Annexure

I. CBHI In-service Training Courses: State/UT institution -wise number of Personnel Trained (2017-18)

S. No.	State / UT	HIM (O)	HIM (NM)	FIC (ICD - 10 & ICF) NM	MT/ ICD - 10	MT/ ICF	MR & IM
1	Andhra Pradesh	2	2				4
2	Arunachal Pradesh						
3	Assam						2
4	Bihar	13	38	42			11
5	Chhattisgarh			30			9
6	Goa						
7	Gujarat	1	1				1
8	Haryana	18	10	21	12	2	30
9	Himachal Pradesh			1	5		
10	Jammu & Kashmir	5				2	6
11	Jharkhand	2	4	8			4
12	Karnataka	15	30	54			6
13	Kerala	2					
14	Madhya Pradesh		25	30			10
15	Maharashtra	2					5
16	Manipur						
17	Meghalaya						
18	Mizoram						
19	Nagaland	1					
20	Odisha	14	39	29			12
21	Punjab	19	16	34	11	6	
22	Rajasthan	4	20	24			20
23	Sikkim						
24	Tamil Nadu						
25	Tripura		3				
26	Uttar Pradesh	15	37	32			14
27	Uttarakhand		1				
28	West Bengal						
29	A & N Islands						
30	Chandigarh			8	4	7	
31	Dadra & Nagar Haveli						
32	Daman and Diu						
33	Delhi	1	2			10	4
34	Lakshadweep						
35	Puducherry						
36	Telngana	5	10				
	Total	**119**	**238**	**313**	**32**	**27**	**150**

Notes:

HIM (O) -Orientation Training Course on Health Information management for Officers.
HIM(NM) -Orientation Training Course on Health Information management for for Non-medical Personnel
FIC(ICD 10 &ICF) -Orientation Training Course on Family of International Classification (ICD 10 & ICF)
MT/FIC (ICD 10 & ICF) -Master Trainers on Family of International Classification (ICD 10 & ICF)
MR&IM - Medical Record and Information management

II. Number of personnel trained for MRT and MRO at training centres of CBHI during 2017-18

Training Centre	MRO*	MRT**
Safdarjung Hospital, New Delhi	13	56
JIPMER Puducherry	12	34
Dr. RML Hospital, New Delhi	-	27
Total	**25**	**117**

Notes:

Duration of MRO and MRT courses are 1 year and 6 months respectively.
*MRT -Training Course for Medical Record Technician
**MRO -Training for Medical Record Officers

Brief on Central Bureau of Health Intelligence (CBHI)

Central Bureau of Health Intelligence (CBHI), established in **1961**, is the **health intelligence** wing of the Director General of Health Services in the Ministry of Health & FW, GOI with the vision to have "**A strong Health Management Information System in entire country**". This national institution is headed by a SAG level medical officer with specialization in public health administration of Central Health Services (CHS), supported by officers from Indian Statistical Services as well as CHS through its field survey and training units.

The Mission of CBHI is "**To strengthen Health Information system in each of the district in the country up to facility level for evidence based decision making in the Health Sector**".

The objective of CBHI

1. To collect, analyze & disseminate Health Sector related data of the country for evidence based policy decisions, planning and research activities;

2. To identify & disseminate innovative practices for Health Sector Reforms;

3. To develop Human resource for scientifically maintaining medical records in both Government & private medical Institutes in India;

4. To carry out Need Based Operational Research for Efficient implementation of Health Information System & Implementation of Family of International Classifications in India;

5. To sensitize & create a pool of Master Trainers in Health sector for implementation of Family of International Classification in India;

6. To collaborate with National & International Institutes for imparting knowledge & skill development and

7. To function as collaborating centre for WHO FIC in India & SEARO countries.

2. Organization

(a) The CBHI under the aegis of Dte. GHS, Government of India and headed by a Director, has three divisions viz. (i) Policy, Training & Coordination, (ii) Information & Evaluation, and (iii) Administration.

(b) It has six Health Information Field Survey Units (FSUs) under the supervision of respective Regional Office of Health & Family Welfare (ROHFW), GOI located at Bengaluru, Bhopal, Bhubaneshwar, Jaipur, Lucknow and Patna; each headed by a Deputy Director with technical & support staff.

(c) It conducts various in-service training courses through its six FSUs and four training centres viz. (i) Regional Health Statistics Training Centre (RHSTC), Mohali (near Chandigarh), Punjab, (ii) Medical Record Department & Training Centre (MRDTC) of Safdarjung Hospital, New Delhi, (iii) JIPMER, Puducherry, and (iv) Medical Record Department & Training Centre (MRDTC), Dr. RML Hospital, New Delhi.

3. Major Activities of CBHI

3.1 CBHI collects primary as well as secondary data on various communicable and non-communicable diseases, human resource in health sector and health infrastructure from various Government organizations/ departments to maintain and disseminate Heath Statistics through its annual publication "National Health

Profile" which highlights most of the relevant health information under 6 major indicators viz. Demographic, Socio-economic, Health Status, Health Finance, Health Infrastructure and Human Resources.

3.2 **CBHI collects the information on reform initiatives for Health Sector Policy Reform Option Database (HS-PROD). [www.hsprodindia.nic.in]**

Though States/UTs of India have been making sincere efforts and reforms in the health care delivery system, a lot of this goes unnoticed and is thus not documented. For this purpose, the European Commission supported Sector Investment Programme (SIP) of MoHFW, GOI initiated steps forward. In this endeavour, MoHFW identified CBHI, Dte. GHS to take up this challenge of creating Health Sector-Policy Reform Options Database (HS-PROD) of India. **More than 250 such initiatives under 16 key management areas** have been taken from a varied range of stakeholders like State/ UT governments, development partners, non-government organizations etc. **Kindly visit this website for appropriate use & replication of reforms. CBHI solicits information on such reforms from State/UT governments, health program managers, researchers, teachers and institutions in order to regularly update this national database.**

Sense of ownership and pride is to be taken in an effort like HS-PROD by all public health professionals.

3.3 National Level Man-power Development Training Programs:-

For capacity building and human resources development in health sector, CBHI conducts in-service training programme for the officers and the staff working in various Medical Record Department & health institutions of the Central/State governments, ESI, Defense and Railways and well as private health institutions through its various training centres.

Following are the long term in-service training programmes for maintenance of Medical Records in Medical Institutions, conducted by the CBHI with the view to strengthen and develop human resources & health information system of the country.

S. No	Name of the training	Batch	Duration	Training Centre
1.	Medical Record Officer	1 (at each training centre)	1 Year	1. Medical Record Deptt. & T.C. at Safdarjung Hospital in New Delhi 2. JIPMER, Puducherry
2.	Medical Record Technician	3 batches at Safdarjung Hospital and JIPMER) 2 batches at Dr.RML Hospital	6 Months	1. Medical Record Department & T.C. at Safdarjung Hospital in New Delhi 2. JIPMER, Puducherry 3. Dr. R M L Hospital, New Delhi

Training Calendar, Eligibility, Guidelines and Application Forms for all the above courses can be downloaded from the CBHI official website www.cbhidghs.nic.in

3.4 Capacity Building & Operation Research for Efficient health information system (HIS) including Family of International Classification (ICD-10 & ICF) use in India and South East Asia Region. CBHI is conducting National Level training course on Master trainers on ICD-10 & ICF at RHSTC at Mohali, Chandigarh. It is also organizing sensitization work shop on ICD-10 & ICF in big Govt. /Pvt. Hospitals and through its FSUs.

S. No.	Name of training	Batch/ year	Training Duration	Training Centre
1.	Training Course on Master Trainers On ICD-10	2	5 days	RHSTC Mohali
2	Training Course on Master Trainers On ICF	2	3 days	RHSTC Mohali
3	Orientation training course on Health Information Management (For Officers)	8	5 days	RHSTC Mohali & 6 FSUs
4.	Orientation training course on Health Information Management (For non medical personnel)	14	5 days	RHSTC Mohali & 6 FSUs
5	Orientation training course on Family of International classification (ICD-10 & ICF) (For Non-Medical Personnel)	20	5 days	RHSTC Mohali & 6 FSUs
6	Orientation training course on Medical Record & Information Management for Non-Medical Personnel	8	5 days	RHSTC Mohali & 6 FSUs

* On regular basis, CBHI conducts 54 batches of Training Courses every year. Special batches of National/ International Training Courses are conducted on request of States/UTs & various organizations like IRDA, WHO, Ministry of Defense etc.

3.5 CBHI Provides Internship and Health Management Programmes for the students of National Universities and Institutes.

3.6 Function as WHO Collaborating Centre on Family of International Classifications (ICD – 10 & ICF) in India with the following major objectives:-

(1) To promote the development & use of the WHO Family of International Classifications (WHO-FIC) including the International Statistical Classification of Diseases and Related Health Problems (ICD), the International Classification of Functioning, Disability and Health (ICF), and other derived and related classifications and to contribute to their implementation and improvement in the light of the empirical experience by multiple parties as a common language.

(2) Contribute to the development of methodologies for the use of the WHO-FIC to facilitate the measurement of health status, interventions and outcomes on a consistent and reliable basis to permit comparisons within and between countries at a same point in time by:

(a) Supporting the work of the various committees and work groups established to assist WHO in the development, testing, implementation, use, improvement, updating and revision of the member components of the WHO-FIC.

(b) Studying aspects related to the structure, interpretation and application of contents concerning taxonomy, linguistics, terminologies and nomenclatures.

(c) Participating in the quality assurance procedures of the WHO-FIC classifications regarding norms of use, training and data collection and application rules.

(3) Networking with current and potential users of the WHO-FIC and act as reference centre by:

a. Assisting WHO Headquarters and the Regional Offices in the preparation of member components of the WHO-FIC and other relevant materials.

b. Participating actively in updating and revising the member components of the WHO-FIC.

c. Providing support to existing and potential users of the WHO-FIC and of the data derived in India and SEARO Region. Linkage will also be made with other countries of Asian Pacific Region for seeking status on FIC implementation.

(4) Work in at least one related and/or derived area of the WHO-FIC: Speciality- based adaptations, primary care adaptations, interventions/procedures, injury classification (ICECI).

3.7 Maintaining three websites: www.cbhidghs.nic.in (Main Website), www.cbhi.nic.in (Data entry portal for on-line data transmission by the States/UTs to CBHI) and www.hsprodindia.nic.in.

4. CBHI Linkages and Coordination

1. All 36 States/UTs of India
2. All 20 Regional Offices of Health & FW of GOI
3. National Rural Health Mission (NRHM) and National Health Programmes in India
4. Medical, Nursing & Paramedical Councils & Educational Institutions
5. Public Health/Medical Care Organizations and Research Institutions under Department of Health Research including ICMR and Various other Ministries
6. Census Commissioner & Registrar General of India
7. NITI Ayog, Government of India
8. Ministry of Statistics & Programme Implementation
9. Ministry of Defence, Railways, Labour, HRD, Rural Development, Communication & Information Technology, Shipping Road Transport & Highways, Home Affairs, Social Justice & Empowerment, etc.
10. WHO and other UN Agencies Concerned with Health and Socio-economic Development
11. All the WHO – Collaborating Centres on Family of International Classification (FIC) in the world Asia Pacific Network on FIC and countries of South East Asia Region
12. European Commission
13. IRDA, Hyderabad
14. Institute of Economic Growth (IEG).
15. Non-Government Organizations in Health & related sectors in India

For more details, please visit CBHI-www.cbhidghs.gov.in

5. CBHI Training Centres

1.	Regional Health Statistics Training Centre (RHSTC), C/o Primary Health Centre Annexe, Phase 3-B-1, SAS Nagar, Mohali (Punjab) -160059. Tel/fax: 0172-2261070 E-mail: mohalirhstc@yahoo.com	2.	Medical Record Department and Training Centre, Safdarjung Hospital, Ansari Nagar, New Delhi -110029 Tel - 011-26707253 and 26165060 Fax No - 011-26163072 E-mail: mrtsjh@yahoo.com
3.	Medical Record Department and Training Centre JIPMER Puducherry - 605006 Tel – 0413 – 2272380 Extn. 4020 & 4022; Fax No – 0413 – 2272066 & 2272067 E-mail: anisax_60@rediffmail.com	4.	Medical Record Department and Training Centre, Dr. RML Hospital, Baba Kharak Singh Marg, New Delhi -110001 Tel - 011-23404325 E-mail: mrdrmlh@gmail.com
5.	CBHI Field Survey Unit Senior Regional Director (H & FW), Regional Office for Health & FW (ROHFW), Ministry of Health & FW, A-28, Vidhya Nagar, Behind Axis Bank, Hoshangabad Road, Bhopal (M.P.) – 462026 Tel: 0755-2416200 E-mail: rohfwbho@mp.nic.in	6.	CBHI Field Survey Unit Regional Office of Health & FW/GOI 2nd floor, F-Wing, Kendriya Sadan, Koramangala, Bangaluru - 560034 (Karnataka) Tel: 080 – 25537688, 25537310 Fax: 080 - 25539249 E-mail: rhobng@.nic.in
7.	CBHI Field Survey Unit, Regional Office of Health & FW/GOI Kendriya Sadan, Block B, Floor II, Sector 10, Vidyadhar Nagar, Jaipur – 302023 (Rajasthan) Tel: 0141 – 2236818 & 2236845; Fax: 0141 – 2233297 & 2236816 E-mail: rdrhojp@.nic.in	8.	CBHI Field Survey Unit Regional Office of Health & FW/GOI BJ-25, BJB Nagar, Bhubaneswar-751014 (Odisha) Tel :0674 - 2431326 & 2431708; Fax: 0674 - 2431904 E-mail: rohfwbbs@rediffmail.com
9	CBHI Field Survey Unit Regional office of Health & FW/GOI 5th Floor, Indira Bhawan, R.C. Singh Path, Patna - 800001 (Bihar) Tel: 0612- 2543711 Fax: 0612- 2547677 E-mail: srdhfw_pat_bih@gov.in	10	CBHI Field Survey Unit Regional Office of Health & FW/GOI Hall No.III, 9th floor, Kendriya Bhavan, Aliganj, Lucknow-226024 (Uttar Pradesh) Tel: 0522- 2332399; Fax: 0522-2325268 E-mail: rdrohlko@yahoo.co.in

6. National Collaborating Institutions of CBHI (WHO - CC on FIC) w.r.t. International Classifications of Functioning, Disability & Health (ICF).

Area of Specialty	S. No.	Name of Institute/Organization
Physical Medicine & Rehabilitation	1	Department of PMR, Safdarjung Hospital, New Delhi - 110029
	2	Department of PMR, All India Institute of Medical Sciences, Ansari Nagar, New Delhi - 110029
	3	Department of Orthopedics, Christian Medical College, Vellore - 632002, Tamil Nadu
	4	Department of Physiotherapy, MCOAHS, Manipal University, Manipal - 576104, Karnataka
Speech & Hearing Disability	5	Ali Yavar Jung, National Institute for the Hearing Handicapped, Mumbai - 400050
Visually Handicapped	6	National Institute for Visually Handicapped, Dehradun - 248001, Uttrakhand.
Mental/Health Psychiatry	7	Department of Psychiatric Social Work, NIMHANS, Hosur Road, Bangalore – 560029, Karnataka
	8	Schizophrenia Research Foundation, R – 7A, North Main Road, Anna Nagar West (Extn.), Chennai – 600101, Tamil Nadu.
Important Participatory Ministries	9	Directorate of Armed Forces Medical Services, Ministry of Defence, New Delhi -110001.
	10	Directorate of Health, Ministry of Railways, New Delhi -110001 and
	11	Health Commissionerate, ESI Corporation, Ministry of labour, New Delhi

Sustainable Development Goals

Over the past 15 years, the Millennium Development Goals (MDGs) have provided the global community a set of goals, targets and tools to monitor progress towards health and development in countries. But, as the Millennium Development Goals (MDGs) reach their December 2015 deadline , a new set of inclusive and universal Sustainable Development Goals (SDGs) have been adopted by the United Nations General Assembly in September 2015 as a part of the Post 2015 Development Agenda and which came into effect on 1st January 2016. The new Sustainable Development Agenda seeks to ensure that the momentum generated by the millennium development goals is carried forward beyond 2015 to achieve not just substantial reductions in poverty, hunger and other deprivations but finally end them to provide a life of dignity to all.

Sustainable Development Agenda consists of 17 Goals and 169 targets to be achieved by 2030.

Goal 1. End poverty in all its forms everywhere.

Goal 2. End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

Goal 3. Ensure healthy lives and promote well-being for all at all ages.

Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

Goal 5. Achieve gender equality and empower all women and girls.

Goal 6. Ensure availability and sustainable management of water and sanitation for all.

Goal 7. Ensure access to affordable, reliable, sustainable and modern energy for all.

Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.

Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.

Goal 10. Reduce inequality within and among countries.

Goal 11. Make cities and human settlements inclusive, safe, resilient and sustainable.

Goal 12. Ensure sustainable consumption and production patterns

Goal 13. Take urgent action to combat climate change and its impacts*

Goal 14. Conserve and sustainably use the oceans, seas and marine resources for sustainable development

Goal 15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.

Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

Goal 17. Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development.

Current Status of Health related SDG targets – Indian Scenario

Health-related SDG Indicators		SDG Target	India
3.1.1	Maternal Mortality Ratio (per 100,000 live births)	70 per 100,000 live births	174
3.1.2	Proportion of births attended by skilled health personnel (%)	To be determined	81.4
3.2.1	Under five mortality rate (per 1000 live births)	25 per 1000 live births	47.7
3.2.2	Neo natal mortality rate (per 1000 live births)	12 per 1000 live births	27.7
3.3.1	New HIV Infections among adults 15-49 years old (per 1000 uninfected population)	0 per 1000 uninfected population	0.11
3.3.2	TB Incidence (per 100,000 population)	80% reduction in TB incidence compared with 2015 baseline	217
3.3.3	Malaria Incidence (per 1000 population at risk)	90% reduction in malaria incidence compared with 2015 baseline	1
3.3.4	Hepatitis B incidence	To be determined	-
3.3.5	Reported number of people requiring interventions against NTDs	0	497,396, 247
3.4.1	Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%)	1/3 reduction from 2012 baseline	23.3
3.4.2	Suicide mortality rate (per 100,000) population)	To be determined	15.7
3.5.2	Total alcohol per capita (>15 years of age) consumption, in litres of pure alcohol	10% reduction in harmful use of alcohol	5
3.6	Road traffic mortality rate (per 100,000) population)	50% reduction	16.6
3.7.1	Proportion of married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)	100%	63.9
3.7.2	Adolescent birth rate (per 1000 women aged 15-19 years)	To be determined	28.1
3.8.1	Coverage of essential health services	100%	57
3.8.2	Financial Protection when using health services	% of household spending more than 10% on health	-
3.9.1	Mortality rate attributed to household and ambient air pollution (per 100,000) population)	To be determined	133.7
3.9.2	Mortality rate attributed to exposure to unsafe WASH services (per 100,000) population)	To be determined	27.4
3.9.3	Mortality rate from unintentional poisoning (per 100,000) population)	To be determined	1.9
3.a.1	Prevalence of tobacco use among persons 15 years and older (%)	30% reduction in current tobacco use	35
3.b.1	Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	To be determined	-
3.b.2	Total net official development assistance to medical research and basic health per capita (constant 2014 US$)	To be determined	0.2
3.c	Skilled health professionals density (physicians/nurses/midwives per 10000 population)	44.5 per 10000 population	30.2
3.d	Average of 13 international Health Regulations core capacity scores	100%	98

Source: *Monitoring Health in the Sustainable Development Goals: 2017, World Health Organization, Regional Office for South East Asia.*

National Health Policy

The primary aim of the National Health Policy, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.

Goal

The policy envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

Specific Quantitative Goals and Objectives:

The indicative, quantitative goals and objectives are outlined under three broad components viz. (a) health status and programme impact, (b) health systems performance and (c) health system strengthening. These goals and objectives are aligned to achieve sustainable development in health sector in keeping with the policy thrust.

1. Health Status and Programme Impact

1.1 Life Expectancy and healthy life

a) Increase Life Expectancy at birth from 67.5 to 70 by 2025.

b) Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories by 2022.

c) Reduction of TFR to 2.1 at national and sub-national level by 2025.

1.2 Mortality by Age and/ or cause

a) Reduce Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.

b) Reduce infant mortality rate to 28 by 2019.

c) Reduce neo-natal mortality to 16 and still birth rate to “single digit” by 2025.

1.3 Reduction of disease prevalence/ incidence

a) Achieve global target of 2020 which is also termed as target of 90:90:90, for HIV/AIDS i. e,- 90% of all people living with HIV know their HIV status, - 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.

b) Achieve and maintain elimination status of Leprosy by 2018, Kala-Azar by 2017 and Lymphatic Filariasis in endemic pockets by 2017.

c) To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.

d) To reduce the prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one third from current levels.

e) To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

2 Health Systems Performance

2.1 Coverage of Health Services

a) Increase utilization of public health facilities by 50% from current levels by 2025.

b) Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.

c) More than 90% of the newborn are fully immunized by one year of age by 2025.

d) Meet need of family planning above 90% at national and sub national level by 2025.

e) 80% of known hypertensive and diabetic individuals at household level maintain “controlled disease status‟ by 2025.

2.2 Cross Sectoral goals related to health

a) Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.

b) Reduction of 40% in prevalence of stunting of under-five children by 2025.

c) Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).

d) Reduction of occupational injury by half from current levels of 334 per lakh agricultural workers by 2020.

e) National/ State level tracking of selected health behavior.

3 Health Systems strengthening

3.1 Health finance

a) Increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025.

b) Increase State sector health spending to > 8% of their budget by 2020.

c) Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.

3.2 Health Infrastructure and Human Resource

a) Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norm in high priority districts by 2020.

b) Increase community health volunteers to population ratio as per IPHS norm, in high priority districts by 2025.

c) Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.

3.3 Health Management Information

a) Ensure district-level electronic database of information on health system components by 2020.

b) Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.

c) Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.

National Health Resource Repository

India is passing through a demographic and environmental transition which is enhancing the burden on public health resources and infrastructure. Situation becomes more complex by the fact that around 70% of Indian population lives in rural areas known for limited access to healthcare. The primary providers of healthcare in these areas are private clinics and hospitals, though there is a presence of Government funded public health services. While government has undertaken multiple initiatives to address the concern for service delivery and access to healthcare, there are still substantial gaps to be addressed for better healthcare infrastructure, access and its equity based distribution.

At this outset, government realizes that effective health resource management, allocation and monitoring based on evidence for timely achievements of goals. There is need of comprehensive picture of Indian healthcare sector to address aforesaid challenges and provide accessible, acceptable, affordable, equity based and patient centered quality healthcare services for the community. There are constraints on public health resources therefore, it is essential to allocate resources based on real world data and do regular monitoring and impact assessment of the allocated resources.

Recognizing the role of private health sector in Indian settings and its potential to supplement government initiatives and planning for public health resources, it has been felt to obtain reliable information on private sector healthcare resource deployment. This will also underpin government strategies to hitherto unreached segments of the population, where public health resources are constrained, potential to tie up with private sector can be explored for better service delivery.

For resource constraint country such as India, having comprehensive information on both public and private health sector is prerequisite for planning resource allocation. Generation and adoption of such evidence will help in driving judicious health resource planning and allocation to reduce the disparities and inequities in all three dimensions to achieve the Universal Health Coverage.

CBHI is committed to build an integrated health informatics platform which can provide reliable, accurate and relevant national health information and enable evidence based policy formulation and decision making. In line with the core strategies of generating evidence to facilitate rational planning and resource allocation, CBHI has embarked on an ambitious project to exhaustively map the healthcare establishments from both public and private sector, as one of its key initiatives.

CBHI now envisages setting up of consolidated platform of healthcare resource information named National Health Resource Repository (NHRR) to fulfill its core objective & intends to develop a single source of healthcare resource information that contains information on healthcare resources of both public and private sector in the country.

Acknowledging the relevance of evidence based health resource planning, CBHI in consultation with DGHS conducted a pilot study of the concept in 2014 to test the feasibility of the concept called NHRR. A street-by-street census was conducted to collect and comprehensively map 2098 public and private health facilities across four districts of Dimapur (Nagaland), Dungarpur (Rajasthan), Hazaribagh (Jharkhand) and Vellore (Tamil Nadu). Furthermore, on 22nd September, 2015, recognizing the relevance of data as a navigating module for planning public health services, Shri.J P Nadda, Hon'ble Union Minister of Health & FW, announced the nation wise roll out of National Health Resource Repository.

Vision

Creating a robust, standardized and secured information technology enabled repository of country's healthcare resources befitting as a building block into country's long term strategy of digitalizing healthcare to strengthen evidence based decision making.

Goal

NHRR envisages creating a single gateway of authentic, standardized, updated public and private healthcare resource intelligence and develop user friendly system with utility to serve as a decision making tool for varied categories of health system stakeholders.

Objectives

It has been mandated to achieve the following objectives

- Promote evidence based planning and decision making in healthcare sector through provision of comprehensive data on healthcare resources (both public and private sector) in the country.
- Provide visibility of private sector healthcare resources to facilitate public private partnership initiatives for improve access and availability of health services
- Provide technology based solutions to improve efficiency of health systems by improving planning, provisioning of healthcare resources
- Improve informed decision making and community awareness by allowing access to holistic information on healthcare resources.
- Promote meaningful use of data collection and exchange services for better healthcare management by providing a common platform for sharing information.
- Promote convergence between similar programmes by providing interoperability
- Enhance effectiveness of programme planning and implementation at centre, state and district level by providing updated healthcare resource status.
- Provide a platform for managing emergencies effectively by providing information on all the healthcare resources (public & private) in the designated geography.
- Furnish standardized data, distribution of resources and trends on the global platform, using regularly updated health status indicators.

Rationale from NHRR Stakeholders and users perspectives

Decision making in the healthcare sector is highly complex and have different levels ranges from single patient to country's policy makers at large. Stakeholders in health system range from single patient, community, providers, professional bodies, health Councils, various professional bodies, State, Central government and various development agencies etc

It was comprehended that envisaged NHRR should be able to cater the requirements of all stakeholders. Considering relevance and classification of data to be captured under NHRR, all stakeholders can be divided into four categories- Policy Makers, National & State Programme Managers, community and Private Providers.

NHRR aims to support decision making of all these stakeholders by providing reliable information, thereby, catering to the unmet needs of these stakeholders.

Needs of Policy Makers:

It is important that larger policy decisions are taken based on latest and reliable information on the available healthcare resources, their deployment and trends that can address entrenched problem of health system with real time solutions. To aid this, health policy and system planning must be demand-driven, and satisfy the needs of modern healthcare systems utilizing up-do-date information on country's healthcare resources.

Needs of National and State Programme Managers

Program planning involves identifying and projecting most critical needs of the different programme and community and by analyzing their existing ability to address those requirements. National and State Programme Managers draw their implementation plan keeping in consideration the gap analysis and priorities, presenting the case to higher –ups, executing the plan and evaluating the outcome of the efforts, and reporting that outcome back to partners, stakeholders, and to policy makers.

Needs of Community:

Community is a major stakeholder in the healthcare system where all the planning, decisions, services and provisions get concentrated, and eventually are the beneficiary of healthcare services and related interventions. In the current scenario, it is widely advocated that role of the community should not only be limited to recipient of services but it should also have community participation in decision making. Community decision making primarily involves decision making at two level; individual level and community at large. Information on availability, and affordability of health services influence access to health services.

Needs of Private Providers:

Private providers constitute a significant part of the health system in India which ranges from single providers to corporate hospitals. Private provider behavior is influenced by the interplay of policy-makers who set policy, enact legislation and enforce regulations. Similarly, it is also affected by purchasing power of populations and providers' experience, skills and motivations to deal with patient, government and their competitor. However, focusing on coverage, quality, cost, along with policy-makers, providers and people, serves as a helpful aide-memoire for private providers to organize their service better and eventually leading to service improvement.

Data Variables

Over 850 variables have been identified from extensive literature review of Indian Public Health Standard Guidelines (IPHS), individual national programme operational guidelines And National Quality Asuurance Guidelines for public health facilities.

A Census at national level for health resource enumeration will be carried out to obtain data from all public and private health facilities of 29 States and 7 Union Territories, concurrently, and mapping all healthcare establishments in all the districts across the country. All the public health facilities including District Hospitals, Sub-Divisional Hospital, Taluka-Community Health Centre, Primary Health Centre, Sub Centre, other government hospitals and private hospitals , private doctors, diagnostic labs and chemists present nationwide shall be covered in the Census.

WHO Collaborating Centers for the Family of International Classifications (ICD-10, ICF & ICHI) In the World and India

WHO works with a network of Collaborating Centers to develop, disseminate, implement and update the WHO Family of International Classifications to support national and international health information systems, statistics and evidence.

The Collaborating Centers have been established to assist WHO and users with the development and implementation of WHO-Family of International Classifications. It is important that users bring to the attention of the respective Centre any significant problems they might encounter in the use of WHO-FIC classifications. Proposals for amendments or additions to the classifications should be directed, in the first instance, to the relevant Centre.

Designated Collaborating Centers

1.1	**Argentina** **Head:** Lic Karina Revirol Dirección de Estadísticas e Información de Salud (DEIS) Ministerio de Salud de la Nación (MSAL) Av. 9 de julio 1925, 6to. Piso, Oficina 606 C1073ABA, Capital Federal, Argentina Tel: +541143799024 Fax: +541143812015 Website: http://www.deis.gov.ar Email: karevirol@gmail.com	**1.2**	**Australia** **Head:** Ms Jenny Hargreaves Australian Institute of Health and Welfare GPO Box 570 Canberra ACT 2601 Australia Tel: +61 2 6244 1000 Fax: +61 2 6244 1111 Website: www.aihw.gov.au Email: who_fic@aihw.gov.au
1.3	**PR China** **Head:** Dr Yipeng Wang and Dr Zhuoying Qiu Peking Union Medical College Hospital (PUMCH) Chinese Academy of Medical Sciences (CAMS) No.1 Shuaifuyuan Hutong, Dongcheng District 100730, Beijing, People's Republic of China Tel: +(86-10) 69155575 Fax: +(86-10) 69155575 Website: http://www.pumch.cn/ksyl/yjks/jbflzx/ Email: ypwang@medmail.com.cn	**1.4**	**PR Cuba** **Head:** Dr Sonia Bess and Dr Miguel Angel Martinez Cuban Centre for Classification of Diseases (CECUCE) National Direction of Medical Records and Health Statistics, Ministry of Public Health of Cuba Street 23 N. 201 10400, Havana City, Vedado, Cuba Tel: +53-7-8383398 Fax: +53-7-8383404 Website: http://www.sld.cu/sitios/dne Email: sonia@mspdne.sld.cu Email: mangel@mspdne.sld.cu
1.5	**France** **Head:** Ms Claire Rondet and Dr Marie Cuenot Centre d'Epidémiologie sur les Causes médicales de Décès (CépiDC) Institut National de la Santé et de la Recherche Médicale (INSERM) 80 Rue du general Leclerc, Bâtiment La Force porte 58, 3ème étage 94270, Le Kremlin-Bicêtre, France Tel: +33 (1) 49 59 19 29 Fax: +33 (1) 49 59 19 30 Website: http://www.cepidc.inserm.fr Email: claire.rondet@inserm.fr Email: Marie.Cuenot@ehesp.fr	**1.6**	**Germany** **Head:** Dr Stefanie Weber and Dr Ulrich Vogel German Institute for Medical Documentation and Information (DIMDI) Abteilung M Waisenhausgasse 36-38A D-50676 Cologne, Germany Tel: +(49-221) 4724 1 Fax: + (49-221) 4724 444 Website: http://www.dimdi.de Email: stefanie.weber@dimdi.de Email: ulrich.vogel@dimdi.de

1.7	**India** **Head:** Dr Madhu Raikwar Central Bureau of Intelligence, Directorate General of Health Services Ministry of Health & Family Welfare Room No. 404, A-Wing, Nirman Bhawan 110108, New Delhi, India Tel: + 91 011 23063175 Fax: + 91 011 23063175 Website: http://www.cbhidghs.nic.in Email: dircbhi@nic.in Email: jdie@cbhidghs.nic.in	**1.8**	**Italy** **Head:** Dr Lucilla Frattura Classification Area, General Directorate Regional Central Health Directorate Via Pozzuolo 330 Friuli Venezia Giulia Region 33100 Udine, Italy Tel: (+39) 0432 805605 Fax: (+39) 0432 805680 Website: http://www.reteclassificazioni.it Email: lucilla.frattura@regione.fvg.it
1.9	**Japan** **Head:** Dr Kei Mori International Classification & Information Management Office (Japan ICD Office) Policy Planning Division, Statistical and Information Department Minister's Secretariat Ministry of Health, Labour and Welfare 1-2-2 Kasumigaseki, Chiyoda-ku 100-8916 Tokyo, Japan Tel: +81-3-3595-3501 Fax: +81-3-3595-1605 Website: http://www.mhlw.go.jp/english/ Email: icdoffice@mhlw.go.jp	**1.10**	**Kuwait** **Head:** Dr Mijbel Alnajjar Health Information and Medical Records Ministry of Health Jamal Abdel Nasir Abdulaziz Hamad Alsaqr St P. O. Box 5286 Safat 13053 Shuwaikh (Sabah Health Region), Mirqab, Kuwait Tel: +965-22429862 Fax: +965-24620638 Website: http://www.moh.gov.kw/ Email: Doctorm80@hotmail.com Email: whoficcckuwait@gmail.com
1.11	**Mexico** **Head:** Dr Hector Hernandez-Bringas Classifications of Information on Health General Direction of Health Information Ministry of Health Ave. Paseo de la Reforma 450, piso 11 Col. Juárez, Delegación Cuauhtémoc 06600 Mexico City, Distrito Federal, Mexico Tel: +(55) 6392 2300 ext 52569 Fax: +(55) 5514 5294 Website: http://www.dgis.salud.gob.mx/contenidos/cemece/cindex.html Email: hector.hernandezb@salud.gob.mx	**1.12**	**The Netherlands** **Head:** Dr Coen H van Gool and Dr Huib ten Napel Center for Health Knowledge Integration (cKVZ) National Institute for Public Health and the Environment (RIVM) A. van Leeuwenhoeklaan 9, PO Box 1 Col. Juárez, Delegación Cuauhtémoc 3720 BA Bilthoven, The Netherlands Tel: +31 30 2748521 Fax: ++31 30 2744450 Website: htttp://www.rivm.nl/who-fic Email: coen.van.gool@rivm.nl Email: Huib.ten.Napel@rivm.nl
1.13	**North America** **Head:** Ms Donna Pickett National Center for Health Statistics (NCHS) Classifications and Public Health Data Standards Centers for Disease Control and Prevention (CDC) 3311 Toledo Road 20782 Hyattsville, Maryland, United States of America Tel: +1 (301) 458 4434 Fax: +1 (301) 458 4022 Website: http://www.cdc.gov/nchs/icd/nacc.htm Email: dfp4@cdc.gov Canadian Contact Dr Keith Denny Email: KDenny@cihi.ca	**1.14**	**Norway** **Head:** Dr Lars Berg Department of Classifications in Health Care Norwegian Directorate of eHealth P.O. Box 6737, St. Olavs plass 0130 Oslo, Norway Tel: +47 2149 50 70 Website: http://www.ehelse.no Email: lars.berg@primnet.se

1.15	**Republic of Korea** **Head:** Dr Yeung-gyu Park Social Security Information Service 17F Namsan Square Bldg., Chungmu-ro 3ga, Jung-gu 04554 Seoul, Republic of Korea Tel: +82 (2) 6360-5599 Fax: +82 (2) 6360-6930 Website: http://www.ssis.or.kr Email: koreawhofic@khwis.or.kr	**1.16**	**Russian Federation** **Head:** Dr Sergei Cherkasov National Research Institute for Public Health 12 Vorontsovo Pole 12/1 105064 Moscow, Russian Federation Tel: +7 495 917 48 86 Fax: +7 495 916 03 98 Website: http://www.nriph.ru Email: cherkasovsn@mail.ru
1.17	**South Africa** **Head:** Dr Lyn Hanmer and Dr Debbie Bradshaw Burden of Disease Research Unit (BoDRU) South African Medical Research Council PO Box 19070 7505 Cape Town, Tygerberg, South Africa Tel: +27 21 938 0959 Fax: +27 21 938 0310 Website: www.mrc.ac.za Email: Lyn.Hanmer@mrc.ac.za Email: debbie.bradshaw@mrc.ac.za	1.18	**Thailand** **Head:** Dr Wansa Paoin Thai Health Standard Coding Center Bureau of Policy and Strategy Office of the Permanent Secretary Ministry of Public Health Tiwanon Road 11000 Nonthaburi, Thailand Tel: +66 2-5901492 Fax: +66 2-9659816 Website: http://www.thcc.or.th/ Email: wansa@tu.ac.th
1.19	**United Kingdom** **Head:** Dr Lynn Bracewell Terminology and Classifications Development NHS Digital Floor 2, Princes Exchange, Princes Square LS1 4HY Leeds, West Yorkshire, United Kingdom Tel: +44(0)113 397 4399 Website: www.digital.nhs.uk Email: lynn.bracewell@nhs.net	**1.20**	**Venezuela** **Head:** Dr Cruz Cordero Venezuelan Centre for Classification of Diseases (CEVECE) Ministerio del Poder Popular para la Salud Simon Bolivar Centre Edif. Sur, piso 3, Ofic. 315 1010 Caracas, Venezuela Tel: +58(212)408-0220 Tel: +58(212)408-0221 Website: http://cevece-venezuela.blogspot.com/ Email: cevece.venezuela@yahoo.es mail: cruzcorba@hotmail.com

Designated Collaborating Centres for Classifications, Terminologies, and Standards

1.	Collaborating Centre for CTS at the China National Health Development Research Center Heads: Dr Wei Fu and Dr Qin Jiang China National Health Development Research Center 38 Xueyuan Rd., Haidian District 100191 Beijing, People's Republic of China Tel: +86 10 82801232 Fax: +1 (507) 202-5818 Website: http://www.nhei.cn Email: fuwei@nhei.cn Email: jiangqin2007@gmail.com	**2.**	Collaborating Centre for CTS at Mayo Clinic Heads of Centre: Dr Hongfang Liu Heads of Centre: Dr Guoqian Jiang Division of Biomedical Informatics Mayo Clinic 200 First Street S.W. 55905 Rochester, Minnesota, United States of America Tel: +1 (507) 284-5506 Fax: +1 (507) 202-5818 Website: http://www.mayo.edu/research/departments-divisions/department-health-sciences-research/division-biomedical-statistics-informatics/overview Email: Liu.Hongfang@mayo.edu Email: jiang.guoqian@mayo.edu
3.	Collaborating Centre for CTS at Stanford University Head of Centre: Dr Mark Musen Stanford Center for Biomedical Informatics Stanford University 1265 Welch Road, Room X-215 94305 Stanford, California, United States of America Tel: +1 (650) 723-6979 Fax: +1 (650) 725-7944 Website: http://bmir.stanford.edu/ Email: Liu.Hongfang@mayo.edu Email: jiang.guoqian@mayo.edu	**4.**	Collaborating Centre for CTS at the University of Calgary Head of Centre: Dr Hude Quan University of Calgary 3280 Hospital Drive NW T2N 4Z6, Alberta, Cananda Tel: +1 (403) 2108617 Fax: +1 (403) 210-3819 Website: http://www.iph.ucalgary.ca/ Email: hquan@ucalgary.ca

Source: *WHO Website accessed at http://www.who.int/classifications/network/collaborating/en/*

Note: Last updated on 26th October 2017.

Various National Programmes/Schemes/Policies in Health Sector in India

1. Ayushman Bharat -National Health Protection Mission (AB-NHPM) (2018)

Ayushman Bharat is National Health Protection Scheme, which will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization. The Union Minister for Finance and Corporate Affairs, Shri Arun Jaitely while presenting the General Budget 2018-19 in Parliament announced this programme. Ayushman Bharat - National Health Protection Mission will subsume the on-going centrally sponsored schemes - Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS). This will be the world's largest government funded health care programme.

Benefits of the scheme are portable across the country and a beneficiary covered under the scheme will be allowed to take cashless benefits from any public/private empanelled hospitals across the country. The beneficiaries can avail benefits in both public and empanelled private facilities. To control costs, the payments for treatment will be done on package rate (to be defined by the Government in advance) basis. States would need to have State Health Agency (SHA) to implement the scheme.

2. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) (2016)

Pradhan Mantri Surakshit Matritva Abhiyan envisages to improve the quality and coverage of Antenatal Care (ANC) including diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy. Shri J P Nadda, Union Minister of Health and Family Welfare, launched PMSMA on 04-November-2016. PMSMA guarantees a minimum package of antenatal care services to women in their 2nd / 3rd trimesters of pregnancy at designated government health facilities. PMSMA is based on the promise — that if every pregnant woman in India is examined by a physician and appropriately investigated at least once during the PMSMA and then appropriately followed up — the process can result in reduction in the number of maternal and neonatal deaths in our country.

3. National Health Mission

The National Health Mission (NHM) encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the newly launched 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 health care services that are accountable and responsive to people's needs.

3.1 National Rural Health Mission (NRHM) (2005)

National Rural Health Mission (NRHM) was launched in April 2005 and it morphed into National Health Mission (NHM) with launch of National Urban Health Mission (NUHM) during 2013. Thereafter, NRHM and NUHM became two sub-missions under the overarching NHM.

NRHM seeks to provide equitable, 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

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. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

3.2 National Urban Health Mission (NUHM) (2013)

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) was approved by the Cabinet on 1st May 2013.

NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out of pocket expenses for treatment. NUHM would endeavour to achieve its goal through:-

i) Need based city specific urban health care system to meet the diverse health care needs of the urban poor and other vulnerable sections.

ii) Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.

iii) Partnership with community and local bodies for a more proactive involvement in planning, implementation, and monitoring of health activities.

iv) Availability of resources for providing essential primary health care to urban poor.

v) Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders.

It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers.

4. National Programme for Prevention & Management of Burn Injuries (NPPMBI) (2014)

NPPMBI as full-fledged programme was approved by Cabinet Committee for Economic Affairs (CCEA) on 6th February, 2014, for covering 67 State Government Medical Colleges and 19 District Hospitals during the 12th Five Year Plan. The Goal of NPPMBI is to ensure prevention of Burn Injuries, provide timely and adequate treatment in case burn injuries do occur, so as to reduce mortality, complications and ensuing disabilities and to provide effective rehabilitative interventions if disability has set in. The objective of NPPMBI is to reduce incidence, mortality, morbidity and disability due to Burn Injuries and improve awareness among the general masses and vulnerable groups especially the women, children, industrial and hazardous occupational workers.

5. The National Mental Health Policy (2014)

The National Mental Health Policy, announced in October, 2014, is based, inter-alia, on the values and principles of equity, justice, integrated and evidence based care, quality, participatory and holistic approach to mental health. The vision of the National Health Policy is to promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span, within a rights-based framework.

6. Rashtriya Kishor Swasthya Karyakram (RKSK) (2014)

The Ministry of Health & Family Welfare launched on 7th January, 2014 a health programme, named Rashtriya Kishor Swasthya Karyakram, for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues. The key principle of this programme is adolescent participation and leadership, Equity and inclusion, Gender Equity and strategic partnerships with other sectors and stakeholders. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well being and by accessing the services and support they need to do so. The objectives of this programme are to Improve Nutrition, Improve Sexual and Reproductive Health, Enhance Mental Health, Prevent Injuries & violence and Prevent substance misuse.

7. WHO on 24th February 2012 removed India from the list of "endemic countries with active polio virus transmission" (2012)

India committed to resolution passed by World Health Assembly for global polio eradication in 1988. National Immunization Day (NID) commonly known as Pulse Polio Immunization programme was launched in India in 1995, and is conducted twice in early part of each year.

India was removed from the list of countries with active endemic wild poliovirus transmission by WHO on 24th February 2012 as no wild poliovirus was detected from any source for more than 12 consecutive months after 13th January 2011 in Howrah district of West Bengal.

Indian along with ten other countries of South East Asia Region of World Health Organization (WHO) was subsequently certified "that the transmission of indigenous wild poliovirus has been interrupted in all countries of the region.

8. Janani Shishu Suraksha Karyakaram (JSSK) (2011)

Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The scheme is estimated to benefit more than 12 million pregnant women who access Government health facilities for their delivery. It is an initiative with a hope that states would come forward and ensure that benefits under JSSK would reach every needy pregnant woman coming to government institutional facility.

The launch of Janani Shishu Suraksha Karyakram signals to huge leap forward in the quest to make "Health for All" a reality. It invokes a new approach to healthcare, placing for the first time, utmost emphasis on entitlements and elimination of out of pocket expenses for both pregnant women and neonates. The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no-expense delivery. All expenses relating to delivery in a public institution are borne by the government. Under this initiative, a pregnant woman is entitled to free transport from home to the government health facility. Entitlement includes free drugs and consumables, free diagnostic, free blood, free diet for the duration of a woman's stay in the facility. Similar entitlements have been put in place for all sick newborns accessing public health institutions for healthcare till 30 days after birth. They are entitled to free treatment besides free transport, both ways and between facilities in case of a referral.

JSSK is estimated to benefit more than one crore pregnant women and newborns every year both in urban and rural areas. It supplements the cash assistance given to a pregnant woman under Janani Suraksha Yojana (JSY).

9. Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) (2010)

National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was launched in 2010 in 100 districts across 21 States with the aim to prevent and control these diseases thorough awareness generation, behaviour and life-style changes, early diagnosis of persons with high levels of risk factors. The programme manages chronic Non-Communicable diseases especially Cancer, Diabetes, CVDs and Stroke through early diagnosis, treatment and follows up through setting up of NCD clinics. It aims to promote health through behavior change with involvement of community, civil society, community based organizations, media etc. Provision has been made under the programme to provide free diagnostic facilities and free drugs for NCD patients attending the NCD clinics at the District and CHC levels.

10. National Programme for the Health Care of Elderly" (NPHCE) (2010)

Keeping in view the recommendations made in the "National Policy on Older Persons" as well as the State's obligation under the "Maintenance & Welfare of Parents & Senior Citizens Act 2007", the Ministry of Health & Family Welfare launched the "National Programme for the Health Care of Elderly" (NPHCE) during the year 2010, in the 11th Plan period, to address various health related problems of elderly people.

11. The National Programme for Prevention and Control of Fluorosis (NPPCF) (2008)

To address the problem of fluorosis, mainly due to intake of high fluoride through drinking water, the National Programme for Prevention and Control of Fluorosis (NPPCF) was initiated in 2008-09 during 11th Five Year Plan.

Objectives of NPPCF:

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

The strategy followed under the programme is surveillance of fluorosis in the community; capacity building (Human Resource) in the form of training and manpower support; establishment of diagnostic facilities in the district; health education for prevention and control of fluorosis cases; management of fluorosis cases including supplementation and surgery.

12. Rashtriya Swasthya Bima Yojana (RSBY) (2008)

Government of India decided to introduce Rashtriya Swasthya Bima Yojana (RSBY) a Health Insurance Scheme for the Below Poverty Line families with the objectives to reduce OOP expenditure on health and increase access to health care. RSBY was launched in early 2008 and was initially designed to target only the Below Poverty Line (BPL) households, but has been expanded to cover other defined categories of unorganised workers. This health insurance scheme for BPL(below poverty line) families was launched for the workers in the unorganized sector in the FY 2007-08 and it became fully operational from 1st April 2008.

It provides for IT-enabled and smart–card-based cashless healthy insurance, including maternity benefit cover up to Rs. 30,000/- per annum on a family floater basis to BPL families (a unit of five) and 11 other defined categories namely Building & Other Construction Workers, licensed Railway porters, Street Vendors, MGNREGA workers

(who have worked for more than fifteen days during preceding financial year), Beedi workers, Domestic workers, Sanitation Workers, Mine Workers, Rickshaw pullers, Rag pickers and Auto/Taxi drivers in the unorganized sector who are enrolled under RSBY.

Since 1st April, 2015, the Scheme Rashtriya Swasthya Bima Yojana (RSBY) has been transferred from Labour and Employment Ministry to Ministry of Health & Family Welfare on "as is where is" basis.

13. National Programme for Prevention and Control of Deafness (NPPCD) (2007)

Ministry of Health & Family Welfare had launched this programme on the pilot phase basis in the year 2006-07(January 2007) in an effort to tackle the high incidence of deafness in the country, in view of the preventable nature of this disability. Under this programme, hearing-aid are provided as per synergy between Assistance to Disabled Persons (ADIP) Scheme of Ministry of Social Justice & Empowerment (MSJE) and National Programme for Prevention and Control of Deafness (NPPCD) of Ministry of Health & Family Welfare.

14. The National Tobacco Control Programme (NTCP) (2007)

In order to protect the youth and masses from the adverse effects of tobacco usage, second hand smoke (SHS) and to discourage the consumption of tobacco, the Govt. Of India enacted and comprehensive tobacco control law namely "Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003. In order to facilitate the effective implementation of the Tobacco Control Law, to bring about greater awareness about the harmful effects of tobacco as well as to fulfil the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Programme (NTCP) in 2007- 08 in 42 districts of 21 States/Union Territories of the country with objective to bring about greater awareness about the harmful effects of tobacco use and Tobacco Control Laws and to facilitate effective implementation of the Tobacco Control Laws. Further, the objective of this programme is to control tobacco consumption and minimize the deaths caused by it.

15. The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) (2003)

PMSSY was announced in 2003 with objectives of correcting regional imbalances in the availability of affordable/ reliable tertiary healthcare services and also to augment facilities for quality medical education in the country.

PMSSY has two components:

(i) Setting up of AIIMS like Institutions.

(ii) Upgradation of Government Medical College Institutions.

Apart from declaration of six AIIMS in 2003, the PMSSY scheme has been enlarged to encompass setting up of many other AIIMS at different states and also upgradation of existing Government Medical Colleges/Institutions (GMCIs) in different states.

16. Janani Suraksha Yojana was launched in April 2005 by modifying the National Maternity Benefit Scheme (NMBS).

The Janani Suraksha Yojana (JSY) is a centrally sponsored Scheme which is being implemented with the objective of reducing maternal and infant mortality by promoting institutional delivery among pregnant women. Under the JSY, eligible pregnant women are entitled for cash assistance irrespective of the age of mother and number

of children for giving birth in a government or accredited private health facility. The scheme focuses on poor pregnant woman with a special dispensation for states that have low institutional delivery rates.

Janani Suraksha Yojana was launched in April 2005 by modifying the National Maternity Benefit Scheme (NMBS). The NMBS came into effect in August 1995 as one of the components of the National Social Assistance Programme (NSAP). The scheme was transferred from the Ministry of Rural Development to the Department of Health & Family Welfare during the year 2001-02. The NMBS provides for financial assistance of Rs. 500/- per birth up to two live births to the pregnant women who have attained 19 years of age and belong to the below poverty line (BPL) households. States were classified into Low Performing States and High Performing States on the basis of institutional delivery rate i.e. states having institutional delivery 25% or less were termed as Low Performing States (LPS) and those which have institutional delivery rate more than 25% were classified as High Performing States (HPS). The scheme also provides performance based incentives to women health volunteers known as ASHA (Accredited Social Health Activist) for promoting institutional delivery among pregnant women.

17. Integrated Disease Surveillance Project (IDSP) (2004)

Government of India initiated Integrated Disease Surveillance Project (IDSP) in 2004 with the aim to detect and respond to outbreaks of epidemic prone diseases. A Central Surveillance Unit (CSU) at Delhi, State Surveillance Units (SSU) at all State/UT head quarters and District Surveillance Units (DSU) at all Districts in the country have been established.

Mission of IDSP is to strengthen the disease surveillance in the country by establishing a decentralized State based surveillance system for epidemic prone diseases to detect the early warning signals, so that timely and effective public health actions can be initiated in response to health challenges in the country at the Districts, State and National level. Objective of IDSP is to strengthen/maintain decentralized laboratory based IT enabled disease surveillance system for epidemic prone diseases to monitor disease trends and to detect and respond to outbreaks in early rising phase through trained Rapid Response Team (RRTs)

18. National Vector Borne Disease Control Programme (NVBDCP) (2003)

The National Vector Borne Disease Control Programme (NVBDCP) is an umbrella programme for prevention and control of Vector borne diseases. Earlier the Vector Borne Diseases were managed under separate National Health Programmes, but now NVBDCP covers all 6 Vector borne diseases namely: 1. Malaria 2. Dengue 3. Chikungunya 4. Japanese Encephalitis 5. Kala-Azar 6. Filaria (Lymphatic Filariasis). The National Vector Borne Disease Control Programme (NVBDCP) is the programme for prevention & control of these vector borne diseases as an integral part of the National Health Mission (NHM) of India. The NVBDCP envisages a self-sustained and well informed, healthy India free from vector borne diseases with equitable access to quality health care services nearest to their residences. The Programme activities are directed in a way to meet with the Millennium Development Goal of halting and reversing the incidence of malaria and other vector borne diseases by the year 2015.

19. National AIDS Control Programme (1992)

National AIDS Control Organization is a division of the Ministry of Health and Family Welfare that provides leadership to HIV/AIDS control programme in India through 35 HIV/AIDS Prevention and Control Societies. In 1992 India's first National AIDS Control Programme (1992-1999) was launched, and National AIDS Control Organization (NACO) was constituted to implement the programme. Over time, the focus has shifted from raising awareness to behavior change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of PLHIV.

In 1992, the Government launched the first National AIDS Control Programme (NACP- I) to combat the disease. NACP I was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country. National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organization (NACO) was set up to implement the project. In November 1999, the second National AIDS Control Project (NACP- II) was launched with two key objectives to reduce the spread of HIV infection in India AND to increase India's capacity to respond to HIV/AIDS on a long-term basis. In response to the evolving epidemic, the third phase of the national programme (NACP -III) was launched in July 2007 with the goal of Halting and Reversing the Epidemic by the end of project period.

Consolidating the gains made during NACP-III, the National AIDS Control Programme Phase-IV (NACP- IV) (2012-17) was launched to accelerate the process of reversal and to further strengthen the epidemic response in India through a cautious and well defined integration process over the period 2012-2017 with key strategies of intensifying and consolidating prevention services with a focus on HRG and vulnerable population, increasing access and promoting comprehensive care, support and treatment, expanding IEC services for general population and high risk groups with a focus on behavior change and demand generation, building capacities at national, state and district levels and strengthening the Strategic Information Management System.

20. Revised National TB Control Programme (RNTCP) (1997)

The Revised National Tuberculosis Control Programme initiated early and firm steps to its declared objective of Universal access to early quality diagnosis and quality TB care for all TB patients'. The year 2012 witnessed innumerable activities happening towards the same. Notification of TB; case based web based recording and reporting system (NIKSHAY); Standards of TB care in India; Composite indicator for monitoring programme performance; Rapid scale up of the programmatic management of drug resistant TB services are few of the worthwhile mention in this regard. NIKSHAY, the web based reporting for TB programme has been another notable achievement initiated in 2012 and has enabled capture and transfer of individual patient data from the remotest health institutions of the country.

21. National Iodine Deficiency Disorders Control Programme (NIDDCP) (1992)

Iodine deficiency disorders (IDD) continue to be a major public health problem in India. Realizing the magnitude of the problem, the Government of India had launched a 100 per cent centrally assisted National Goitre Control Programme (NGCP) in 1962. In August, 1992 the National Goitre Control Programme (NGCP) was renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view of wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf mutisim, cretinism, still births, abortions etc.. The programme is being implemented in all the States/UTs for entire population. The goal of NIDDCP is to bring the prevalence of IDD to below 5% in the country and to ensure 100% consumption of adequately iodated salt (15ppm) at the household level.

22. National Leprosy Eradication Programme (NLEP) (1983)

Govt. of India started National Leprosy Control Programme in 1955 based on Dapsone domiciliary treatment through vertical units implementing survey education and treatment activities. Govt. of India established a high power committee under chairmanship of Dr. M.S. Swaminathan in 1981 for dealing with the problem of leprosy. Based on its recommendations the NLEP was launched in 1983 with the objective to arrest the disease activity in all the known cases of leprosy. The National Health Policy, Govt. of India sets the goal of elimination of leprosy i.e. to reduce the no. of cases to < 1/10,000 population by the year 2005. The National Leprosy Eradication

Programme took up the challenge and as a result of the hard work and meticulously planned and executed activities, the country achieved the goal of elimination of leprosy as a public health problem, defined as less than 1 case per 10,000 population, at the National Level in the month of December, 2005.

23. National Mental Health Program (NMHP) (1982)

To address the huge burden of mental disorders and shortage of qualified professionals in the field of mental health, Government of India has been implementing National Mental Health Program (NMHP) since 1982. The Program was re-strategized in 2003 to include two schemes, viz. Modernization of State Mental Hospitals and Up-gradation of Psychiatric Wings of Medical Colleges/General Hospitals. The Manpower development scheme (Scheme-A & B) became part of the Program in 2009.

The Government has supported the establishment of 23 Centres of Excellence under the National Mental Health Programme (NMHP) since initiation of Scheme. To address the acute shortage of qualified mental health professionals in the country, the Central Government, under the National Mental Health Programme (NMHP) is providing support for implementation of manpower development schemes by States/UTs for establishment of Centres of Excellence and strengthening/ establishment of Post Graduate (PG) Departments in mental health specialties. These schemes have resulted in increasing the availability of additional Human Resources in the field of mental health.

24. National Programme for Control of Blindness and Visual Impairment (NPCB) (1976)

National Programme for Control of Blindness and Visual Impairment (NPCB&VI) was launched in the year 1976 with the goal of reducing the prevalence of blindness to 0.3% by 2020. Various activities/initiatives undertaken during the Five Year Plans under NPCB are targeted towards achieving the goal of reducing the prevalence of blindness to 0.3% by the year 2020.

Definitions of various Terms used in NHP-2018

Accidental Deaths: The total number of deaths caused by an accident or by causes attributable to forces of nature per 1,00,000 population during the reference year in a given country, territory, or geographical area.

ANC (Ante natal care): It is a systemic supervision of a woman during pregnancy at regular intervals to monitor maternal wellbeing, fetal wellbeing and progress of fetal growth. Minimum ante natal cares include at least three ante natal check-ups, TT immunization and IFA supplement.

Annual Exponential Growth Rate: Annual population growth rate for year t is the exponential rate of growth of midyear population from year t-1 to t, expressed as a percentage. Population is based on the de facto definition of population, which counts all residents regardless of legal status or citizenship.

Annual GDP Growth Rate: The annual rate of change of the gross domestic product (GDP) at market prices based on constant local currency, for a given national economy, during a specified period of time. It expresses the difference between GDP values from one period to the next as a proportion of the GDP from the earlier period, usually multiplied by 100.

Birth Rate: The number of live births per 1000 estimated midyear population, in a given year.

Calorie: A calorie is a unit of measurement for energy. In most fields, it has been replaced by the joule, the SI unit of energy. However, it is used for the amount of energy obtained from food.

Case Fatality Rate: the ratio of the number of deaths caused by a specified disease to the number of diagnosed cases of that disease.

Communicable diseases: An illness due to a specific infectious agent or its toxic products capable of being directly or indirectly transmitted from man to man, animal to animal or from the environment(through air, dust, soil, water, food etc.) to man or animal.

Contraceptive Methods: Preventive methods that help women to avoid unwanted pregnancies which include all temporary and permanent measures to prevent pregnancy resulting from coitus.

Crude Birth Rate: The crude birth rate (CBR) is defined as the number of live births in a year per 1,000 population estimated at midyear.

Crude Death Rate: The crude death rate (CDR) is defined as the number of deaths in a year per 1,000 population estimated at midyear.

Daily Calorie Requirement Per Capita: The average number of calories needed to sustain a person at normal levels of activity and health, taking into account the distribution of the population by age, sex, body weight and environmental temperature.(UNDP, human development report 1994)

Decadal Growth rate: It is defined as the percentage of total population growth in a particular decade. The decadal growth rate is a vital part of Census operations.

Density of Population: Number of persons, living per square kilometer.

Dentists Ratio: The average number of dentists available per every 10,000 inhabitants in a population, at a given year, for a given country, territory, or geographic area.

Dependency Ratio: The average number of economically dependent population per 100 economically productive population, for a given country, territory, or geographic area, at a specific point in time. In demographic terms, economically dependent population is defined as the sum of the population under 15 years of age plus the

population 65 years of age and over, for a given country, territory, or geographic area, at a specific point in time, usually mid- year; economically productive population is defined as the population between 15 and 64 years of age, for the same country, territory, or geographic area, at the same specific point in time.

Employment: Any type of work performed or services rendered in exchange for compensation. Compensation may include money (cash) or the equivalent in tuition, fees, books, supplies, room, or for any other benefit.

Family Planning: Family planning refers to practices that help individuals or couples to attain certain objectives:

a) to avoid unwanted births

b) to bring about wanted births

c) to regulate the intervals between pregnancies

d) to control the time at which births occur in relation to the ages of the parent

e) To determine the number of children in the family.

Fertility: Fertility means the actual bearing of children during a woman's reproductive period i.e. roughly from 15 to 45, a period of 30 years.

Fertility Rate: The number of live births during a year per 1000 female population aged 15-49 years at the midpoint of the same year.

Foeticide: Induced termination of a pregnancy with destruction of the foetus or embryo; therapeutic abortion.

Gross Domestic Product: The gross domestic product (GDP) at market prices is the sum of gross value added by all resident producers in the economy plus any taxes and minus any subsidies that are not included in the valuation of output. GDP measures the total output of goods and services for final use occurring within the domestic territory of a given country, regardless of the allocation to domestic and foreign claims; it provides an aggregate measure of production. The residency of an institutional unit is defined on the basis of economic interest in the territory for more than a year.

Gross National Product (GNP): The sum of gross value added by all resident producers, plus any taxes (less subsidies) that are not included in the valuation of output, plus net receipts of primary income (employee compensation and property income) from non-resident sources, divided by the mid-year population and converted to us dollars using the world bank's atlas method. This involves using a three-year average of exchange rates to smooth the effects of transitory exchange rate fluctuations.

Habitation: It is a term used to define a group of families living in proximity to each other, within a village. It could have either heterogeneous or homogenous demographic pattern. There can be more than one habitation in a village but not vice versa.

Health expenditures: Health expenditure covers the provision of preventive and curative health services, public health affairs and services, health applied research, and medical supply and delivery systems, but it does not include provision of water and sanitation.

House: Every structure, tent, shelter, etc. was considered as a house irrespective of its use. It might be used for residential or non-residential purposes or both or might not even be vacant.

Household: A group of persons normally living together and taking food from a common kitchen constituted a household. The members of a household might or might not be related by blood to one another.

Infanticide: Putting to the death to a new born with the consent of the parent, family, or community.

Infant Mortality Rate (IMR): Infant mortality rate - (or IMR) is defined as the number of infant deaths in a year per 1,000 live births during the year.

Life expectancy at Birth: The average number of years that a newborn could expect to live, if he or she were to pass through life exposed to the age and sex-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory, or geographic area.

Low Birth Weight: Birth weight less than 2500 grams (up to and including 2499 grams).

Malnutrition: Malnutrition is a general term for the medical condition in a person caused by an unbalanced diet-either too little or too much food, or a diet missing one or more important nutrients. Most commonly, malnourished people either do not have enough calories in their diet, or are eating a diet that lacks protein, vitamins, or trace minerals.

Maternal & Child Health: The term maternal & child health refers to the promotive, preventive, curative & rehabilitative health care for mother & children which includes the sub areas of maternal health, child health, family planning and health aspects of care of children.

Maternal Mortality Ratio (MMR): Annual number of maternal deaths per 100,000 live births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Mortality Rate from Communicable Diseases: The total number of deaths from communicable diseases in a population of a given sex divided by the corresponding total number of this population, after removing the effect of differences in the age distribution, expressed per 100,000 population for a given year, in a given country, territory, or geographic area.

Mortality Rate from Non-communicable Diseases: The total number of deaths from non-communicable diseases in a population of a given sex divided by the corresponding total number of this population, after removing the effect of differences in the age distribution, expressed per 100,000 population for a given year, in a given country, territory, or geographic area.

Non-communicable Diseases: Diseases that cannot be directly transmitted from man to man, animal to animal or from the environment (through air, dust, soil, water, food etc.) to man or animal are deemed as non-communicable diseases.

Old Age Dependency Ratio: The proportion of persons above 65 years of age are considered to be dependent on the economically productive age group (15-64 years)

One year-olds immunized against measles: Percentage of l-year-olds who have received at least one dose of measles-containing vaccine in a given year. For countries recommending the first dose of measles among children older than 12 months of age, the indicator is calculated as the proportion of children aged less than 24 months receiving one dose of measles-containing vaccine.

Percentage covered with Safe Water: The percentage of the population that has safe drinking water available in the home or with reasonable access.

Percentage covered with Sanitation: The percentage of the population that has adequate excreta-disposal facilities available.

Percentage of Contraceptive Users: Percentage of eligible couples effectively protected against childbirth by one or the other approved methods of family planning, viz sterilization, IUD (intra-uterine devices), condom or oral pills.

Percentage of Infants Immunized: The percentage of infants reaching their first birthday that have been immunized against each of the six EPI-target diseases (Diphtheria, Pertussis, tetanus, polio, measles and tuberculosis). The denominator used in the calculation is the number of infants surviving to age one.

Peri-natal Mortality Rate: Peri-natal mortality rate includes late foetal deaths (28 weeks gestation & more) and early neonatal deaths (first week) in one year per 1000 live births in the same year.

Pharmacists Ratio: The average number of pharmacists available per every 10,000 inhabitants in a population, at a given year, for a given country, territory, or geographic area.

Physicians Ratio: The average number of physicians available per every 10,000 inhabitants in a population, at a given year, for a given country, territory, or geographic area.

Population: All inhabitants of a country, territory, or geographic area, for a given sex and/or age group, at a specific point of time. In demographic terms it is the number of inhabitants of a given sex and/or age group that actually live within the border limits of the country, territory, or geographic area at a specific point of time, usually mid- year. The mid-year population refers to the actual population at July 1st.

Population 65 Years & Over: The percentage of total population of a country, territory, or geographic area, 65 years of age and over, for a given sex and at a specific point of time, usually mid-year. Proportion of Urban Population: The percentage of total population of a country, territory, or geographic area living in places defined as urban, at a specific point of time, usually mid-year.

Post-natal Mortality Rate: Number of deaths of Children between 28 days and one year of age in a given year per 1000 total live births in the same year.

Poverty: It is a situation in which a person is unable to get minimum basic necessities i.e. food, clothing and shelter for his /her sustenance. The inability to attain a minimum standard of living. The World Bank uses a poverty line of consumption less than us$1.00 a day (at constant 1985 prices) per person.

Poverty Line: Poverty estimates in our country are derived from the household consumer expenditure data collected by National Sample Survey organisation (NSSO) every fifth year. The' Poverty line' has been calculated for 2009-10 to be Rs. 672.8 per month per capita for rural India and Rs.859.6 per month per capita for urban India.(according to Tendulkar Committee Report).

Prevalence: The number of events, e.g., instances of a given disease or other condition, in a given population at a designated time; sometimes used to mean "prevalence rate': When used without qualification, the term usually refers to the situation at a specified point in time (point prevalence).Prevalence rate (ratio) is the total number of all individuals who have an attribute or disease at a particular time (or during a particular period) divided by the population at risk of having the attribute or disease at this point in time or midway through the period.

Primary Health Care: Essential health care that is technically valid, economically feasible and socially acceptable. Primary health care includes eight essential elements: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

Professional Nurses Ratio: The average number of certified nurses available per every 10,000 inhabitants in a population, at a given year, for a given country, territory, or geographic area. Certified nurses do not include auxiliary and unlicensed personnel.

Proportion of Population below National Poverty Line: The percentage of the population living below the national poverty line in a given country, territory, or geographic area, for a given sex and/or age group, at a specific period in time, usually a year. The operational definition for a national poverty line varies from country to country and

represents the amount of income required by each household to meet the basic needs of all its members and Percentage of Population below poverty line has declined from 37.2 (2004-05) to 29.8 (2009-10 as per Tendulkar Methodology).

Proportion of Deliveries attended by Trained Personnel: The number of deliveries assisted by trained personnel in a specific year, regardless of their site of occurrence, expressed as a percentage of the total number of births in that same year, in a given country, territory, or geographic area. Trained personnel include medical doctors, certified nurses and midwifes; not included are traditional birth attendants, trained or not.

Public Sector Expenditures: Annual public health expenditure as a proportion of the national health expenditure. The size of the public expenditure on health care goods and services for a given national economy, at a given period in time, usually a year, expressed as a percentage of the corresponding national health expenditure. It represents the governmental share, not limited to the ministry of health, of the total annual expenditure for covering the provision of preventive and curative health services, public health affairs and services, health applied research, and medical supply and delivery systems, excluding the provision of water and sanitation.

Still Birth Rate: Death of a foetus weighing 1000g (equivalent to 28 weeks of gestation)or more, during one year in every 1000 total births.

Total Fertility Rate: Number of children that would be born per woman, assuming no female mortality at childbearing age and the age-specific fertility rates of a specified country and reference period.

Unmet need of Planning: Unmet need for family planning refers to fecund women who are not using contraception but who wish to postpone the next birth (spacing) or stop childbearing altogether (limiting). Specifically, women are considered to have unmet need for spacing if they are:

- At risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next two years, or are unsure if or when they want to become pregnant.
- Pregnant with a mistimed pregnancy.
- Postpartum amenorrheic for up to two years following a mistimed birth and not using contraception.

Women are considered to have unmet need for limiting if they are:

- At risk of becoming pregnant, not using contraception, and want no (more) children.
- Pregnant with an unwanted pregnancy.
- Postpartum amenorrheic for up to two years following an unwanted birth and not using contraception.

Women who are classified as in fecund have no unmet need because they are not at risk of becoming pregnant. Unmet need for family planning is the sum of unmet need for spacing plus unmet need for limiting.

Urban: The term urban refers to towns (places with municipal corporation, municipal area committee, notified area committee or cantonment board); also, all places having 1000 or more inhabitants, a density of not less than 1000 persons per sq mile or 390 per sq km, pronounced urban characteristics and at least three-fourths of the adult male population employed in pursuits other than agriculture. Proportion of Rural Population: The percentage of total population of a country, territory, or geographic area living in places defined as rural, at a specific point of time, usually mid-year. The term rural refers essentially to villages and other rarely populated areas.