Child Health Programme, Janani Suraksha Yojana Maternal Health, National Rural Health Mission.*

INTRODUCTION

The National Health. Mission (NHM) sought to revitalize rural and urban health sectors by providing flexible finances to State Governments. The National Health Mission comprises of 4 components namely the National Rural Health Mission, the National Urban Health Mission, Tertiary Care Programs and Human Resources for Health and Medical Education. The National Health Mission represents India's endeavor to expand the focus of health services beyond Reproductive and Child Health, so as to address the double burden of Communicable and Non-Communicable diseases as also improve the infrastructure facilities at District and Sub District Levels.

REPRODUCTIVE AND CHILD HEALTH PROGRAMME (RCH-II)

The RCH.-II, a flagship programme of the Government of India on Reproductive and Child Health was launched in April 2005 under NRHM. This programme has been reoriented and revitalised to give a pro-outcome and pro-poor focus. It aims at reducing the Maternal Mortality Ratio the Infant Mortality Rate and Total Fertility Rate. This programme evolves a shared vision and a common programme encompassing the entire Family Welfare Sector, lending a strong focus on results, especially improving the use of RCH services by the poorest and the underserved populations.

This programme also allows states to have greater flexibility in programming and use of allocated funds. This enhances accountability of the states. As a result larger portions of funds are targeted towards

the poor. At the same time, use of innovative approaches and enhancing the participation of the private and the NGO sector are hallmarks of this programme. As per RCH-II goals, reduction of Infant Mortality Rate (IMR) to 30 per 1000 live births, reduction of Maternal Mortality Ratio (MMR) to 100 per 1,00,000 live births and reduction of Total Fertility Rate to 2.1 to be achieved by 2010. Against the above goals, IMR of 55 per 1,000 live births (SRS-2007) MMR of 254 per 1,00,000 live births (SRS 2004-06) & TFR of 27 (SRS 2007) had been achieved.

MATERNAL HEALTH

Maternal Mortality Ratio (MMR) in India was exceptionally high in 1990 with 600 women dying during child birth per hundred thousand live births. Approximately 1.5 lakh women were dying every year on account of complications related to pregnancy and child birth. The global MMR at the time was much lower at 400. There has however, been an accelerated decline in MMR in India. In 2011, MMR in the country has declined to 178 against a global MMR of 210. The number of maternal deaths stands reduced by 70%. India's share among global maternal deaths has declined significantly from 27.3% in 1990 to 16.4% in 2011. State of the art Maternal and Child Health Wings (MCH wings) have been sanctioned at District Hospitals/District Women's Hospitals and other high case load facilities at sub- district level, as integrated facilities for providing quality obstetric and neonatal care. More than 28,400 beds for women & children are being added across 470 health facilities in 18 States. For bringing pregnant women to health facilities for ensuring safe delivery and emergency obstetric care, Janani Suraksha Yojana (JSY), a demand promotion scheme was launched in April 2005. The number of JSY beneficiaries has risen from 7.39 lakhs in 2005 to more than 106.00 lakhs in 2013, with the expenditure on this scheme increasing from Rs 38.29 crores to Rs 1640 crores. Institutional deliveries in India have risen sharply from 47% in 2008 to over 84 % now.

Building on the phenomenal progress of the JSY scheme, Government of India has launched Janani Shishu Suraksha Kaiyakaram (JSSK) on 1st June, 2011. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery, including caesarean section. The entitlements include free drugs and consumables, free diet up to 3 days during normal delivery and up to 7 days for C-section, free diagnostics, and free blood wherever required. This initiative also provides for free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements were put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. In 2013, the scheme was expanded to cover complications during ante-natal and post-natal period and also sick infants upto 1 year of age. To implement this scheme, over Rs 5500 crores have so far been allocated to the States under NHM.

Utilization of public health infrastructure by pregnant women has increased dramatically 7 as a result of JSY & JSSK. As many as 1.66 crore women delivered in Government and accredited health facilities last year. RMNCH+A approach emphasizes the role of highly skilled & empowered nurses in maternal and child Health. To improve the quality of training of nurses, training institutions for nursing - midwifery are being strengthened. Skill labs are being set up to enable service providers to acquire the necessary skills for providing quality RMNCH+A services. A new initiative has been taken for advance distribution of Misoprostol during late pregnancy by ASHAS, to prevent post-partum haemorrhage and incentivisation of ANMs to conduct domiciliary deliveries in notified areas where institutional deliveries are difficult.

Mother and Child Tracking System (MCTS) & Mother and Child Tracking Facilitation Centre (MCTFC)

MCTS is a name based web based service that captures the details of pregnant women and children up to 5 years and aims to ensure that every pregnant woman gets complete and quality ANC and PNC and every child receives a full range of immunization services. Over 10.5 crore pregnant women and children have been registered in MCTS till now. ANMs and ASHAs are given system generated work-plans that contains list of services due to pregnant women and children in their jurisdiction. In addition, SMSes on services due to pregnant women and children are being sent to ANMs, ASHAs, pregnant women and parents of children about due services.

MCTS system is increasingly making use of opportunity to directly communicate with the ANMs, ASHAs and pregnant women and parents of young children on their mobiles. Over 8.92 Crore mobile numbers of beneficiaries have so far been captured. This facility will inter-alia be used for:

- Sending appropriate health promotion messages in voice and text to beneficiaries that are relevant according to the month of pregnancy or age of the child.
- Transfer of JSY benefits to pregnant women as is presently being done in 121 DBT districts.
- Transfer of ASHA payments directly into their accounts. This will help to ensure that ASHAs receive full range of incentives payment timely and regularly as it will be easy to monitor 'which all ASHAs have not received payments for which activities in which block' etc.
- Training of ASHAs through an IVR system as per need and requirement.

Mother and Child Tracking Facilitation Centre is a major step taken by Government of India under the National Health Mission in improving the maternal and child health care services. The facilitation Centre has 80 Helpdesk Agents (HAs). The Facilitation Centre will act as a supporting framework to MCTS and help in validating the data entered in MCTS by making phone calls to pregnant women and parents of children and health workers. This Facilitation Centre is also a powerful tool in providing relevant information and guidance directly to the pregnant women, parents of children and to community health workers, thus creating awareness among them about health services and promoting right health practices and behavior.

The service providers and recipients of mother and child care services will be contacted to also get their feedback on various mother and child care services, programmes and initiatives like JSSK, JSY, RBSK, National Iron plus Initiative (NIPI), Contraceptive distribution by ASHAs etc. This feedback would help the Government of India/state governments to easily and quickly evaluate the programme interventions, and plan appropriate corrective measures to improve the health service delivery. It will also be used to check with ASHAs and ANMs regarding availability of essential drugs and supplies like ORS packets and contraceptives.

Janani Suraksha Yojana

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 Aprll 2005 is being implemented in all states and UTs. The Yojana is being implemented in all states and Union Territories. JSY is a 100% centrally sponsored scheme.

The Yojana has identified ASHA, the Accredited Social Health Activist as an effective link between the Government and the poor pregnant women in 10 low performing states, namely the 8 (EAG) - Empowered Action Group (EAG) states and Assam and J&K and the remaining NE States. Her main role is to facilitate pregnant women to avail Services of maternal care and arrange referral transport.

The scheme focuses on the poor pregnant woman with special dispensation for states having low institutional delivery rate namely, the states of Uttar Pradesh, Uttrakhand, Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Assam, Orissa, Rajasthan and Jammu and Kashmir, While these states have been classified as Low Performing Statures (LPS), the remaining states have been named as High performing States (HPS). Besides the maternal care, the scheme provides cash assistance to all eligible mothers for delivery care.

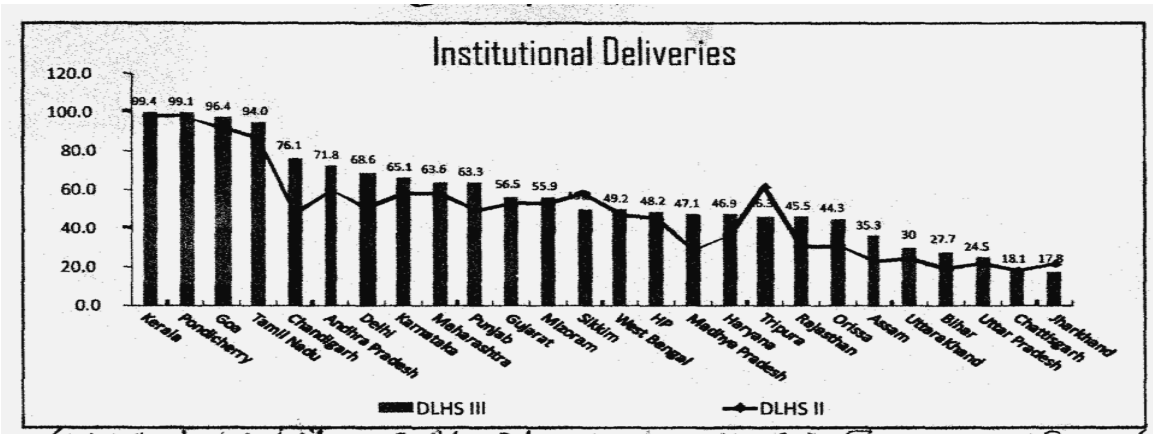
	Eligibility for Cash Assistance
In LPS States	All women, including those from SC and ST families, delivering in Government health centres like Sub-centre, PHC/CHC/FRU/ general wards of District and state Hospitals or accredited private institutions
In HPS	BPL pregnant woman, aged 19years and above and the SC and ST permanent woman

Scale of Cash Assistance(in Rs) for Institutional Delivery				
Category	Rural Area		Urban Area	
	Mother's Package	ASHA Package	Mother's Package	ASHA Package
In LPS	1400	600	1000	200
In HPS	700	200 (w.e.f. 1/4/09)	600	200 (w.e.f. 1/4/09)

	Limitations of Cash Assistance for Institutional Delivery
In LPS States	All births, delivered in a health centre- Government or Accredited Private Health Institutions.
In HPS States	Up to 02 live births

The Yojana subsidizes the cost of Caesarean Section or for the management of Obstetric complications, upto to Rs. 1500/- per delivery to the Government Institutions, where Government specialists are not in position.

Chart 1: Institutional Deliveries



Source: Website of Ministry of Health and Family Welfare, Government of India

LPS and HPS States, all such BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs.500/-per delivery, up to two live births.

CURRENT STATUS OF IMPLEMENTATION

The Janani Suraksha Yojana (JSY) integrates cash assistance with delivery and post delivery care. The scheme was launched with focus on demand promotion for institutional deliveries in states and regions where these are low. It targeted lowering of MMR by ensuring that deliveries were conducted by Skilled Birth Attendants at every birth. The Yojana has identified ASHA, the accredited social health activist as an effective link between the Government and the poor pregnant women.

The JSY scheme has shown phenomenal growth in the last three years. Starting with a modest number of 7.39 Lakhs beneficiaries in 2006-07, the total number reached 73.29 Lakhs in the year 2007-08 - a Ten Fold growth. The expenditure also rose from Rs. 38 Crores in the year 2006-07 to 880 Crores in the year 2007-08. For the year 2008-09, the reported expenditure under JSY is Rs. 1207.17 Crores.

Rapid increase in the institutional deliveries, coupled with improvement in infrastructure, manpower and training has resulted in improvement in the figures of Institutional deliveries in all major states except Jharkhand in the DLHS III data as compared with DLHS III. The growth in the institutional delivery figures is substantial in the five major states of U.P. Rajasthan, M.P., Orissa and Bihar.

Child Health

Table 1: Child Health Goal under RCH II

Child Health Goal under RCH II			
Child Health Indicator	**Current Status**	**RCH II/ NRHM 2010/2012**	**MDG 2015**
IMR(Infant Mortality Rate)	55 (SRS 2007)	<30	27
Neonatal Mortality Rate	37 (SRS 2007)	<20	<20
Under 5 Mortality Rate	74 (NHHS III 2006)		<36

Source: Website of Ministry of Health and Family Welfare, Government of India

Encouraging progress has been made in the country in terms of reducing child mortality rates. In 1990, when the global U5M rate was 88 per 1000 live births, India carhed a much higher burden of child mortality at 118 per 1000 live births. In 2012, the gap between the global and India's under five mortality has substantially narrowed. India's child mortality of 52 per 1000 Live births is dose to the global average of 48. Overall global under five mortality has declined by 44.8% whereas India achieved 54.4% decline in the same period (1990-2012). Number of child deaths has been reduced from approximately 30 lakhs in 1990 to nearly 14 lakhs in 2012. Seven states have already achieved MDG 4 target of under five mortality of less than 38 viz., Kerala (13), Tamil Nadu (24), Delhi (28), Maharashtra (28), Punjab (34), Karnataka (37), and West Bengal (38).

India has the largest annual birth cohort of 2.6 crore babies born in different geographical, climatic and socio-cultural conditions. Initiatives have been started to provide both home based care and facility based care. A three tier approach for treatment and referral of sick newborns at health facilities has been adopted representing a huge scale up of infrastructure and facilities for care of the newborns since 2008. In order to strengthen the care of sick, premature and low birth weight newborn Special New Born Care Units (SCNU) have been established at District Hospitals and Tertiary Care Hospitals. These are 12-20 bedded units, with 4 trained doctors and 10-12 nurses and support staff with provision of 24x7 services to sick newborns. 507 Sick New Born Care Units (SNCUs) are currently functioning at district hospitals and medical colleges. This is a 175 % increase over a baseline of 184 SNCUs functional in 2008. Yearly admissions of newborns in SNCUs have now exceeded 5 lakhs.

Another smaller unit known as the Newborn Stabilisation Unit (NBSU), which is 4 bedded unit providing basic level of sick newborn care, established at Community Health Centres/First Referral Units.

Provision of newborn care at these units increases the chances of survival for babies with health conditions requiring observation and stabilization soon after birth or in the period thereafter. 1737 New Born Stabilisation Units (NBSUs) have been established at First Referral Units. This is a 55% increase over a baseline of 1120 units in 2010.

Recognizing that events at the time of birth are critical to newborn survival, Newborn Care Corners (NBCC) are established at delivery points and providers trained in basic newborn care and resuscitation through Navjaat Shishu Suraksha Karyakram (NSSK). Saturation of all delivery points with SBA and NSSK trained personnel and functional new born corners are the topmost priority under the national programme. Linkages with sick newborn care at health facilities at FRUs and DH are in place to refer newborns requiring special/advanced newborn care. Currently 13,653 NBCCs are functional across the country and 1, 24,352 health care providers have been trained under the Navjaat Shishu Suraksha Karyakram.

The Home Based Newborn Care Scheme launched in 2011 provides for immediate postnatal care (especially in cases of home delivery) and essential new born care to all newborns up to the age of 42 days. Frontline workers (ASHAs/ANMs) are being trained.

Key Strategies wider RCH II for Newborn & Child Health

- Increase coverage of skilled care at birth for newborns in conjunction with maternal care.
- Implement, by 2010, a newborn and child health package of preventive, promotive and curative interventions using a comprehensive IMNCI approach.
- Strengthen and augment existing services (care at birth/Essential new born care, ARI and diarrhoea control) in areas where IMNCI is yet to be implemented.
- Implement the multiyear strategic plan for the UIP (Universal Immunization Program)

Child Health Situation in India

Of the 9.7 milllon under-five (U5) deaths globally, 2.1 million are in India alone. Approx 25 million births occur every year in India out of which approx 1.57 million children die before one year of age and approx 1 million newborns die within one month of age. 52 percent of under- five deaths continue to occur in the first month of life. 75% of neonatal deaths occur in first week of life, which means that the proportion of U5 deaths by neonatal causes is disproportionately high. 37 per cent of all infant deaths in India are concentrated in two states: Uttar Pradesh and Bihar. 70 per cent of all infant deaths in India are concentrated in eight states: Bihar, UP, Madhya Pradesh, Orissa, Rajasthan, Andhra Pradesh, Maharashtra and Gujarat. The primary causes of neonatal deaths are sepsis, low birth weight and Asphyxia. The primary causes of child deaths are Pneumonia, Diarrhoea and in some states Malaria, meningitis and measles.

In India 43 per cent of children under age five are underweight. 8.3 million Infants in India low birth weight (less than 2500 grams). According to SRS 2007, Infant Mortality is highest in Madhya Pradesh (72), and Orissa (71) and the lowest in Manipur (12), Goa (13) and Kerala (13) RGI,SRS (2017). According to NFHS III (2015-16) Infant mortality is highest in Uttar Pradesh (73) and lowest in Kerala and Goa (15). With respect to under-five mortality, Uttar Pradesh has the highest rate (96) and Kerala has the lowest rate (16).

Components of child health care include:

- Essential newborn care
- Immunisation
- Infant and young child feeding
- Vitamin A supplementation and Iron and Folic Acid supplementation
- Early detection and appropriate management of Acute Respiratory Infections, Diarrhoea and other infections
- Integrated management of neonatal and childhood Illnesses (IMNCI) and PreService IMNCI
- Facility Based New Born Care.

- Home Based Newborn Care

CHILD HEALTH STRATEGIES

Essential Newborn Care

As the majority of births in India still occur at home and 66% of all deaths occur in the first month of life, it is essential to ensure that skilled health care is provided to babies at birth. Further appropriate referral health care must be made available and accessible at health facilities.

Infant and young child feeding

Promotion of early initiation of breast feeding (within one hour of delivery) and exclusive breast feeding till 6 months and timely complementary feeding with continued breast feeding is emphasized under infant and young child feeding.

Vitamin - A

The policy was recently revised with the objective of decreasing the prevalence of Vitamin A deficiency to levels below 0.5%, the strategy being implemented is:

- 1,00,000 IU dose of Vitamin A is being given at nine months
- Vitamin A dose of 2,00,000 IU (after 9 months) at six monthly intervals up to five years of age
- All cases of severe malnutrition to be given one additional dose of Vitamin A.
- Iron and Folic Add supplementation
- To manage the widespread prevalence of anaemia in the country, the policy has recently been revised
- Infants from the age of 6 months onwards up to the age of five years shall receive iron supplements in liquid formulation in doses of 2Omg elemental iron and lOOmcg folic acid per day per child for 100 days in a year.
- Children 6-10 years of age shall receive iron in the dosage of 30 mg elemental iron and 25Omcg folic acid for 100 days in a year.
- Children above the age of ten years and adolescents are also to be included in the iron supplementation programme. They shall be supplemented at the dose rates for adults.

Management of Diarrhoea

The Government of India in order to control diarheal diseases has adopted the WHO guidelines on Diarrhoea management

- India was the first country in the world to introduce the low osmolarity Oral Rehydration Solution (ORS), as recommended by WHO for the management of diarrhea.
- Zinc has been approved as an adjunct to ORS for the management of diarrhoea. Addition of Zinc is likely to result in reduction of the number and severity of episodes of diarrhoea as well as in the duration of each episode.
- New Guidelines on Management of Diarrhoea has recently been modified.

Integrated Management of Neonatal and Childhood Illness

Integrated Management of Neonatal and Childhood Illness (IMNCT) strategy is one of the main interventions under the RCH. The strategy encompasses a range of interventions to prevent and manage the commonest major childhood illnesses which cause death i.e. neonatal illnesses, Acute Respiratory Infections, Diarrhoea, Measles, Malaria and Malnutrition. It focuses on preventive, promotive and curative aspects, i.e. it gives a holistic outlook to the programme. The Child survival strategy of IMNCI has been introduced in 219 districts of the country and 90401 health persons have been trained.

Pre Service IMNCI

PreService IMNCI has been accepted has an important strategy to scale up IMNCI by GOI and has been included in the curriculum of 79 Medical colleges of the country. 4000 students have been trained. This will help in providing the much required trained (IMNCI) manpower in the public and the private sector.

Facility Based New Born Care (FBNC)

As more and more sick children are screened and detected at the peripheries through IMNCI and referred to the health facilities, care of sick newborn and child at health facilities (CHCs FRUs, District Hospitals and Medical College Hospitals) assumes priority. Building up the capacity of the Medical Officer at these facilities to handle such cases thus becomes important. 146 SNBCU have been set up to address sick new born care at facilities.

Home Based New Born Care

The Government of India has approved the implementation of Home Based Newborn Care (HBNC). In the five high focus states to be covered under the Indo Norway Initiative (NIPI), the HBNC shall be implemented. It has been Incorporated into the ASHA training and duties. As home based care of the newborn is a skill based task, material to enhance the skills of the ASHAs is being done by the NIPI secretariat. In addition, a course module recently developed by WHO headquarters has been field tested in UP, found useful and shall be adapted to suit Indian conditions and the material shared with the states.

Management of malnutrition

To effectively tackle the huge burden of malnourished children in the country. nutrition rehabilitation centres have been set up. Malnourished children (grades III and IV) are admitted at these centres, nurtured back to normalcy through the provision of hot cooked high ca1ore foods using locally available food materials. 582 Nutritional Rehabilitation Centres have been established to address malnutrition among children. Community based guidelines for management of malnutrition shall be developed to supplement the facility based guidelines.[6]

Currently the care of children with severe acute malnutrition is mainly through facility based care. In order to reduce the risk of mortality in children with severe acute malnutrition, Nutritional Rehabilitation Centres have been established for providing medical and nutritional care. Tribal areas and high focus districts are prioritised for setting up these units. The number of NRCs has increased nearly four times from a baseilne of 180 units in 2008 to 872 NRCs that are currently functional at the District Hospitals or FRUs depending on the availability of infrastructure and human resources as well as the accessibility of the facility to the surrounding areas.

In order to address the most common causes under 5 child deaths in India, an integrated strategy that includes both preventive and curative interventions has been adopted. This is known as the Integrated Management of Neonatal and Childhood Illnesses (or IMNCI). The strategy also addresses aspects of nutrition, immunization, and other important elements of disease prevention and health promotion. The strategy includes three main components: lmprovements in the case-management skills of health staff, Improvements in the overall health system required for effective management of neonatal and childhood illnesses; and Improvements in family and community health care practices.

IMNCI has been implemented in 508 districts across the country and 5.8 lakhs health personnel have been trained in IMNCI. Nearly 25,412 doctors and nurses have been trained in facility based IMNCI for providing inpatient care for childhood illnesses.

Considering that the leading causes of death beyond the neonatal period are diarrhoea and pneumonia, priority attention is given to the management of these two illnesses. Availability of ORS and Zinc is ensured at all sub-centres and with frontline workers. Use of Zinc is being actively promoted along with use of ORS in cases of diarrhoea in children and guidelines reinforced during various trainings/meetings of ASHAs, and other frontline workers. Oral Cotrimoxazole is being supplied upto the sub centre level and is

recommended as first line drug for community based management of pneumonia by frontline health workers and ASHAs. ASHAs and ANMs are incentivized to provide special care to preterms and newborns, identification of illnesses, appropriate care and referral through home visits. Newborns discharged from the Special newborn care units are also being followed up at home by frontline workers. Nearly 5.2 lakh ASHA workers are already trained to conduct home visit to each newborn delivered in rural areas for referral of sick newborns to health facilities.

National Iron Plus Initiative launched in 2013 to bring about renewed emphasis on tackling high prevalence of anaemia, comprehensively, across all age groups. Provision for iron folic acid supplementation made for children 6 months to 10 years, adolescents girls and boys, pregnant and lactating women and women in reproductive age group.

One of the key preventive interventions for preventing undernutrition in children is the promotion of Infant and Young Child feeding practices. The first two years of life are considered a "critical window of opportunity" for prevention of growth faltering. Optimal breastfeeding and complementary feeding practices together allow children to reach their full growth potential. The various opportunities for maternal and child health contacts now available in the health system, both at the health facility and community level, are being leveraged to reinforce the key messages around infant and child feeding, growth monitoring and promotion. States are being encouraged to set up IYCF (Infant and Young Child Feeding) counselling centres at high case load facilities. Guidelines for Enhancing Optimal Infant and Young Child Feeding Practices were launched by the Ministry of Health & Family Welfare in this respect in 2013.

As part of the Government's policy for Vitamin A supplementation, children between nine months to five years are given six monthly doses of Vitamin A. A child must receive 9 doses of Vitamin A by the 5th birthday. A biannual approach is being used in many states where two specific months in a year are designated for carrying out the supplementation.

CONCLUSION

India's flagship health sector program, the National Health Mission (NHM) sought to revitalize rural and urban health sectors by providing flexible finances to State Governments. The National Health Mission comprises of 4 components namely the National Rural Health Mission, the National Urban Health Mission, Tertiary Care Programs and Human Resources for Health and Medical Education. The National Health Mission represents India's endeavor to expand the focus of health services beyond Reproductive and Child Health.

Reproductive and Child Health services were the primary focus of NHM. The successful implementation of JSY and ASHA programs had a significant impact on behavioral changes and brought pregnant women in large numbers to public health institutions. The NRHM flexi pool resources were utilized to create adequate infrastructure at public health institutions to cope with the heavy rush of maternity cases. Ambulance services were introduced for transportation of maternity cases to public health institutions and for emergency care.

The NHM created a peoples' movement for health care. Accredited Social Health Activists Care (ASHA) workers were deployed as transformational change agents in every village. The ASHA workers acted as mobilizers for institutional deliveries, focused on integrated management of neonatal and childhood illness and advised on home based neo-natal care. The NHM has also empowered people through Village Health and Sanitation Committees to formulate village health plans and exercise supervisory oversight of ASHA workers. At the PHC and CHC level, Rogi Kalyan Samitis have been activated to establish systems of oversight over the public health facilities for creating a patient friendly institution. Besides rural areas, the urban slums are now receiving attention with the launch of the National Urban Health Mission.

The Ministry of Health and Family Welfare has added several new schemes since 2014 to enable implementation of the Health For All Vision for the Nation. Mission Indradhanush, sought to achieve full immunization coverage of 90 per cent children by 2020. The mission has made good progress in improving immunization coverage by 6.7 per cent since 2014. A basket of new vaccines has been added to the

Universal Immunization Program to increase the number of vaccines from 6 to 12. The prominent among them are the Inactivated Polio Vaccine, the Rota Virus Vaccine, the Adult Japanese Encephalitis Vaccine and the Rubella Vaccine as Measles Rubella Vaccine.

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