after graduation. The Policy emphasises the need to expose medical students, through the undergraduate syllabus, to the emerging concerns for geriatric disorders, as also to the cutting edge disciplines of contemporary medical research.

7. Need for Specialists in Public Health and Family Medicine

In order to alleviate the acute shortage of medical personnel with specialization in the disciplines of public health and family medicine, the Policy envisages the progressive implementation of mandatory norms to raise the proportion of postgraduate seats in these discipline in medical training institutions, to reach a stage wherein one-fourth of the seats are earmarked for these disciplines.

8. Nursing Personnel

The Policy emphasizes the need for an improvement in the ratio of nurses vis-vis doctors/beds. Policy emphasis on improving the skill-level of nurses, and on increasing the ratio of degree-holding nurses vis-vis diploma-holding nurses. The Policy also recognizes the need for establishing training courses for super-speciality nurses required for tertiary care institutions.

9. Use of Generic Drugs and Vaccines

This Policy emphasizes the need for basing treatment regimens, in both the public and private domains, on a limited number of essential drugs of a generic nature. The production and sale of irrational combinations of drugs would be prohibited through the drug standards statute. The National Programme for Universal Immunization against Preventable Diseases requires to be assured of an uninterrupted supply of vaccines at an affordable price. This policy envisages that not less than 50% of the requirement of vaccines/sera be sourced from public sector institutions.

10. Urban Health

Policy envisages the setting up of an organised urban primary health care structure and the funding for the urban primary health system will be jointly borne by the local self-government institutions and state and central governments.

11. Mental Health

It envisages a network of decentralized mental health services for ameliorating the more common categories of disorders. The programme outline for such a disease would involve the diagnosis

a. In primary care—from selective care to assured comprehensive care with linkages to referral hospitals.
b. In secondary and tertiary care—from an input oriented to an output based strategic purchasing.
c. In public hospitals—from user fees and cost recovery to assured free drugs, diagnostic and emergency services to all.
d. In infrastructure and human resource development–from normative approach to targeted approach to reach underserviced areas.
e. In urban health—from token interventions to on-scale assured interventions, to organize primary health care delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
f. In national health programmes—integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency.
g. In AYUSH services—from stand-alone to a three-dimensional mainstreaming.

4. ***National health programmes***
   a. *Universal immunization:* Improve immunization coverage with quality and safety, improve vaccine security as per National Vaccine Policy, 2011 and introduction of newer vaccines based on epidemiological considerations.
   b. *Communicable diseases:* The policy recognizes the interrelationship between communicable disease control programmes and public health system strengthening.
   c. *Control of tuberculosis:* The policy acknowledges HIV and TB coinfection and increased incidence of drug resistant tuberculosis as key challenges in control of tuberculosis. The policy calls for more active case detection, with a greater involvement of private sector supplemented by preventive and promotive action in the workplace and in living conditions.
   d. *Control of HIV/AIDS:* Policy recommends focused interventions on the high-risk communities (MSM, transgender, FSW, etc.) and prioritized geographies. There is a need to support care and treatment for people living with HIV/AIDS

Chapter

2

National Population Policy, 2000

Background

The overriding objective of economic and social development is to improve the quality of lives that people lead, to enhance their well-being, and to provide them with opportunities and choices to become productive assets in society. In 1952, India was the first country in the world to launch a national programme, emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy". After 1952, sharp declines in death rates were, however, not accompanied by a similar drop in birth rates. The National Health Policy, 1983 stated that replacement levels of total fertility rate (TFR) should be achieved by the year 2000. Stabilising population is an essential requirement for promoting sustainable development with more equitable distribution. However, it is as much a function of making reproductive health care accessible and affordable for all as of increasing the provision and outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, besides empowering women and enhancing their employment opportunities, and providing transport and communications. **Population growth in India continues to be high on account of the following.**

- Higher fertility due to unmet need for contraception (estimated contribution 20%). India has 168 million eligible couples, of which just 44% are currently effectively protected.
- The large size of the population in the reproductive age-group (estimated contribution 58%). This momentum of increase in population will continue for some more years because high TFRs in the past have resulted in a large proportion of the

of the health care providers and public health research and support to health and family welfare programmes.

At State Level

At the state level, the Mission functions under the overall guidance of the State Health Mission (SHM) headed by the State Chief Minister. The State Health Society (SHS) would carry the functions under the Mission and would be headed by the Chief Secretary.

At District Level

The District Health Mission (DHM)/City Health Mission (CHM) would be headed by the head of the local self-government, i.e. Chair Person Zila Parishad/Mayor as decided by the state depending upon whether the district is predominantly rural or urban. Every district will have a District Health Society (DHS), which will be headed by the District Collector.

Financing Components of NHM

NHM has six financing components:

i. NRHM-RCH flexipool,
ii. NUHM flexipool,
iii. Flexible pool for communicable disease,
iv. Flexible pool for non-communicable disease including injury and trauma,
v. Infrastructure maintenance and
vi. Family welfare central sector component.

National Rural Health Mission (NRHM)

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the empowered action group (EAG) states as well as north eastern states, Jammu and Kashmir and Himachal Pradesh have been given special focus.

The thrust of the mission is:

- To establishing a fully functional, community owned, decentralized health delivery system with intersectoral 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.