WHITE PAPER

The State of Health in Delhi

November 2021

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I. Foreword

The capital city, Delhi, like various other Indian cities, faced harsh trials during the second wave of the COVID-19 pandemic. These, brought to the forefront, the importance of adequate health services, infrastructure and of maintaining health related data and the same has been highlighted in this report. Praja Foundation would first like to thank the COVID healthcare personnel, volunteers, NGOs and Civil Society Organisations and all the citizens of Delhi for their continuous and relentless efforts to fight the pandemic.

There is an urgent need for real time health data management and timely monitoring to formulate data driven healthcare policies. However, this has been an ongoing problem in Delhi. As per the Registration of Birth and Death (RBD) Act, causes for both institutional and non-institutional deaths are to be recorded. This data provides an understanding of the reasons for deaths and the diseases causing the deaths to enable better planning of healthcare services as well as better policy making. However, in Delhi, the data of causes of death of only institutional deaths are available in the annual reports. In 2020, 39% of deaths (56,306 deaths) out of the 1,42,789 total deaths were marked as non-institutional and therefore, no information is available on the cause of these deaths.

It is important to look at the health services and infrastructure as well as the budget to understand if Delhi has adequate infrastructure and if the budget is being properly utilised. There is 1 dispensary for 18,226 people in Delhi while the UDPFI (Urban Design Plan Formulation and Implementation) norm states there should be one dispensary for 15,000 population. Delhi is quite close to the UDPFI norms however, there exists major gaps in human resource allocation for healthcare. Municipal Corporation of Delhi (MCD) & State dispensaries and hospitals cumulatively had 22% vacancy of medical staff, 37% vacancy of para-medical staff and a 25% vacancy of nurses as on 31st December, 2020.

The question thus arises if the vacancies are due to shortage of budget or not. When we looked at the allocation and utilisation, we found that in F.Y. 2019-20, 25% of the overall MCD health budget went unutilised. On the other hand, 23% of the State Health Capital budget went unutilised. Delhi's consistent underutilisation of health budget signals a shift in priorities from healthcare.

Let us now look at the ailment data to understand how they stack up against Sustainable Development Goals (SDGs) and other programme and scheme goals:

- Dengue, a menace that has overwhelmed Delhi for some time, has no data available in the Health Management Information System (HMIS), on the number of tests conducted. While data on the number of positive cases (22,425 in F.Y. 2019-20 and 7040 in F.Y. 2020-21) are available, it is impossible to analyse if the reason behind the sudden decline is due to lower number of tests conducted or if Delhi is indeed has seen a reduction in dengue cases in 2021.
- The SDG target for communicable diseases like Tuberculosis is 0 TB cases/1 lakh population. However, there were 521 TB cases/1 lakh population reported in 2020.
- For non-communicable diseases, SDG target is to reduce premature mortality from NCDs by one third by 2030. However, deaths due to diabetes has increased by 8% from 2015 to 2020.
- Furthermore, SDG targets to reduce Maternal Mortality Rate to 70 (deaths per 1,00,000 live births) by 2030, whereas in Delhi, it is very high at 252 – an increase of 47% from F.Y. 2019-20 to F.Y. 2020-21.
- Between the age group of 25 to 64 years, which is the productive age, a majority of 17,284 (54%) deaths were reported in 2020, out of a total of 32,156 non-communicable diseases (NCD) deaths.

- Tackling air pollution – one of the biggest reasons for respiratory diseases, has always been a major challenge for Delhi. Despite that, none of the health policies include chronic respiratory diseases.
- Child healthcare is an extremely vital aspect of any city's health infrastructure as children are the future of the country. However, overall child immunisation for example polio has decreased by 21% from F.Y. 2019-20 to F.Y. 2020-21.
- A reduction of anaemia interventions was also noticed amongst school students (6th -12th class) who were provided 4 IFA tablets in schools saw a reduction of 99% from F.Y. 2019-20 to F.Y. 2020-21. IFA tablets are iron supplements that are used to treat or prevent low blood levels of iron and are extremely important for young adults.

Effective deliberations by Delhi councillors and MLAs can lead to better health service provisions in the city. Delhi MLAs Assembly meeting occurred only for 8 days in the year F.Y. 2020-21 and they raised only 29 questions on health issues wherein it was topic to be deliberated more during the pandemic. Furthermore, out of the total issues raised by councillors in the Medical Relief and Public Health Committee, no issues were raised on major diseases such as hypertension, TB and diabetes – which have contributed to some of the highest number of deaths in the city.

What we need to look at is our national and SDG goals and continuously look towards meeting the targets set for 2030. We also need to ensure that allocated health budget is used completely and greater focus is given to adequately staffing our dispensaries and hospitals to fill the vacancies. For data driven health policies, there is a need to maintain a robust and real time Health MIS. Cause of Death (COD) data needs to be maintained for both institutional and non-institutional deaths as it can allow for effective monitoring, tracking and implementation of various health polices and schemes in the city. There are 9 more years left for Delhi to achieve the 2030 SDGs. Improving Delhi's healthcare system, outcome based budgeting & appropriate budget utilisation, better deliberations and robust management & monitoring of data can help the city achieve the SDG targets. This will improve the overall healthcare ecosystem of Delhi and its citizens.

NITAI MEHTA
Founder Trustee, Praja Foundation

II. Acknowledgement

Praja has obtained the data used in compiling this white paper through the Right to Information Act, 2005. Hence it is very important to acknowledge the RTI Act and everyone involved, especially the officials who have provided us with this information diligently.

We would like to appreciate our stakeholders; particularly, our Elected Representatives and government officials, the Civil Society Organisations (CSOs) and the journalists who utilise and publicise our data and, by doing so, ensure that awareness regarding various issues that we discuss is distributed to a wide-ranging population. We would like to take this opportunity to specifically extend our gratitude to all government officials for their continuous cooperation and support.

Praja Foundation appreciates the support given by our supporters and donors, namely Friedrich Naumann Foundation, Madhu Mehta Foundation and numerous other individual supporters. Their support has made it possible for us to conduct our study and publish this white paper.

We would also like to thank our group of Advisors and Trustees and lastly but not the least, we would like to acknowledge the contributions of all members of Praja's team including our research interns, who worked to make this white paper a reality.

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III. Sources of Data

The sources of information for this study have been collected by filing RTIs (Right to Information) to the relevant departments and through Government Websites:

Data Points	Year	Source
Cause of Death	2016 to 2020	Annual Reports of Registration of Births and Deaths in Delhi from Delhi Government website. Data for the year 2020 is provisional as mentioned in the Annual report 2020.
Health Facilities		
Density of Dispensary per population	2020-21	Population used to compare number of dispensaries per population is taken from Delhi Government Website, 2016 after delimitation of MCD zones.
Human Resource		
Municipal Health Department and Hospitals	2020	Through RTI filed in MCD Hospitals and Head offices of the three MCDs. Data for 6 MCD hospitals received, For CAMO: NDMC- 4 out of 5, EDMC- 4 out of 5 and SDMC- 3 out of 5 received.
State Hospitals	2020	Through RTI filed in State Hospitals and DGHS. Data of all 11 districts (CDMO) and 35 out of 38 hospitals received.
Health Budget	2017-18 to 2020-2021	MCD Budget Books
ER Deliberations		
Councillor Questions	2017-18 to 2020-21	MS Department (MCD) through RTI
MLA Questions	24th February 2020 to 12th March 2021	Vidhan Bhavan through RTI
Government Health Programmes & Schemes		
Health Programmes/Schemes	2018-19 to 2020-21	Health management Information System (HMIS) portal. Data for the year 2020-21 is provisional as mentioned on the portal. Delhi Health Annual Reports from Delhi Government website contain information and data about health policies which is used in this paper for certain data points that were not available in the HMIS.
RNTCP	2018 to 2020	Nikshay Portal as on 19.10.2021 and Delhi TB cell (RTI)
National Programme for Control of Blindness, National Programme for Prevention and Control of Deafness, National Programme for Palliative Care, Silicosis Control Programme, National Programme for Prevention and Control of Fluorosis and National Iodine Deficiency Disorders Control Programme		Data not available on HMIS and Annual Report of DGHS for 2020-21 is not released.

Note: Due to the COVID-19 pandemic and the subsequent difficulty in receiving complete data from the related departments the paper suffers from the limitation of not including certain data points and/or different data points reported of varying time periods. An attempt is however made to portray the holistic situation of Delhi using published data from online sources and to suggest changes in strengthening health services in the city.

Section A: Health Status of Delhi

1. Causes of Death

1.1 Summary of the Current Status of the Cause of Deaths Data in Delhi

It is a vital requirement to maintain complete and up to date information on the births and deaths registered in a city.[1] According to the Civil Registration System annual report publish in 2019, within Delhi, all local bodies have a computerized birth and death registration system. Similarly, all major Government / Private hospitals/ Nursing Homes are provided a facility of online reporting of birth/ death events through an Online Institutional Registration (OLIR) system.[1] However, this data is not maintained on a real time basis and thus at a given time, data on current and accurate numbers of registered deaths is unavailable.

Total deaths registered have decreased by 2% from 1,45,284 in 2019 to 1,42,789 in 2020. Further, Cause of Death (COD) data that maps the specific illness/ailments that led to a citizen's death decreased by 10 % from 95,860 in 2019 to 86,483 in 2020. However, the COD data includes only institutionalised deaths recorded in Delhi, while there is no information on the cause of death of non-institutionalised deaths in the Annual report. **To emphasis, in 2020, 1,42,789 total deaths were registered in Delhi of which 61% were institutional deaths and COD information for these deaths are recorded. But, for the remaining 39% of deaths, the COD information is unavailable.**

More so, as total deaths decreased only by 2% from 2019 to 2020, there was a **37% decline from 2019 to 2020 in the cases registered for major diseases** in Delhi on HMIS (Health Management Information System). Thus, **with no proper information on Cause of Death (COD) data for 2020, even with the decline in the HMIS data, there is an absence of information on the actual scenario of the occurrence of deaths other than COVID in the city.**

There is however, a learning from Delhi NCT COVID management that can be replicated in future to improve Delhi's health data system holistically. Since information was updated regularly on various COVID-19 indicators with an aim to provide effective COVID health care to all, similarly with better utilisation of the computerized systems, **maintaining other health data real time is crucial as it can allow for effective tracking and implementation of various health polices and schemes in the city.**

[1] CRS 2019 report.pdf (crsorgi.gov.in)

Table 1: Total Deaths and Institutional/Non-Institutional [2] Deaths in Delhi from 2016 to 2020[3]

Year	2016	2017	2018	2019	2020
Total Deaths	1,41,632	1,36,117	1,45,533	1,45,284	1,42,789
Institutional Deaths	90,517	89,377	98,153	95,860	86,483
% of Institutional to Total Deaths	64%	66%	67%	66%	61%
Non-Institutional Deaths	51,115	46,740	47,380	49,424	56,306
% of Non-Institutional to Total Deaths	36%	34%	33%	34%	39%

Inference:

- Total deaths registered have decreased by 2% from 1,45,284 in 2019 to 1,42,789 in 2020.
- Percentage of registered institutional deaths to the total deaths have decreased from 67% in 2018 to 61% in 2020.
- Annual report records the causes of death data only for institutional deaths and hence, the COD is unavailable for the remaining **39% of non-institutional deaths in Delhi.**
- Non-institutional deaths are showing an increasing trend i.e. from 33% in 2018 to 39% in 2020.

Table 2: Comparison of Covid-19 deaths[4] with total Institutional deaths in Delhi

2016	2017	2018	2019	2020*		
				Excluding Covid deaths	**Covid deaths**	**% of Covid deaths**
90,517	89,377	98,153	95,860	76,620	9,863	11%

Note (*): Government of NCT of Delhi began registering COVID deaths on delhi.gov.in from April 2020.

Inference:

- Out of the total institutional deaths (86,483) registered in 2020, 9,863 (11%) COVID deaths were registered.
- Institutional deaths have declined by 2.34% from 2018 to 2019.

[2] *The data is retrieved from:* http://des.delhigovt.nic.in/wps/wcm/connect/4b997b004d57156a84b1f7982ee7a5c7/vital_4320_new.pdf?MOD=AJPERES&lmod=-1539013530&CACHEID=4b997b004d57156a84b1f7982ee7a5c7 The table has been prepared exclusively on the basis of data on institutional deaths published in the MCCD report in Delhi. In domiciliary cases MCCD is not reported, so the readers of this report may bear in mind that this study is confined to institutional deaths.

[3] Please note cause of death data is available as per calendar year.

[4] http://health.delhigovt.nic.in/wps/wcm/connect/doit_health/Health/Home/Covid19/Bulletin+July+2020

Table 3: Major Causes of Institutional deaths in Delhi from 2016 to 2020

Cause of Death	2016	2017	2018	2019	2020
Symptoms Signs and Abnormal Clinical and Laboratory finding not elsewhere classified (R00-R99)	19,454	19,524	22,929	22,737	20,070
Diseases of the circulatory system (I00-I99)	15,919	17,203	19,445	18,621	13,955
Respiratory diseases (J00-J98)	8,260	7,511	8,453	8,014	8,057
Other Bacterial Diseases (A20-A49)	8,080	8,463	8,863	9,855	6,768
Diseases of the Digestive System (K00-K92)	3,976	4,602	4,561	5,410	4,178
Neoplasms (C00-D48)	4,812	5,162	6,396	5,815	3,938
Tuberculosis (A15-A19)	3,733	3,656	3,834	3,935	2,592
Injury, poisoning and certain other consequences of external causes (S00-T98)	3,569	3,133	3,266	3,208	2,528
Diseases of the Genitourinary System (N00-N99)	1,894	1,916	1,965	2,286	2,218
Certain Conditions Originating in the Perinatal Period (P00-P96)	3,449	3,662	3,237	3,257	2,070
Diseases of the nervous system (G00-G98)	1,542	1,889	2,157	1,662	1,520
Diabetes (E10-E14)	2,557	2,561	2,205	1,656	1,461
Dengue fever (A90)	206	317	77	150	64
HIV (B20-B24)	161	131	123	89	62
Malaria (B50-B54)	122	114	115	95	48
Other Cause of deaths	12,783	9,533	10,527	9,070	16,954
Total	**90,517**	**89,377**	**98,153**	**95,860**	**86,483**

Inference:

- 16.1% of the total deaths registered in 2020 were caused due to diseases of the circulatory system, including various heart diseases.
- Deaths reported due to respiratory diseases decreased by 5% from 8,453 deaths in 2018 to 8,014 deaths in 2019 but increased marginally by 1% from 2019 to 2020.
- From the total deaths registered in 2020, 4.6% (3,938) were cancer related deaths (neoplasms), 3% (2,592) were tuberculosis deaths, and 1.7% (1,461) were deaths caused due to diabetes.

Table 4: Number of cases of Major Diseases[5] registered in Delhi from 2018 to 2020

Disease	2018	2019	2020	% change from 2019 to 2020
Tuberculosis (A15-A19)	80,613	1,07,896	86,913	-19%
Malaria (B50-B54)	8,978	17,313	2,300	-87%
Dengue Fever (A90)	30,702	22,328	6,832	-69%
Diabetes (E10-E14)	8,53,204	9,18,301	5,94,828	-35%
Hypertension (I10-I15)	12,17,486	11,78,922	7,25,958	-38%
(HIV) (B20-B24)	9,369	6,782	3,255	-52%
Total	**22,00,352**	**22,51,542**	**14,20,086**	**-37%**

Inference:

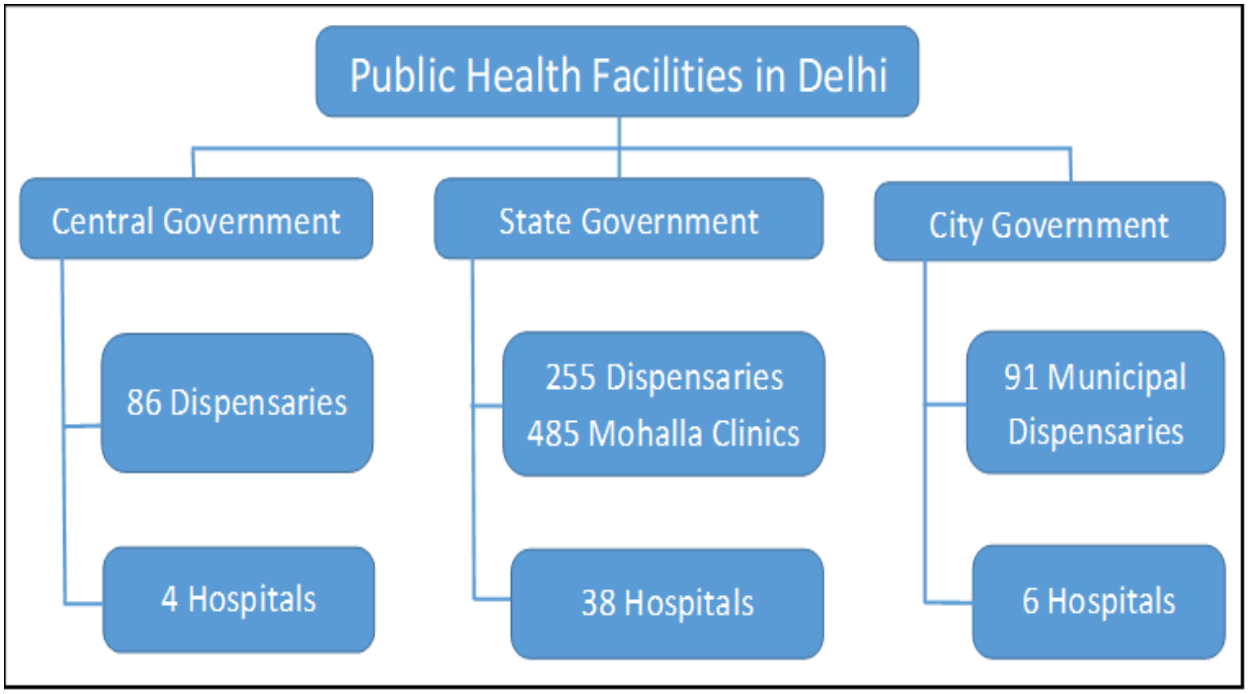
- The number of registered cases of major diseases in HMIS (Health Management Information System) showed a decline of 37% from 2019 to 2020.
- Major decline has occurred in Malaria cases (87%) and Dengue cases (69%) from 2019 to 2020.
- This decline in registered cases of diseases could be attributed to the lockdown restrictions and major shift in focus towards COVID management.

[5] Tuberculosis data is from Nikshay portal and data of other diseases is from HMIS portal

2. Physical, Financial and Human Resources for Health Systems in Delhi

2.1. Health Infrastructure

Figure 1: Number of Government Hospitals and Dispensaries in Delhi



An imperative aspect of a strong, well-functioning healthcare system is the strength and adequacy of its infrastructure. With regards to the upgradation and strengthening of healthcare infrastructure, the Central Government has three major policies namely Ayushman Bharat, The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), and Integrated Disease Surveillance Programme (IDSP), while the state government also has policies like Mohalla Clinics and Mobile Health Scheme.

The infrastructure component of **Ayushman Bharat** aims to create 1,50,000 Health and Wellness Centres (HWCs) by 2022, by transforming PHCs/SCs to provide Comprehensive Primary Health Care (CPHC). HWCs will enable a focus on wellness and health promotion, and provide an expanded range of primary healthcare services, including access to medicines and diagnostics, and be delivered close to the community. As reported by the States/UTs on the AB-HWC Portal, 76,588 HWCs have been operationalised across India as on 30 June 2021.[6] There are no HWCs set up in Delhi.

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) that also aims at correcting the imbalances in the availability of affordable healthcare facilities in different parts of the country has two components- setting up of All India Institute of Medical Sciences (AIIMS) and up-gradation of existing government medical colleges/institutions and is being taken up in a phased manner[7]. The scheme is currently being

[6] file:///D:/User/Downloads/AB_HWC_Brochure_June_2021_English.pdf
[7] https://main.mohfw.gov.in/sites/default/files/Annual%20Report%202019-2020%20English.pdf

implemented in Delhi for civic construction works of the GTB Hospital[8], which is a state government institution.

The **Integrated Disease Surveillance Project** aimed to strengthen disease surveillance by setting up a Central Disease Surveillance Unit and a State Surveillance Unit in each State where data is collected and analysed. The same has been set up in Delhi as well.[9]

Mobile Healthcare Units was launched in Delhi in 1989 to provide basic health care to the residents of unauthorised colonies at their door-step according to their needs. Facilities provided include medical examination and dispensing of medicines. According to the Delhi Government website there are 45 Mobile health vans which cover 144 areas in unauthorised colonies in Delhi.[10]

The Aam Aadmi Mohalla Clinics initiative was launched by the government of Delhi in 2015, based upon the idea of Mobile Medical Units. The clinics function from 8.00 a.m. to 2.00 p.m. on all days from Monday to Saturday. The clinics were envisioned to provide the following services: 1) Basic medical care based on standard treatment protocols which include curative care for common illnesses like fever, diarrhoea, skin problems, respiratory problems etc., first aid for injuries and burns, dressing and management of minor wounds and referral services. 2) All lab investigations are to be carried out by the empanelled laboratory for the clinics 3) All drugs as per the essential drug list shall be provided free of cost to the patients 4) Preventive services such as antenatal and postnatal care of pregnant women, assessment of nutritional status and counselling and preventive and promotive component of National/State Health Programmes 5) Health information, education and awareness. At the start of the scheme, the Government of Delhi had announced 1,000 such clinics to be opened in Delhi. However, 485 Mohalla clinics are functional as per the Annual Report 2019-20 of the Directorate General of Health[11].

[8] https://pmssy.nhp.gov.in/pms/
[9] https://idsp.nic.in/index1.php?lang=1&level=1&sublinkid=5769&lid=3701
[10] http://health.delhigovt.nic.in/wps/wcm/connect/doit_health/Health/Home/Directorate+General+of+Health+Services/Mobile+Health+Scheme
[11] DGHS Annual Report 2019-20.pdf

Table 5: Zone-wise number of Dispensaries/Hospitals compared to required norm in Delhi[12]

Corporation	MCD Zone	Population[13]	No. of Government Dispensaries/ Mohalla clinics[14]	Dispensary (1 For 15,000)[15]	No. of Government Hospitals	Density of Government dispensary to Population
EDMC	Shahdara North	21,22,359	105	141	6	20,213
	Shahdara South	18,27,487	85	122	3	21,500
	Total	**39,49,846**	**190**	**263**	**9**	**20,789**
NDMC	Narela	10,13,641	80	68	2	12,671
	Karol Bagh	8,29,322	42	55	4	19,746
	Rohini	16,01,561	71	107	2	22,557
	Civil Lines	10,70,338	54	71	5	19,821
	Keshavpuram	10,09,356	77	67	3	13,109
	City and Sadar Paharganj	7,30,540	33	49	8	22,138
	Total	**62,54,758**	**357**	**417**	**24**	**17,520**
SDMC	Central	17,70,032	95	118	1	18,632
	West	17,08,400	69	114	5	24,759
	South	12,74,071	85	85	5	14,989
	Najafgarh	14,61,556	100	97	2	14,616
	Total	**62,14,059**	**349**	**414**	**13**	**17,805**
New Delhi Municipal Council		2,57,803	19	17	2	13,569
Delhi		**1,66,76,466**	**915**	**1,112**	**48**	**18,226**

Inference:

- There is one dispensary for 18,226 people in Delhi while the UDPFI (Urban Design Plan Formulation and Implementation) norm states there should be one dispensary for 15,000 population.
- NDMC has the lowest density of government dispensaries with 1 dispensary for 17,520 people, while EDMC has the highest density of government dispensaries with 1 dispensary for 20,789 people. Only 5 zones of MCD meet the UDPFI norm.
- Delhi will need 197 more dispensaries to meet the requirement of 1 dispensary for 15,000 population.

[12] The table includes central, state and city government dispensaries.

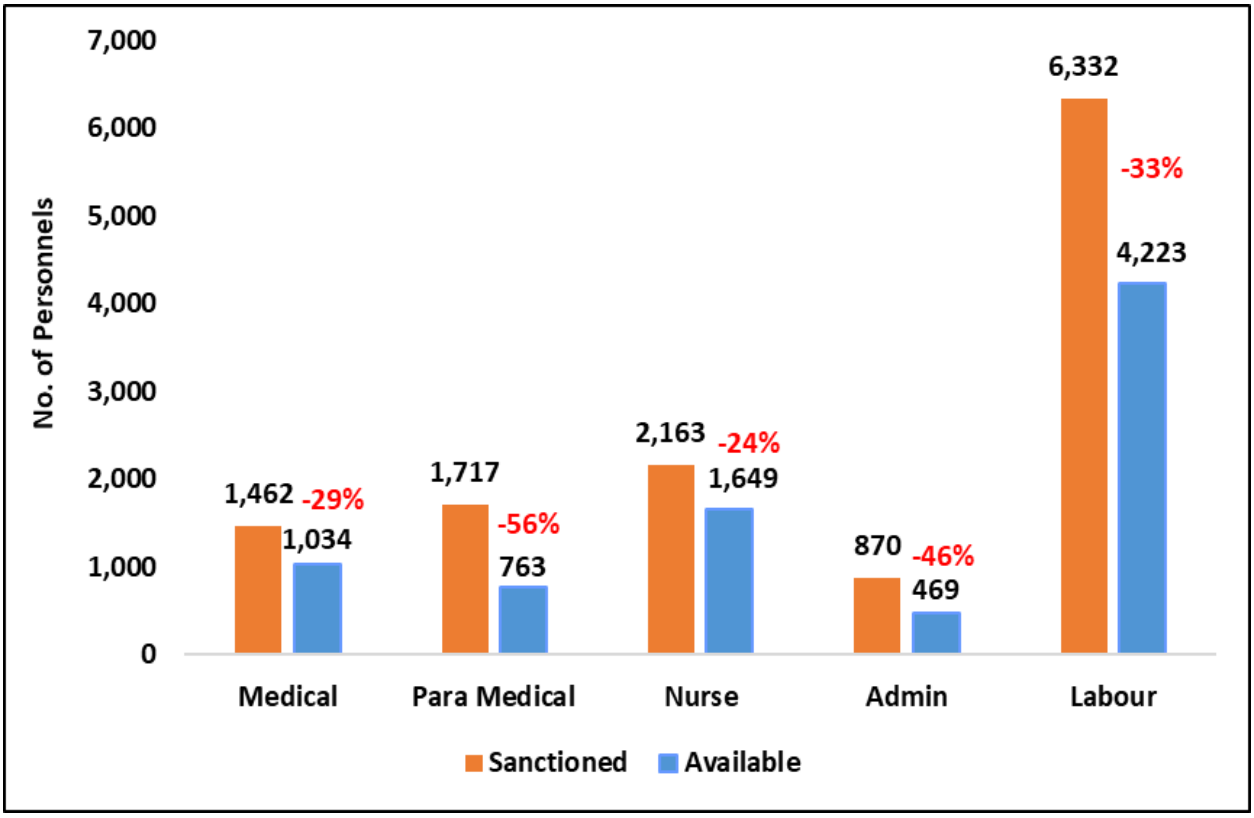
[13]Population for New Delhi Municipal Council is as per 2011 census, while the zone wise population is data after delimitation in 2016.
http://sec.delhigovt.nic.in/wps/wcm/connect/doit_dsec/Delhi+State+Election+Commission/Home/Delimitation+2016/Delimitation+2016%28Draft%29/

[14] Two Mohalla Clinics are from Delhi Cantonment zone, hence not included.

[15] The Urban Design Plan Formulation and Implementation (UDPFI) by the Ministry of Housing and Urban Affairs suggests one dispensary is required for a population of 15,000.

2.2 Health Personnel

Figure 2: Shortage[16] of staff in dispensaries and hospitals of Municipal Corporation of Delhi as of December 2020.



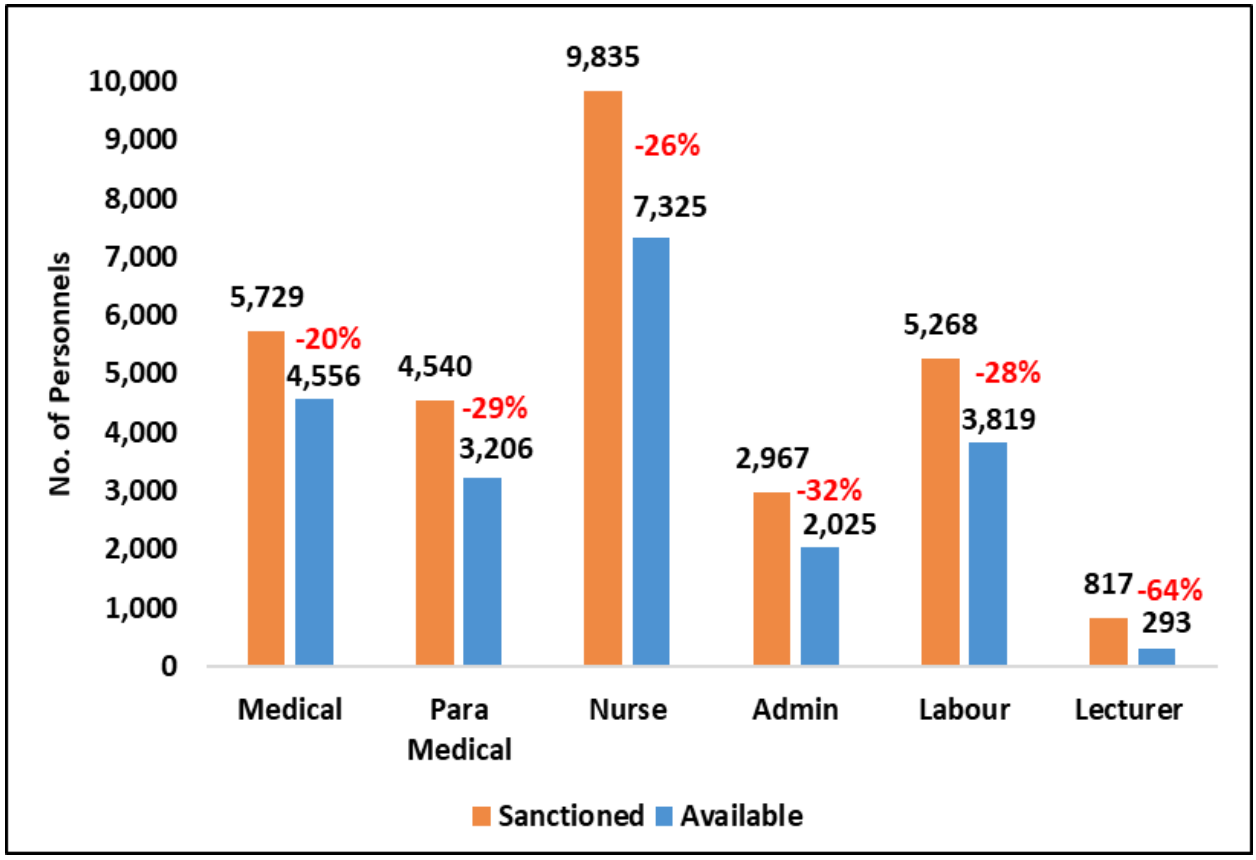
Note: Above figure does not include data from Central heathcare agencies

Inference:

- Municipal Corporation of Delhi (MCD) dispensaries and hospitals had a 29% vacancy of medical staff, 56% vacancy of para-medical staff and a 24% vacancy of nurses as on 31st December, 2020.

[16] Personnel shortage has been calculated by subtracting the available positions from the sanctioned positions given by all the health units. There are some positions which have been abolished but people who were earlier working on those positions will continue to work till they retire. For such cases, sanctioned positions excluding the number of abolished positions has been considered.

Figure 3: Shortage[17] of staff in State Government dispensaries and hospitals as of December 2020



Note: Above figure does not include data from Central healthcare agencies

Inference:

- State government dispensaries and hospitals had a 20% vacancy of medical staff and 29% vacancy of para-medical staff as on 31st December, 2020.
- There is a 26% vacancy in nursing staff as on 31st December, 2020.
- There was a 64% shortage reported in post of lecturers in medical colleges.

[17] Personnel shortage has been calculated by subtracting the available positions from the sanctioned positions given by all the health units. There are some positions which have been abolished but people who were earlier working on those positions will continue to work till they retire. For such cases, sanctioned positions excluding the number of abolished positions have been considered.

2.3. Health Budgets

Table 6: Health Budget[18] Estimate and Actual Expenditure of MCDs from 2017-18 to 2020-21 (Rs. in crores)

MCD	Type	2017-18			2018-19			2019-20			2020-21
		RBE	Actuals	U %	RBE	Actuals	U %	RBE	Actuals	U %	RBE
NDMC	Non-Plan	718	558	78%	768	662	86%	849	623	73%	857
	Plan	539	497	92%	133	148	112%	338	273	81%	509
	Total	1,258	1,055	84%	900	810	90%	1,187	895	75%	1,366
EDMC	Non-Plan	318	201	63%	290	247	85%	332	215	65%	308
	Plan	56	45	81%	61	85	138%	102	66	65%	81
	Total	373	246	66%	351	331	94%	435	281	65%	389
SDMC	Non-Plan	228	225	98%	356	251	71%	324	245	75%	297
	Plan	392	384	98%	48	44	93%	135	133	98%	183
	Total	620	609	98%	404	295	73%	459	377	82%	480
Total MCD	Non-Plan	1,264	984	78%	1,413	1,160	82%	1,505	1,083	72%	1,461
	Plan	987	925	94%	242	277	115%	575	472	82%	773
	Total	**2,251**	**1,910**	**85%**	**1,655**	**1,437**	**87%**	**2,081**	**1,554**	**75%**	**2,234**

Note: RBE is Revised Budget Estimate, Actuals is Actual Expenditure and U% is percentage of actual utilisation to Revised Budget Estimate i.e. percentage of utilisation.

Inference:

- SDMC utilised maximum budget of 82% while EDMC utilised the least 65% of the budget allocated in 2019-20.
- 18% of MCD planned budget went unutilised in 2019-20
- 25% of the total MCD health budget went unutilised in 2019-20.

[18] We are considering only State and MCD budget but there are other agencies which spend money on Health e.g. Centre.

Table 7: Health Budget Estimate and Actual Expenditure of State Government[19] from 2017-18 to 2020-21 (Rs. in crores)

Type	2017-18			2018-19			2019-20			2020-21
	RBE	Actuals	U%	RBE	Actuals	U%	RBE	Actuals	U%	RBE
Revenue	4,743	4,388	93%	5,555	5,189	93%	5,597	5,387	96%	6,763
Capital	398	346	87%	413	306	74%	463	357	77%	679
Total	**5,141**	**4,733**	92%	**5,968**	**5,495**	92%	**6,060**	**5,745**	95%	**7,443**

Note: RBE is Revised Budget Estimate, Actuals is Actual Expenditure and U% is percentage of actual utilisation to Revised Budget Estimate i.e. percentage of utilisation.

Inference:

Utilisation of capital expenditure has fallen from 87% in 2017-18 to 77% in 2019-20.

[19] https://finance.delhigovt.nic.in/content/budget. Data taken from Annual financial statement for the respective year

3. Deliberations by Municipal Councillors and MLAs on Health Issues

Table 8: Total numbers of Meeting, Attendance and Issue Raised in Medical Relief and Public Health Committee of MCDs from 2017-18 to 2020-21

Year	MCD	No of Members	No. of Meetings	Attendance (in %)	Total Issues Raised
2017-18	EDMC	14	8	78%	193
	NDMC	21	5	51%	74
	SDMC	21	9	60%	373
2018-19	EDMC	14	8	77%	224
	NDMC	21	6	49%	86
	SDMC	21	8	42%	62
2019-20	EDMC	14	7	63%	71
	NDMC	21	3	51%	52
	SDMC	21	6	36%	48
2020-21	EDMC	14	10	68%	250
	NDMC	21	5	62%	104
	SDMC	21	8	39%	146

Inference:

- The councillor attendance in the Medical Relief and Public Health Committee of all three MCDs has increased from 2019-20 to 2020-21 – EDMC by 5%, NDMC by 11% and SDMC by 3%.
- In 2020-21, although EDMC has the least number of members, a greater number of meetings were held (10 meetings). Thus, maximum number of issues were raised in EDMC (250 issues).

***Note:** Medical Relief and Public Health Committee is constituted at the beginning of every financial year. Medical and Public Health Committee gives advice to Corporation to establish and maintain hospitals, dispensaries and Maternity and child welfare centres, on Registration of births and deaths, on Public vaccination and inoculation, on measures for preventing and checking the spread of diseases. It comprises of 56 members (14- EDMC, 21-NDMC and 21 SDMC).*

Table 9: Issues Raised by Medical Relief and Public Health Committee Councillors of MCDs from 2017-18 to 2020-21

Issues	No. of issues raised in 2017-18	No. of issues raised in 2018-19	No. of issues raised in 2019-20	No. of issues raised in 2020-21
Total Issues Raised	**640**	**372**	**171**	**500**
Budget	29	0	0	*12*
Cemeteries / Crematorium related	0	0	0	*20*
Contaminated Water Supply	1	0	0	0
Equipments	6	1	1	6
Eradication Programme	1	0	0	3
Epidemic/Sensitive Disease	18	7	2	22
Covid 19	-	-	-	*14*
Dengue/Malaria/Chikungunya	*18*	*9*	*2*	*7*
Diabetes	*0*	*0*	*0*	*0*
Hypertension	*0*	*0*	*0*	*0*
Diarrhoea/Typhoid/Cholera	*0*	*0*	*0*	*0*
Tuberculosis	*0*	*1*	*0*	*0*
Garden	0	0	0	4
Solid Waste Management	0	0	0	4
Pest Control	0	0	0	4
Fogging	6	17	0	11
Health Related Issues	16	18	1	7
Health Service Related	54	44	4	31
Health Education Institute	0	0	0	1
Human Resources Related	74	74	7	71
Infrastructure	52	23	20	49
Issue of Birth/ Death certificates	8	6	0	3
License	217	95	51	92
Maternity homes/Primary Health Centre (PHC)	8	5	2	9
Municipal Corporation Related	30	13	15	52
Negligence in duty of Municipal Corporation officials/Staff related	0	0	1	0
Nuisance due to stray dogs, monkeys etc.	60	23	22	68
Private Health Services	0	0	0	0
Schemes/Policies in Health	30	19	26	2
Treatment Medicines	24	25	17	28
Vets Medical Medicines Related	6	2	2	1

(**Note:** One question/issue may be related to multiple sub issues in health and is counted issue wise, hence total questions raised does not equal issue wise total)

Inference:

Highest numbers of issues were raised on License (92) in 2020-21 while no issues were asked on diabetes, TB or hypertension in the health committees.

Table 10: Number of Issues Raised on Health by Councillors in all other Committees from 2017-18 to 2020-21

Issues	Number of Issues Raised			
	2017-18	2018-19	2019-20	2020-21
Total Issues Raised	**1,014**	**880**	**942**	**869**
Budget	27	10	12	1
Cemeteries / Crematorium related	41	40	7	54
Contaminated Water Supply	4	0	2	8
Compensation	0	0	0	2
Equipments	9	3	7	7
Eradication Programme	2	3	9	7
Epidemic/Sensitive Disease	202	117	169	167
Covid 19	-	-	-	124
Dengue/Malaria/Chikungunya	165	152	105	28
Diabetes	0	1	0	0
Hypertension	0	0	0	0
Diarrhoea/Typhoid/Cholera	2	1	0	0
Tuberculosis	0	6	1	1
Fogging	70	59	59	58
Health Related Issues	63	60	74	41
Health Service Related	121	126	79	71
Health Education Institute	11	1	22	3
Human Resources Related	149	184	214	213
Infrastructure	145	131	102	102
Issue of Birth/ Death certificates	10	10	47	25
License	44	43	46	44
Maternity homes/Primary Health Centre (PHC)	14	23	8	8
Municipal Corporation Related	0	0	8	1
Negligence in duty of Municipal Corporation officials/Staff related	0	0	0	0
Nuisance due to stray dogs, monkeys etc.	0	0	0	1
Private Health Services	2	0	1	2
Schemes/Policies in Health	54	30	53	12
Treatment/Medicines	21	39	42	42
Vets Medical Medicines Related	11	1	0	0
Water Logging	14	0	0	0

(**Note:** One question/issue may be related to multiple sub issues in health and is counted issue wise, hence total questions raised does not equal issue wise total)

Inference:

Highest number of issues were raised on human resource related issues, 213 in 2020-21 while no issues were asked on diabetes, hypertension, diarrhoea, typhoid and cholera and only 1 issue was raised on tuberculosis, although a large number TB cases have been reported in the city.

Table 11: Health Issues Raised by MLAs from 24th February 2020 to 12th March 2021

Issues	2020*	2021*	Total
Cemeteries/Crematorium related	0	0	0
Contaminated Water Supply	3	2	5
Eradication Programme	0	0	0
Epidemic/Sensitive Disease	2	2	4
Covid 19	*3*	*0*	*3*
Dengue/Malaria/Chikungunya	*0*	*0*	*0*
Diabetes	*0*	*0*	*0*
Hypertension	*0*	*0*	*0*
Diarrhoea/Typhoid/Cholera	*0*	*0*	*0*
Tuberculosis	0	0	0
Dispensary/Municipal Hospital/State Hospital	2	0	2
Fogging	0	0	0
Health Related Issues	3	1	4
Health Service Related	0	1	1
Health Education Institute	0	0	0
Human Resources Related	3	0	3
Infrastructure	1	4	5
License	0	0	0
Maternity homes/Primary Health Centre (PHC)	0	0	0
Pollution	0	0	0
Private Health Services	0	0	0
Private Hospital/Clinics	0	1	1
Schemes/Policies in Health	0	1	1
Treatment Medicines	0	0	0
Total	**17**	**12**	**29**

(**Note:** One question/issue may be related to multiple sub issues in health and is counted issue wise, hence total questions raised does not equal issue wise total)

Inference:

- Although highest number of issues (5 each) were raised related to Infrastructure and Contaminated water supply by MLAs in 2020 and 2021 no questions were raised regarding diseases that have a high occurrence in the city such as diabetes, hypertension and tuberculosis.
- A total of only 3 questions were raised on Covid 19 by MLAs in 2020 and 2021.

**Annual period for 2020 was 24th Feb 2020 to 18th Dec'2020 and for 2021 was 8th March 2021 to 12th March 2021*

4. Recommendations

Data Management

- There is a need for a robust and open Health Management Information System (HMIS) that maintains data on various diseases, patients registered and other health related services and indicators.
- Cause of Death data should be maintained on a real-time basis. Furthermore, data should also be accessible to all tiers of the government.
- Measures should be created to register non- institutional deaths data in the COD data.
- Additionally, all health data that is maintained, must be effectively utilised by various health policy & planning agencies. This will allow for efficient tracking and monitoring of the status of health as well as the progress of implementation for various schemes/programmes in Delhi.

Healthcare services and facilities.

- Primary and preventive healthcare systems need to be strengthen to test and treat regular health issues to decrease the burden on hospitals. Also, these health centres should be easily accessible to the citizens.
- For both hospitals and dispensaries medical, paramedical and other staff vacancies need to be filled.
- For dispensaries there is a need to have visiting specialist doctors along with general practitioner.

Budget Allocation and Spending:

- It is important that the budget focus on allocating sufficient amounts to improve primary health care by strengthening dispensaries.
- Focus needs to be given on increasing utilisation of budgeted amounts.

Governance:

- All three levels of government have hospitals and dispensaries in Delhi, there needs to be a clear co-ordination between them to avoid duplication of health services and to share required resources.
- Effective deliberations on health issues needs to initiated at all tiers of government and should focus on direct health issues which citizens face.

Section B: SDG and Government Health Programmes & Schemes

1. Analysis of Government Health Policies Implemented in Delhi

The report aims to analyse the implementation of healthcare schemes and programmes in the city with the purpose of adjudging whether they are meeting their intended targets, to see if there are any gaps in the scheme or in the implementation of the scheme, and to provide suggestions for improvement.

Policy Making on Health in India

The Constitution of India delegates the responsibility of the provision of healthcare to the state governments. Every state is responsible for "raising the level of nutrition and the standard of living of its people and the improvement of public health" as among its primary duties. However, policy making related to public healthcare is divided between the Central and State Governments. While the Central Government is responsible for addressing healthcare issues with a wider reach, such as prevention of major diseases and all-encompassing family welfare, the State Governments handle targeted aspects such as local hospitals, public health, promotion and sanitation.

Overall Health Policy Framework

National Health Policy

The approach taken by the health sector has been guided by the NHP, 1983, the NHP, 2002, and most recently, the NHP, 2017. The goal, as set out by the NHP 2017 is "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."[20] The policy recognises the pivotal importance of Sustainable Development Goals (SDGs), and strives to achieve them by increasing access, improving quality and lowering the cost of healthcare delivery.

National Health Mission

The National Health Mission (NHM) – is a flagship programme of the Ministry of Health and Family Welfare that supports States/UTs to strengthen their health care systems so as to provide universal access to equitable, affordable and quality health care services. In the Twelfth five year plan (FYP), The Government of India decided to expand the National Rural Health Mission (2005) to the entire country, and renamed it as the National Health Mission (NHM). The NHM seeks to improve and strengthen the healthcare system of the country through its focused components namely Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A), Communicable and Non-Communicable Diseases.

The National Urban Health Mission (NUHM)[21] was approved in 2013 as a sub-mission of the NHM. Working in 779 cities and towns, the NUHM focused on expanding and providing primary health care services to the urban poor. The aim of the NUHM was to focus on three levels of improvement namely Community level outreach programs, Urban Health Center level infrastructure and existing health system improvement, and Secondary/Tertiary level Public-Private partnerships. The onus of executing these

[20] https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf

[21] https://www.nhp.gov.in/national-urban-health-mission_pg

improvement plans was allotted to municipal governments, with the additional duty of improving the social determinants that impact health such as sanitation, drinking water, and nutrition.

AYUSH

Apart from the host of programmes offering allopathic remedies, we also have the Ministry of AYUSH which focuses on the medical systems that have historically been practiced in India such as Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (acronym, AYUSH). Due to the growing challenges in the medical field regarding Non Communicable Diseases (NCDs), Lifestyle disorders, long term diseases, multi drug resistant diseases, and the emergence of new diseases, there was a great curiosity to understand the principles and practice of AYUSH. Therefore, in 1995, with the objective of optimal and focused development of these systems, the Department of Indian Medicine and Homeopathy (ISM and H) was created in the Union Ministry of Health and Family Welfare. In 2003, this Department was renamed as Department of AYUSH. In 2014, it was turned into a separate Ministry of AYUSH[22].

The objectives of AYUSH aim to upgrade the educational standards of Indian Systems of Medicines and Homoeopathy colleges in the country, to strengthen existing research institutions and to ensure a time-bound research programme on identified diseases for which these systems have an effective treatment, to draw up schemes for promotion, cultivation and regeneration of medicinal plants used in these systems, and to evolve Pharmacopoeial standards for Indian Systems of Medicine and Homoeopathy drugs.

Drugs and Medicines

With regards to medical drug pricing, regulation, and supply, there are two important policies that come into place, The Drug Price Control Orders Act (DPCO) and The National Pharmaceutical Pricing Authority (NPPA).

The Drug Price Control Orders Act (DPCO) is an order issued by the government under the "Essential Commodities Act" which enables it to fix the prices of some essential bulk drugs and their formulations. The objective of the DPCO is to ensure the availability of essential and lifesaving prophylactic medicine of a good quality at a reasonable price. Every few years, the Ministry of Health and Family Welfare, in consultation with experts, draws up a National List of Essential Medicines (NLEM). These medicines, deemed essential for the treatment of common conditions, automatically come under price control under the Drug Price Control Order (DPCO). In addition, under Para 19 of the DPCO, 2013, the government has special powers to bring any item of medical necessity under price controls. As an example, this provision was used to regulate the prices of cardiac stents and knee implants.

The National Pharmaceutical Pricing Authority (NPPA) established by the Government of India in 1997 under the Department of Pharmaceuticals (DoP), Ministry of Chemicals and Fertilisers works as an independent Regulator for pricing of drugs and to ensure availability and accessibility of medicines at affordable prices. The functions of the NPPA include implementing and enforcing the provisions of the Drugs (Prices Control) Order in accordance with the powers delegated to it. The NPPA also monitors the availability of drugs, identifies shortages, if any, and takes necessary remedial measures. It also maintains

[22] https://www.ayush.gov.in/

data on production, exports and imports, market share of individual companies for bulk drugs and formulations and undertakes/sponsors relevant studies in respect of pricing of drugs/pharmaceuticals. Lastly, the NPPA is in charge of rendering advice to the Central Government on changes/ revisions in drug policies[23].

Analysing Health Policies

Apart from these overarching policy directives the Central and State Governments have created various detailed policies and programmes in an effort to tackle the varied health problems faced. In order to ensure that these policies are on the path to meeting their intended outcomes, it is important to empirically analyse them and ensure that every gap is filled, that every individual is included, and that no one is left behind. This section aims to analyse the Central, State, and Local Government policies being implemented in Delhi, and to gauge whether our public healthcare system is accessible to everyone who requires it, whether every individual is covered by it, and to suggest improvements or interventions if required.

The schemes are divided into 6 main categories namely: (1) Communicable diseases, (2) Non-Communicable diseases (NCD), (3) Mental Health (4) Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA+), (5) Nutrition and (6) Insurance schemes. The logic of dividing the schemes as such was laid out by the NHP, 2017. Each scheme studied contains information such as the year of implementation, a background of the scheme, the objectives of the scheme, targets it had set out to meet, the beneficiaries of the scheme, and the implementation status of the scheme (i.e. relevant and recent data pertaining to the outcomes of the scheme). The year 2020 will be the fifth anniversary of the adoption of Sustainable Development Goals (SDGs) by 193 countries at the UN General Assembly which set out targets to be achieved by 2030. Each component will thus also be analysed based on the relevant SDG targets.

Note: The section includes analysis of only major schemes that are being implemented in Delhi.

[23] http://www.nppaindia.nic.in/en/

Table 12: Summary of Major Health Schemes Implemented in Delhi

Scheme	Implementing body	Target	Status
Communicable Diseases			
Revised National Tuberculosis Control Programme	Delhi State Government	Prevalence of less than one case per one lakh population by 2025	521 cases per 1 lakh population in 2020
National AIDS Control Programme	Delhi AIDS Control Society	To reduce new infections by 50%	HIV cases decreased from 2019-20 to 2020-21 for males by 50% and females by 49%.
Financial Assistance Scheme for PLHIV	Delhi State Government	Monetary aid to PLHIV	Beneficiaries provided financial assistance has increased by 19% from 4,043 in 2018-19 to 4,831 in 2019-20.
National Vector Borne Disease Control Programme	Delhi State Government	Reducing the prevalence and morbidity of malaria and dengue	Malaria cases decreased by 88% from 17,185 in 2019-20 to 2,148 in 2020-21 Dengue cases decreased by 69% from 22,425 in 2019-20 to 7,040 in 2020-21.
National Viral Hepatitis Control Programme	National Centre for Disease Control	Elimination of Viral Hepatitis by 2030	Hepatitis cases fell by 54% from 10,713 in 2019-20 to 4,942 in 2020-21.
National Rabies Control Programme	National Centre for Disease Control	Prevent Human Deaths due to Rabies, Prevent transmission of Rabies due to canine (dog)	2 rabies deaths were reported in 2020
National Leprosy Eradication Programme	Delhi State Government	Prevalence of less than one case per 10,000 individuals	According to Delhi Government data the prevalence rate of leprosy in Delhi is 1.03.
Non-Communicable Diseases			
National Programme For Prevention And Control Of Cancer, Diabetes, Cardiovascular, Diseases, and Stroke	Delhi State Government	To prevent and control chronic NCDs especially cancer, diabetes, cardiovascular diseases (CVDs) and stroke.	Deaths due to circulatory system 13,955 in 2020 respiratory diseases 8,057 in 2020 and cancers 3,938 in 2020

National Tobacco Control Programme	Delhi State Government	Reducing the prevalence of tobacco use by 5% by the end of the 12th FYP (2012-17)	Third Global Adult Tobacco Survey (GATS3) is not yet conducted.
National Programme for Prevention and Control of Deafness	Delhi State Government	Reducing the total disease burden by 25% of the existing burden by the end of 12th FYP (2012-17)	Data is not been published since 2018-19 in Directorate General of Health Services (DGHS) Annual reports and is available till 2017-18.
National Programme for Prevention and Management of Burn Injuries	Delhi State Government	To increase availability of skille health professionals, increasing awareness and safety measures	Burn cases has decreased by 44% from 4,526 in 2019-20 to 2,544 in 2020-21.
National Programme for Control of Blindness	Delhi State Government	To reduce the prevalence of blindness to 0.3%.	*No data was available regarding cases of blindness, number of ophthalmologists, or facilities for the same.*
National Programme for Palliative Care	Delhi State Government	Availability and accessibility of rational, quality pain relief and palliative care	*No data of specific implementation was available in the public domain.*
National Programme for Healthcare of Elderly	Delhi State Government	To provide preventive, curative and rehabilitative services to the elderly persons at various levels of the health care delivery system of the country	Special facilities for elderly in Delhi government hospitals and dispensaries. In 2019-20, 11,35,216 elderly patients were reported in Delhi OPDs.
Silicosis Control Programme	Delhi State Government	Reduction in new silicosis cases	Awareness activities, surveys and clinical examinations are being conducted by the state government

National Programme for Prevention and Control of Fluorosis	Delhi State Government	Comprehensive management of fluorosis through early detection, creation of awareness and medical management.	Data is not been published since 2019-20 in Directorate General of Health Services (DGHS) Annual reports and is available till 2018-19.
Thalassemia Control Programme	Delhi State Government	Free testing and blood transfusion facilities	16 thalassemia deaths reported in 2020.
Mental Health			
National Mental Health Programme	Delhi State Government	Prevention and treatment of mental and neurological disorders	People accessing mental healthcare decreased by 36% from 2,12,776 in 2019-20 to 1,36,338 in 2020-21.
Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCHA+)[24]			
Pulse Polio Programme	Delhi State Government	To achieve universal coverage of polio vaccine	Average number of children with OPV and IPV dosage decreased by 21% from 2,92,098 in 2019-20 to 2,30,454 in 2020-21.
Universal Immunisation Programme	Delhi State Government	To achieve universal coverage of vaccine	Of the vaccines covered under UPI for children (0 to 14 years), a high number of deaths were still reported due to tuberculosis (215 in 2020) and diarrhoea (56 in 2020).
Rashtriya Kishor Swasthya Karyakram	Delhi State Government	Increasing availability and access to adolescent health services	While counselling services are an important component under the scheme, the percentage of adolescents who received counselling out of the total who registered in Adolescent Friendly Health Clinics was 77% for girls and 51% for boys in 2020-21.
School Health Scheme	Delhi State Government	To provide comprehensive health care to approx. 16 lakh school children of Delhi state government and government aided schools	The number of Referral centres under the School Health Scheme has increased marginally by 3% from 2018-19 to 2019-20 and so has the number of students who received OPD service under the scheme has increased by 55% from 2018-19 to 2019-20.

[24] Some of the RMNCHA+ schemes are implemented under the state government but services such as antenatal care are also provided in health facilities of the Municipal Corporations of Delhi.

Janani Suraksha Yojana	Delhi State Government	Reducing the Maternal and Neonatal Mortality rate by promoting institutional deliveries	Neonatal mortality is 15.5 in 2020-21. Maternal Mortality Rates is 252 in 2020-21.
Janani Shishu Suraksha Karyakram	Delhi State Government	Improve access of pregnant women and newborns to health services	The number of pregnant women who registered for antenatal care decreased by 24% from 2019-20 to 2020-21. Only 52% of total registered women received four or more antenatal checkups in Delhi in 2020-21.
Pradhan Mantri Surakshit Matritva Abhiyan	Central Government	To ensure quality antenatal care	
Family Welfare Services	Delhi State Government	To facilitate provision of family planning services	Female contraceptive interventions, made up to an average of 99.66% of all family planning interventions from 2018-19 to 2020-21.
Nutritional Schemes			
Weekly Iron and Folic Acid Supplement (WIFS) Programme	Delhi State Government	Weekly tablets to 13.82 lakhs Students (6^{th} to 12^{th} standards) in all 1,218 state government and aided schools in Delhi.	In 2020-21, 8,866 girls and 7,741 boys (6^{th} to 12^{th} class) have been given IFA tablets.
Integrated Child Development Scheme(ICDS)	Delhi State Government	Improving the health, nutrition and education of women and children	Number of children reported severe acute malnourished decreased by 70% from 3,675 in 2019-20 to 1,105 in 2020-21. Majority deaths of malnutrition occurred in the age group of 0-4 years- in 2020, 68% of all deaths took place in this age group.
Mid-Day Meal Scheme	Delhi State Government	Improve the effectiveness of primary education by improving the nutritional status of all primary school children.	The scheme is being implemented in government schools in Delhi, but there is no data available regarding the quality of food provided.
National Iodine Deficiency Disorders Control Programme	Delhi State Government	To bring the prevalence of iodine deficiency disorders to below 5%	No data related to iodine deficiency disorders available in the public domain

Insurance Schemes			
Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana	Delhi State Government	Health insurance to 10.74 crores families in India	In a response received from Health and Family Welfare Department to an RTI application, it was stated that the information is segregated and not available with single public authority. It was further transferred to DGHS and Revenue department.

1.1. Communicable Disease Schemes

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the infection, presence and growth of pathogens (viruses, bacteria, fungi) in an individual human host.

The table depicts the making and implementation of major programmes/schemes in Delhi

Government	Central	State	City
Central	• National Viral Hepatitis Surveillance Programme • National Rabies Control Programme		
State	• Revised National Tuberculosis Control Programme • National AIDS Control Programme • National Vector Borne Disease Control Programme • National Leprosy Eradication Programme	Financial Assistance Scheme for PLHIV	
City			

PROGRAMME MAKING PROGRAMME IMPLEMENTATION

SUSTAINABLE DEVELOPMENT GOALS

Target: ***0 TB cases/1 lakh population by 2030*** [1]

Status: ***521 TB cases/ 1 lakh population*** [2]

KEY FINDINGS [3]

- *The highest number of TB deaths has been found in the productive ages of 25 to 64 in 2020. In the past 5 years from 2016 to 2020, these deaths contribute to 63% of total deaths registered.*
- *The proportion of those recorded HIV positive in 2020-21 to those tested is 1.03% in males and 0.51% in females.*
- *The number of blood smears examined for Malaria fell by 64% and RDT tests conducted fell by 53% from 2019-20 to 2020-21.*
- *The number of dengue cases requiring hospitalisation has fallen from 54% in 2018-19 to 43% in 2020-21.*
- *Deaths due to viral hepatitis was 79 in both 2018 and 2019 but decreased to 77 in 2020 of which maximum deaths (51) occurred in the age groups of 25 to 64.*

[1] SDG India Index, Niti Aayog [2] Nikshay Portal Data [3] HMIS website and cause of death data from Annual Reports of Registration of Births and Deaths in Delhi

1.1.1 National Tuberculosis Elimination Programme (NTEP)

Year:
1997

Background:
Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium Tuberculosis. It mainly affects the lungs but can also affect other parts of the body such as lymph nodes, the brain, bones, kidney etc. TB spreads through air. When a person suffering from pulmonary TB coughs or sneezes, infectious pathogens are spread in air through droplets. The National TB Control Programme (NTCP)[25] was started in 1962 to address the problem of high morbidity in TB, but had limited success with only 30-40% treatment completion rate amongst patients put on treatment. In view of this, the Government of India started the Revised National TB Control Programme (RNTCP) with Directly Observed Treatment short course (DOTS) strategy at few selected sites in 1993[26]. This programme was renamed to National Tuberculosis Elimination Programme on 1st January, 2020.[27]

Drug resistant TB (DR-TB), that is Multi-Drug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB) is a form of TB which is resistant to at least four of the core anti-TB drugs, (isoniazid and rifampicin, fluoroquinolones (such as levofloxacin or moxifloxacin) and to at least one of the three injectable second-line drugs (amikacin, capreomycin or kanamycin).) MDR-TB and XDR-TB both take substantially longer to treat than ordinary (drug-susceptible) TB, and require the use of second-line anti-TB drugs, which are more expensive and have more side effects than the first-line drugs used for drug-susceptible TB.

As per the guidelines of the Central Government, RNTCP has been implemented in Maharashtra since 1997-98 in a phased manner. To implement this programme effectively, the State TB Society and 79 District/City TB Societies have been established. Detailed planning for implementation of the programme is done at State and District levels.

The Central TB division launched **Nikshay Portal** in 2012. Nikshay is a web based platform for the monitoring of TB patients under the RNTCP. The two broad objectives of Nikshay are to create a database of all TB patients including Multi-Drug Resistant TB cases across India and to use this database for monitoring and research purposes at all levels for controlling TB.

Target:
To control the spread and incidence of cases of TB. TB is said to be in control if the prevalence rate of the disease is below 1 per lakh of the population. The NHP 2017 aims 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.

[25] https://www.nhp.gov.in/revised-national-tuberculosis-control-programme_pg
[26] https://tbcindia.gov.in/WriteReadData/NSP%20Draft%2020.02.2017%201.pdf
[27] file:///C:/Users/Anubhooti/Downloads/5845%20(1).pdf

Objectives:

1. To achieve 90% notification rate for all TB cases.
2. To achieve 90% success rate for all new and 85% for re-treatment cases.
3. To significantly improve the successful outcomes of treatment of Drug Resistant TB cases.
4. To achieve decreased morbidity and mortality of HIV associated TB
5. To improve outcomes of TB care in the private sector

Beneficiaries:

All persons infected with TB or at a high risk of getting the infection.

Implementation Status in Delhi:

Table 13: Tuberculosis Notification on Nikshay Portal[28] for Delhi from 2018 to 2020[29]

2018			2019			% change from 2018 to 2019	2020			% change from 2019 to 2020
Public	Private	Total	Public	Private	Total		Public	Private	Total	
70,248	10,365	80,613	79,807	28,089	1,07,896	34%	59,725	27,188	86,913	-19%

Table 14: Age wise deaths due to Tuberculosis in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Tuberculosis (A15-A16 , A17, A18-A19)	2016	93	125	585	1,194	1,145	546	45	3,733
	2017	48	133	589	1,172	1,176	513	25	3,656
	2018	76	163	566	1,187	1,246	583	13	3,834
	2019	106	157	533	1,172	1,313	644	10	3,935
	2020	53	162	446	826	810	287	8	2,592

Inference:

- TB Notifications have decreased by 19% from 1,07,896 in 2019 to 86,913 in 2020.
- The highest number of TB deaths has been found in the productive ages of 25 to 64 in 2020. In the past 5 years from 2016 to 2020, these deaths contribute to 63% of total deaths registered.
- The number of cases notified as per Nikshay portal in 2020 was 86,913. Based on which, 521 TB cases/ 1 lakh population was registered however, the SDG targets zero cases/ 1 lakh population by 2030.

[28] https://reports.nikshay.in/Reports/TBNotification
[29] Downloaded from Nikshay portal as on 19th October, 2021

Table 15: Drug Resistant TB Cases in Delhi from 2018 to 2020

Years (year in which case registered)	2018	2019	2020
No. of notified cases under Nikshay (Public and Private) diagnosis (from Nikshay Portal)	80,613	1,07,896	86,913
No. of notified cases from TB cell through RTI (a)	80,624	1,08,506	86,900
MDR Cases registered under NTEP (from TB cell through RTI)	2,190	2,692	2,159
XDR Cases registered under NTEP (from TB cell through RTI)	47	57	65
% of TB Drug Resistance (MDR and XDR) cases	2.8%	2.5%	2.6%
Defaulters from DOTS Programme (from TB cell through RTI) (b)	1,112	1,515	1,699
Defaulter cases in % (b*100/a)	1%	1%	2%
Number of deaths under NTEP from TB cell through RTI	1,728	2,579	2,485
Number of deaths under Registration of Births and Deaths. ***(from Annual Report on Registration of Births and Deaths In Delhi - 2019)***	3,834	3,935	2,592

Inference:

- In 2020, 2,159 MDR cases were registered and 65 XDR cases were registered under NTEP.
- The percentage of patients diagnosed with DR-TB has marginally increased by 0.1% from 2019 to 2020.
- The percentage of Defaulters has also increased from 2019 to 2020.
- In 2020, 2,485 TB deaths have occurred under the NTEP, a decline from 2,579 TB deaths in 2019.

1.1.2 National AIDS Control Programme

Year:
1992

The National AIDS Control Programme (NACP)[30] is being implemented as a comprehensive programme for prevention and control of HIV/AIDS in India. Over time, the focus has shifted from raising awareness to behavior change, from a national response to a more decentralised response and to increasing involvement of NGOs and networks of People living with HIV (PLHIV).

- The NACP I started in 1992 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.
- In 1999, the second National AIDS Control Project (NACP II) was launched 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.
- NACP III was launched in 2007 with the goal of Halting and Reversing the Epidemic over its five-year period.
- NACP IV, launched in 2012, aimed to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the next five years.

The NHP 2017 sets out the goal to achieve the global target of 2020 set by the Joint United Nations Programme on HIV/AIDS (UNAIDS) which is also termed as target of 90:90:90[31] 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[32].

Objectives:

To halt and reverse the epidemic in India by integrating programmes for prevention, care, support and treatment through a four pronged strategy i.e.:

1. Prevent infections through saturation of coverage of high-risk groups with targeted interventions (TIs) and scaled up interventions in the general population.
2. Provide greater care, support and treatment to a larger number of people living with HIV/AIDS.
3. Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment programmes at district, state and national levels.
4. Strengthen the nationwide Strategic Information Management System.

Target:

To reduce the rate of incidence by 60 percent in the first year of the programme in high prevalence states to obtain the reversal of the epidemic, and by 40 percent in the vulnerable states to stabilise the epidemic. In Delhi, the target is to reduce new infections by 50% (2007 Baseline of NACP III).[10]

[30] http://naco.gov.in/nacp
[31] https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf
[32] https://main.mohfw.gov.in/sites/default/files/24%20Chapter%20496AN2018-19.pdf

Beneficiaries:

All persons afflicted by HIV/AIDS and those at high risk of contracting the disease.

Implementation Status in Delhi:

Table 16: Number of cases tested positive for HIV in Delhi from 2018-19 to 2020-21

HIV Cases		2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Male	Tested	3,87,430	3,71,308	-4%	1,87,310	-50%
	Positive	4,622	3,868	-16%	1,923	-50%
	%	1.19%	1.04%	-0.15%	1.03%	-0.02%
Female	Tested	6,27,607	5,91,751	-6%	2,83,828	-52%
	Positive	4,194	2,832	-32%	1,437	-49%
	%	0.67%	0.48%	-0.19%	0.51%	0.03%
Pregnant Women (Out of the Total)	Tested	3,48,490	3,26,278	-6%	1,56,002	-52%
	Positive	2,250	1,554	-31%	591	-62%
	%	0.65%	0.48%	-0.17%	0.38%	-0.10%

Inference:

- The number of positive HIV cases decreased from 2019-20 to 2020-21 for males by 50% and fell by 49% for females.
- However, the proportion of those recorded positive to those tested has remained the same in males and has increased from 0.48% to 0.51 for females.
- Thus, focus is needed to tackle the spread of HIV especially on male testing since the positive rate is much higher than females.
- This can also be compared to the kind of contraceptive distribution (Table 50) where condom distribution has fallen by 22% from 2019-20 to 2020-21.

Table 17: Age wise deaths due to HIV in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Human Immunodeficiency Virus (HIV) (B20-B24)	2016	1	2	11	99	38	9	1	161
	2017	1	4	6	79	33	6	2	131
	2018	3	1	18	71	27	3	0	123
	2019	0	1	11	50	24	3	0	89
	2020	2	1	12	23	21	3	0	62

Inference:

123 deaths were recorded due to HIV in 2018 which decreased to 62 in 2020. On an average, 55% of HIV deaths in the past five years were reported among people aged 25 to 44.

1.1.3 Financial Assistance Scheme for People Living with HIV

Year:
2012

Background:
To augment the efforts of NACP in Delhi, the state government started this scheme for financial assistance to the poor fighting HIV/AIDS.[33] The scheme is looked after by the mainstreaming division of Delhi State AIDS Control Society.

Objectives:

1. Improve compliance and access to Anti-Retroviral Treatment (ART) for people living in HIV and children/orphan/destitute children infected by HIV/AIDS.
2. Money/aid is provided to eligible PLHIV to cover the transportation cost of accessing the ART Centers and thus helping to achieve the requisite level of drug adherence, preventing emergence of drug resistance and obviating the need for costly second line treatment and to improve nutritional status and physical capacity of the person to earn livelihood, help orphan children in accessing ART, treatment of other infections that they are at risk, nutritional support, education and skill building.

Target:
Not specified.

Beneficiaries:
People living in HIV and children/orphan/destitute children infected by HIV/AIDS.

Implementation Status in Delhi:

Table 18: Beneficiaries under the scheme from 2017-18 to 2019-20[34]

Beneficiaries	Number of Beneficiaries			% Change from 2017-18 to 2019-20
	2017-18	2018-19	2019-20	
People/Children living with HIV/AIDS on Anti-Retroviral Treatment	3,787	4,043	4,831	28%
Destitute Children infected with HIV/AIDS in institutional care	58	66	76	31%
Orphan children affected by HIV/AIDS	23	24	26	13%

Inference:

- The number of beneficiaries on Anti-Retroviral Treatment who were provided financial assistance has increased by 28% from 3,787 in 2017-18 to 4,831 in 2019-20.
- Financial assistance to destitute children infected with HIV/AIDS in institutional care have also increased by 31%.

[33] http://web.delhi.gov.in/wps/wcm/connect/doit_dsacs/DSACS/Home/Financial+Assistance+to+PLHAs
[34] AR 2019-20 (delhi.gov.in)

1.1.4 National Vector Borne Disease Control Programme

1.1.4.1 Malaria

Year:
2003

Background:
The control of malaria in the urban areas is a complementary programme in line with National Vector Borne Disease Control Programme (NVBDCP)[35] in rural areas.

Objectives:

1. To actively search for malaria patients and ensure provision of complete radical treatment to control the spread of malaria.
2. Reduction of the disease to a tolerable level in which human population can be protected from malaria transmission with the available means.
3. Prevention of malaria related deaths
4. Reduction in transmission and morbidity

Target:
Elimination of malaria by 2030.

Beneficiaries:
Those afflicted with malaria and at high risk of contracting malaria (High risk is measured by the Epidemiological Cell after analysing disease trends pertaining to the spread of diseases in communities).

[35] https://main.mohfw.gov.in/sites/default/files/5201617.pdf

Implementation Status in Delhi:

Table 19: Testing and cases of Malaria from 2018-19 to 2020-21[36]

Malaria	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Total Blood Smears Examined for Malaria	3,15,356	2,95,862	-6%	1,07,656	-64%
Malaria (Microscopy Tests) positive	5,765	14,002	143%	1,280	-91%
Positivity %	1.8%	4.7%	2.9%	1.2%	-3.5%
RDT conducted for Malaria	1,63,271	1,63,945	0.4%	76,853	-53%
Malaria (RDT) positive	2,951	3,183	8%	868	-73%
Positivity %	1.8%	1.9%	0.1%	1.1%	-0.8%
Total Malaria Cases	8,716	17,185	97%	2,148	-88%
Hospitalised cases	7,373	6,578	-11%	2,021	-69%

Inference:

- The number of blood smears examined for Malaria fell by 64% and RDT tests conducted fell by 53% from 2019-20 to 2020-21.
- The percentage of positive malaria cases out of total tested has decreased by 88% from 17,185 in 2019-20 to 2,148 in 2020-21.
- To tackle malaria effectively more testing should be carried out in Delhi.

Table 20: Age wise deaths due to Malaria in Delhi for the years 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Malaria (B50-B54)	**2016**	14	13	24	34	26	7	4	122
	2017	7	15	27	32	24	8	1	114
	2018	7	12	24	43	19	9	1	115
	2019	7	13	24	26	20	5	0	95
	2020	2	9	9	14	8	6	0	48

Inference:

115 malaria deaths were reported in 2018, which decreased to 48 in 2020 of which maximum deaths (23) were registered in the age groups of 15 to 44.

[36] Microscopy is inexpensive and allows the identification of species and parasite density. However, the quality of microscopy-based diagnosis is frequently inadequate due to a variety of reasons. Microscopy has low sensitivity when performed by poorly trained personnel and may result in the over- or under-diagnosis of malaria, with excessive use of anti-malarial drugs or negligent treatment, which invariably contributes to malaria morbidity and the development of resistance. Malaria rapid diagnostic tests (RDTs) assist in the diagnosis of malaria by providing evidence of the presence of malaria parasites in human blood. RDTs are an alternative to diagnosis based on clinical grounds or microscopy, particularly where good quality microscopy services cannot be readily provided. Malaria RDTs detect specific antigens (proteins) produced by malaria parasites in the blood of infected individuals.

1.1.4.2 Dengue

Year:

2003

Background:

Dengue Fever is caused by four antigenically related but distinct dengue virus serotypes transmitted by the infected mosquitoes, Aedes Aegypti. According to the National Vector Borne Disease Control Programme, Dengue infections have historically peaked during the monsoon and post monsoon months in India (July-October). This is due to the fact that areas where rainwater collects or is stored present themselves as high risk breeding grounds for dengue.[37]

Objectives:

1. Surveillance for disease and outbreaks
2. Early diagnosis and prompt case management
3. Vector control through community participation and social mobilisation
4. Capacity building for the effective control over transmission of the disease

Target:

Not specified.

Beneficiaries:

All those afflicted with dengue or at risk of contracting dengue

Implementation Status in Delhi:

Table 21: Testing and cases of Dengue from 2018-19 to 2020-21

Dengue	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Dengue - RDT Test Positive	16,851	13,435	-20%	4,969	-63%
Dengue - Enzyme- Linked Immuno Sorbent Assay (ELISA) Test Positive	12,987	8,990	-31%	2,071	-77%
Total Dengue Cases	29,838	22,425	-25%	7,040	-69%
Cases with hospitalisation	16,076	7,907	-51%	3,042	-62%

Inference:

- Total dengue cases fell from 29,838 in 2018-19 to 7,040 in 2020-21, although the number of dengue cases are much higher compared to malaria.
- The number of cases requiring hospitalisation has fallen from 54% in 2018-19 to 43% in 2020-21.

[37] https://nvbdcp.gov.in/index4.php?lang=1&level=0&linkid=443&lid=3720

Table 22: Age wise deaths due to Dengue in Delhi for the years 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Dengue Fever (A90)	2016	30	52	38	40	24	19	3	206
	2017	22	68	37	101	60	26	3	317
	2018	2	21	15	15	18	6	0	77
	2019	15	39	31	29	24	12	0	150
	2020	2	17	9	16	12	8	0	64

Inference:

Delhi recorded more malaria deaths (115) than dengue (77) in 2018, while it was the opposite in 2020 (64 dengue deaths and 48 malaria deaths in 2020). However, number of cases reported and deaths show that both malaria and dengue are major health issues in Delhi and need to be tackled effectively.

Table 23: Month-wise Malaria and Dengue cases in Delhi from 2018-19 to 2020-21[38]

Month	Malaria			Dengue		
	2018-19	2019-20	2020-21	2018-19	2019-20	2020-21
April	881	139	171	364	130	171
May	308	334	39	417	553	197
June	520	603	40	453	414	157
July	655	852	91	570	842	150
August	1,110	1,169	471	1,740	1,818	457
September	2,763	11,978	585	5,087	4,263	1,119
October	1,438	1,180	285	12,186	6,205	1,933
November	398	398	178	6,838	5,543	1,192
December	149	166	74	1,318	1,695	494
January	72	230	69	363	389	330
February	129	72	106	306	309	467
March	293	64	39	196	264	373

Inference:

- The month wise analysis of both diseases showed September month had the highest malaria cases while October month had highest dengue cases.
- In this scheme specifically, attention must be given to the social determinants that cause these diseases i.e. sanitation and stagnating water.

[38] While the malaria mosquito (Anopheles) breeds in accumulating water in open areas, the dengue mosquito (Aedes aegypti) breeds in freshwater in domestic areas in and around the household. A combination of conditions such as bouts of heavy rainfall, succeeded by dry spells of no rain, leading to the accumulation of water creates an atmosphere for mosquitoes to breed and for their eggs to grow from a larval stage to an adult stage. When there is continuous rainfall, water is constantly washed away thereby making it impossible for mosquito larvae to grow to full adulthood (which takes 7 days). It is the period of no rain following this that allows them to reach maturity and consequently start infecting humans.

1.1.5 National Viral Hepatitis Surveillance Programme

Year:

2012

Background:

Viral hepatitis is caused by infection with one of the five known hepatotropic viruses, which are named as hepatitis A virus (HAV), hepatitis B virus (HBV), hepatitis C virus (HCV), hepatitis D virus (HDV), and hepatitis E virus (HEV). These viruses are quite divergent in their structure, epidemiology, routes of transmission, incubation period, clinical presentations, natural history, diagnosis, and preventive and treatment options. The National Program on Surveillance of Viral Hepatitis is an integrated initiative for the prevention and control of viral hepatitis in India.

Objectives:

1. To establish laboratory networks for laboratory-based surveillance of viral hepatitis in different geographical locations of India.
2. To ascertain the prevalence of different types of viral hepatitis in different zones of the country.
3. To provide laboratory support for outbreak investigation of hepatitis through an established network of laboratories.
4. To develop technical material for generating awareness among healthcare providers and in the community about waterborne and blood borne hepatitis.[39]

Target:

1. Establishment of laboratory-based surveillance for viral hepatitis in the country for collection of data. Development of testing and surveillance guidelines and its dissemination.
2. A network of laboratories with quality testing for hepatitis markers will be established covering the entire country.
3. Training of manpower/health care providers in 10 regional labs including NCDC i.e. the reference lab.
4. Development of Information, Education and Communication (IEC) for providers and community.
5. Establishment of baseline data for hepatitis to see the impact
6. Elimination of Viral Hepatitis by 2030.[38]

Beneficiaries:

People afflicted by or suffering from viral hepatitis.

[39] https://ncdc.gov.in/showfile.php?lid=440

Implementation Status in Delhi:

Table 24: Cases for Hepatitis in Delhi from 2018-19 to 2020-21

Number of Cases	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Hepatitis	6,611	10,713	62%	4,942	-54%

Table 25: Age wise deaths due to Viral Hepatitis in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Viral Hepatitis (B15, B16, B17-19)	**2016**	1	2	16	42	36	14	0	111
	2017	6	5	19	35	32	12	0	109
	2018	3	10	12	23	18	12	1	79
	2019	7	7	9	15	28	13	0	79
	2020	1	2	16	21	30	7	0	77

Inference:

- The number of Hepatitis cases reported decreased by 54% from 10,713 in 2019-20 to 4,942 in 2020-21.
- Deaths due to viral hepatitis was 79 in both 2018 and 2019 but decreased to 77 in 2020 of which maximum deaths (51) occurred in the age groups of 25 to 64.

1.1.6 National Rabies Control Programme

Year:

2013

Background:

Rabies is an acute viral disease transmitted from wild and domestic animals to other animals and to humans through the saliva (following bites, scratches, licks on broken skin and mucous membrane). The progression of rabies can be prevented to a large extent if animal bites are managed appropriately and in time. In this regard, the National Rabies Control Programme aims to limit the morbidity and mortality.[40]

Objectives:

1. Training of Health Care professionals on appropriate Animal bite management and Rabies Post Exposure Prophylaxis.
2. Strengthening of Regional Laboratories under NRCP for Rabies Diagnosis.
3. Creating awareness in the community through advocacy and communication and social mobilisation.
4. Advocacy for states to adopt and implement intradermal route of Post exposure prophylaxis for Animal Bite Victims and Pre exposure prophylaxis for high-risk categories.

Target:

1. Prevent Human Deaths due to Rabies.
2. Prevent transmission of Rabies due to canine (dog) rabies.

Beneficiaries:

No specific beneficiaries defined, applicable for all.

Implementation Status in Delhi:

Table 26: Age wise deaths due to Rabies in Delhi for the years 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Rabies (A82)	2016	2	1	2	1	1	3	1	11
	2017	0	3	3	3	7	2	0	18
	2018	0	2	3	8	3	0	0	16
	2019	0	4	2	3	4	1	0	14
	2020	0	0	0	1	1	0	0	2

Inference:

- Rabies deaths decreased drastically from 14 in 2019 to 2 in 2020.

[40] https://ncdc.gov.in/index1.php?lang=1&level=1&sublinkid=146&lid=150

1.1.7 National Leprosy Eradication Programme

Year:
1983

Background:
The National Leprosy Eradication Programme (NLEP)[41] aimed to reduce the burden of leprosy in the country. The country achieved the goal of leprosy elimination as a public health problem (i.e. prevalence rate of less than 1 case/ 10,000 population) at national level by December 2005, as set out by The NHP 2002. The NHP 2017 sets out the goal to achieve and maintain elimination status of leprosy[42].

Objectives:

1. Elimination of leprosy i.e. a prevalence of less than 1 case per 10,000 population in all districts of the country.
2. Strengthen Disability Prevention and Medical Rehabilitation of persons affected by leprosy.
3. Reduction in the level of stigma associated with leprosy.

Target:
Prevalence of less than 1 case per 10,000 population in all districts of the country. Elimination of leprosy by 2018. Elimination the proportion of grade-2 cases amongst new cases keeping in mind the global goal of reduction of grade 2 disability to less than 1 per million by 2020.

Beneficiaries:
Afflicted leprosy patients and those at high risk of contracting leprosy

Implementation Status in Delhi:

Table 27: Age wise deaths due to Leprosy in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Leprosy (A30)	2016	3	0	0	1	9	10	0	23
	2017	1	0	0	3	11	4	1	20
	2018	0	0	0	1	6	1	0	8
	2019	0	0	1	1	4	9	0	15
	2020	0	1	1	0	6	6	0	14

Inference:
According to Delhi Government data, the prevalence rate of leprosy in Delhi is 1.03[43]. However, the deaths reported due to leprosy increased from 8 in 2018 to 15 in 2019 but decreased to 14 in 2020.

[41] https://dghs.gov.in/content/1349_3_NationalLeprosyEradicationProgramme.aspx
[42] https://www.nhp.gov.in/national-leprosy-eradication-programme_pg
[43] http://web.delhi.gov.in/wps/wcm/connect/106f68804d076b7a9f6eff88a2e43d90/A+R+2018-19.pdf?MOD=AJPERES&lmod=-85530309&CACHEID=106f68804d076b7a9f6eff88a2e43d90

1.2. Non-Communicable Disease (NCD) Schemes

Non Communicable Diseases, also known as chronic diseases, tend to be of long duration and are the result of a combination of genetic, physiological, environmental and behavioral factors.

The table depicts the making and implementation of major programmes/schemes in Delhi

Government	Central	State	City
Central			
State	• *National Programme For Prevention And Control Of Cancer, Diabetes, Cardiovascular Diseases, and Stroke* • *National Tobacco Control Programme* • *National Programme for Prevention & Management of Burn Injuries* • *National Programme for Control of Blindness* • *National Programme for Prevention and Control of Deafness* • *National Programme for Healthcare of Elderly* • *National Programme for Palliative Care* • *National Programme for Prevention and Control of Fluorosis*	• Silicosis Control Programme • Thalassemia Control Programme	
City			

PROGRAMME MAKING PROGRAMME IMPLEMENTATION

SUSTAINABLE DEVELOPMENT GOALS

Target: *To reduce by one third premature mortality from NCDs by 2030.*[1]

Status: *Deaths due to diabetes has increased by 8% and due to hypertension has decreased by 17% from 2015 to 2020.*[2]

KEY FINDINGS [3]

- *Highest NCD deaths were reported due to diseases of the circulatory system (13,955 in 2020) followed by respiratory diseases (8,057 in 2020) and cancers (3,938 in 2020).*
- *Although the policy aims to tackle major NCDs it does not include chronic respiratory diseases which are a major concern in Delhi due to high air pollution.*
- *There is either limited or no data available on other NCD programmes in Delhi.*

[1] SDG Index India, Niti Aayog [2&3] Cause of Death Data from Annual Reports of Registration of Births and Deaths in Delhi

1.2.1 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke

Year:
2010

Background:
The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) aims at integration of NCD interventions in the NHM framework for optimisation of scarce resources and provision of seamless services to the patient and also for ensuring long term sustainability of interventions. The National Cancer Control Programme (NCCP) and National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPDCS) were merged under it. It was introduced in 100 districts across 21 States, in order to prevent and control the major NCDs. The main focus of the programme is on health promotion, early diagnosis, management and referral of cases of NCDs, besides strengthening the infrastructure and capacity building. The NCD cell at state and district level will ensure implementation and supervision of the programme activities.[44]

Objectives:
1. Prevent and control common NCDs through health promotion, behaviour and lifestyle changes with involvement of community, civil society, community based organisations, media etc.
2. Screening at all levels in the health care delivery system from sub-centre and above for early detection of diseases covered under the program including management and follow up.
3. To build capacity at various levels of health care for prevention, early diagnosis, treatment, rehabilitation, IEC, operational research and rehabilitation.
4. Train human resources within the public health setup (doctors, paramedics and nursing staff) to cope with the increasing burden of NCDs.
5. Establish and develop capacity for palliative and rehabilitative care.
6. To provide logistic support for diagnosis and cost effective treatment at primary, secondary and tertiary levels of health care.
7. To support the development of databases of NCDs through the Surveillance System and to monitor NCD morbidity and mortality and risk factors.

Target:
To prevent and control chronic NCDs especially cancer, diabetes, cardiovascular diseases (CVDs) and stroke.

Beneficiaries:
Individuals suffering from diabetes, hypertension, cardiovascular diseases, common cancers, etc.

[44] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1048&lid=604

Implementation Status in Delhi:

Table 28: Age wise Deaths due to Non Communicable Diseases (NCD) in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Diabetes Mellitus (E10-E14)	2016	2	9	33	246	1,285	972	10	2,557
	2017	2	5	27	217	1,341	952	17	2,561
	2018	4	11	25	210	1,053	896	6	2,205
	2019	3	7	17	142	792	695	0	1,656
	2020	4	5	17	109	686	638	2	1,461
Hypertension (I10-I15)	2016	260	57	190	946	2,900	2,408	74	6,835
	2017	38	16	65	843	2,842	2,264	16	6,084
	2018	41	26	226	1,328	3,074	2,270	16	6,981
	2019	36	36	372	1,445	2,983	2,061	4	6,937
	2020	26	10	106	554	1,376	1,146	7	3,225
Disease of The Circulatory System (I00-I99)	2016	565	157	555	2,309	6,325	5,843	165	15,919
	2017	456	214	524	2,621	6,956	6,326	106	17,203
	2018	545	227	786	3,337	7,813	6,642	95	19,445
	2019	439	214	817	3,172	7,541	6,420	18	18,621
	2020	289	137	472	2,085	5,474	5,320	178	13,955
Diseases of The Respiratory System (J00-J98)	2016	832	241	430	1,281	2,785	2,554	137	8,260
	2017	732	212	424	1,142	2,495	2,361	145	7,511
	2018	877	235	416	1,252	2,722	2,854	97	8,453
	2019	1,018	251	368	1,113	2,581	2,663	20	8,014
	2020	659	221	382	1,136	2,691	2,814	154	8,057
Diseases of the Nervous system (G00-G98)	2016	272	141	150	349	351	244	35	1,542
	2017	366	200	203	388	431	269	32	1,889
	2018	323	212	207	468	565	360	22	2,157
	2019	274	162	168	317	467	271	3	1,662
	2020	222	132	161	293	423	281	8	1,520
Neoplasms (Cancer) (C00-D48)	2016	136	171	312	1,017	2,126	1,008	42	4,812
	2017	121	187	293	1,074	2,253	1,213	21	5,162
	2018	143	225	323	1,262	2,800	1,622	21	6,396
	2019	123	210	281	1,122	2,563	1,513	3	5,815
	2020	106	144	179	742	1,715	1,040	12	3,938

Inference:

- Highest NCD deaths were reported due to diseases of the circulatory system (13,955 in 2020) followed by respiratory diseases (8,057 in 2020) and cancers (3,938 in 2020).
- Maximum deaths are concentrated in the age groups of 45 to 64.
- Although the policy aims to tackle major NCDs it does not include chronic respiratory diseases which are a major concern in Delhi due to high air pollution.
- There is either limited or no data available on other NCD programmes in Delhi.

1.2.2 National Tobacco Control Programme

Year:

2007

Background:

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. Government of India launched the National Tobacco Control Programme (NTCP) during the 11th Five-Year-Plan, with the aim to (i) create awareness about the harmful effects of tobacco consumption, (ii) reduce the production and supply of tobacco products, (iii) ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA) (iv) help people quit tobacco use, and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by World Health Organisation (WHO) Framework Convention of Tobacco Control . [45]

In Delhi, Tobacco Control Programme is being executed through State Tobacco Control Cell (STCC), Directorate of Health Services of the State Government. Two acts namely, Cigarettes and Other Tobacco Products Act (COTPA) 2003 and Delhi Prohibition of Smoking and Non-Smokers Health Protection Act 1996 are applicable in Delhi. Delhi is among the pioneer states in India which has separate tobacco control Legislation even before enactment of Cigarettes and Other Tobacco Products Act (COTPA) 2003. Apart from that STCC Delhi is also implementing Tobacco Free Delhi Project through awareness, campaigns and various other activities.

Objectives:

1. To bring about greater awareness about the harmful effects of tobacco use and about the tobacco control laws.
2. To facilitate effective implementation of the tobacco control laws

Target:

To reduce the prevalence of tobacco use by 5% by the end of the 12th FYP (2012-17).

Beneficiaries:

Users of tobacco (smoking, chewing, khaini, etc)

[45] https://main.mohfw.gov.in/major-programmes/other-national-health-programmes/national-tobacco-control-programme-ntcp

Implementation Status in Delhi:

Third Global Adult Tobacco Survey (GATS3) is yet to be conducted.

Table 29: Percentage of tobacco use, exposure and cessation in Delhi between 2009-10 and 2016-17 as per Global Adult Tobacco Survey (GATS)[46]

Tobacco Use, Exposure and Cessation	GATS1 2009-10	GATS2 2016-17
Tobacco Users		
Current tobacco smokers	17.4%	11.3%
Daily tobacco smokers	16.4%	7.8%
Current cigarette smokers	9.9%	4.9%
Current bidi smokers	8.7%	8.2%
Current smokeless tobacco users	10.5%	8.8%
Daily smokeless tobacco users	10%	6.5%
Current 'betel quid with tobacco' users	1.4%	2.6%
Current khaini users	3.1%	4.9%
Current gutka users	8.2%	3%
Current 'oral tobacco application' users	0.3%	1.6%
Current 'pan masala' with tobacco users	NA	1.3%
Current dual tobacco users (Smoke and Smokeless)	3.6%	2.3%
Cessation		
Smokers who made a quit attempt in past 12 months	12.4%	45.7%
Current smokers who planned to or were thinking about quitting	33.2%	79.5%
Smokers advised to quit by a health care provider in past 12 months	43.3%	25.6%
Smokeless tobacco users who made a quit attempt in past 12 months	8.3%	48%
Current smokeless tobacco users who planned to or were thinking about quitting	24.5%	74.5%
Smokeless tobacco users advised to quit by a health care provider in past 12 months	23.6%	12.3%
Passive Smoking		
Adults exposed to tobacco smoke at home	61.7%	38.4%
Adults exposed to tobacco smoke at the workplace	24.4%	20.4%
Adults exposed to tobacco smoke at any public place	32.4%	30.3%

Inference:

- The percentage of tobacco users has fallen in the second GATS survey as compared to the first, except for oral application, khaini and paan with tobacco users which has increased from 2009-10 to 2016-17.
- Percentage of passive smokers has fallen although it is high at 38% exposed at home, 20% at workplace and 30% in public places in 2016-17.
- Tobacco users' attempts to quit has increased in the second GATS survey as compared to the first, although the percent of users advised by health care providers has fallen drastically.

[46] https://ntcp.nhp.gov.in/assets/document/surveys-reports-publications/Global-Adult-Tobacco-Survey-Second-Round-India-2016-2017.pdf and https://ntcp.nhp.gov.in/assets/document/surveys-reports-publications/Global-Adult-Tobacco-Survey-India-2009-2010-Report.pdf

1.2.3 National Programme for Prevention and Management of Burn Injuries

Year:

2014

Background:

Keeping in view the rising number of deaths due to burn injuries, a project was initiated during the 11th Five Year Plan by the Directorate General of Health Services, State government for development of burn units in identified Medical Colleges and District Hospitals. The project is now being continued as a full-fledged National Programme in the name of National Programme for Prevention and Management of Burn Injuries (NPPMBI).[47]

Objectives:

1. To reduce incidence, mortality, morbidity and disability due to burn Injuries.
2. To improve awareness among the general masses and vulnerable groups especially women, children, industrial and hazardous occupational workers.
3. To establish an adequate network of infrastructural facilities along with trained personnel for burn management and rehabilitation.
4. To carry out research for assessing behavioral, social and other determinants of burn Injuries in our country for effective need based program planning for burn injuries, monitoring and subsequent evaluation.
5. To organise burn injury training programmes for doctors, nurses and paramedical staff associated in management of burn injuries from the identified district hospitals and medical colleges[48].

Target:

1. Dedicated Burns Care Services in 70 medical colleges and 25 district hospitals.
2. Availability of skilled manpower at the medical college and district hospitals.
3. Increased awareness regarding prevention of burns injuries, safety measures and availability of services through IEC

Beneficiaries:

Victims of burn injuries.

[47] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1050&lid=610

[48] https://dghs.gov.in/content/1357_3_NationalProgrammePreventionManagement.aspx

Implementation Status in Delhi:

Table 30: Number of burn cases in Delhi from 2018-19 to 2020-21

Number of Cases	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Burns	3,381	4,526	34%	2,544	-44%

Table 31: Age wise deaths due to burns in Delhi for the years 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Burns and Corrosions (T20-T32)	**2016**	92	60	325	479	135	53	36	1,180
	2017	77	51	232	346	131	56	22	915
	2018	69	37	197	354	125	44	17	843
	2019	84	37	187	343	106	55	0	812
	2020	45	26	88	168	80	42	0	449

Inference:

- The number of burn cases has decreased from 3,381 in 2018-19 to 2,544 in 2020-21.
- Deaths reported due to burns also decreased from 812 in 2019 to 449 in 2020.

1.2.4 National Programme for Control of Blindness

Year:
1976

Background:
In accordance with the global initiative to reduce the incidence of blindness by 2020, The Government of India started the National Programme for Control of Blindness in order to strengthen the systems to reduce preventable blindness, promote awareness, and increase institutional capacity[49]. The implementation of the programme was decentralised in 1994-95 with formation of District Blindness Society in each district of the country.

Objectives:
1. To reduce the backlog of avoidable blindness through identification and treatment of curable blindness at primary, secondary and tertiary levels, based on assessment of the overall burden of visual impairment in the country;
2. Develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment; through provision of comprehensive universal eye-care services and quality service delivery;
3. Strengthening and up-gradation of Regional Institutes of Ophthalmology (RIOs) to become centres of excellence in various subspecialties of ophthalmology and also other partners like Medical College, District Hospitals, Sub-district Hospitals, Vision Centres, NGO Eye Hospitals;
4. Strengthening the existing infrastructure facilities and developing additional human resources for providing high quality comprehensive Eye Care in all Districts of the country;
5. To enhance community awareness on eye care and lay stress on preventive measures; Increase and expand research for prevention of blindness and visual impairment;
6. To secure participation of Voluntary Organisations /Private Practitioners in delivering eye Care.

Target:
1. To reduce the prevalence of blindness from 1.49% (in 1986-89) to 0.3%. As per Survey in 2001-02, prevalence of blindness is estimated to be 1.1%.
2. To establish an infrastructure and efficiency levels in the programme to be able to cater new cases of blindness each year to prevent future backlog

Beneficiaries:
Individuals with moderate or severe visual impairment, visual acuity of less than 3/60 (Snellen) or its equivalent, corneal blindness, etc.

Implementation Status in Delhi:
No data was available regarding cases of blindness, number of ophthalmologists, or facilities for the same.

[49] https://dghs.gov.in/content/1354_3_NationalProgrammeforControlofBlindnessVisual.aspx#:~:text=Introduction-,National%20Programme%20for%20Control%20of%20Blindness%20and%20Visual%20Impairment%20(NPCB%26VI,blindness%20to%200.3%25%20by%202020.

1.2.5 National Programme for Prevention and Control of Deafness

Year:

2007

Background:

The National Programme for Prevention and Control of Deafness (NPPCD) was initiated in 2007 on pilot mode in 25 districts of 11 State/UTs and expanded to 192 districts in 20 States/UTs. At the state level there is a state cell, to strengthen the monitoring of the programme. There are 260 Delhi government dispensaries and 46 government hospitals supporting the programme.[50]

Objectives:

1. To prevent the avoidable hearing loss on account of disease or injury.
2. Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness. To medically rehabilitate persons of all age groups, suffering with deafness.
3. To strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, for persons with deafness.
4. To develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

Target:

1. To prevent and control major causes of hearing impairment and deafness, so as to reduce the total disease burden by 25% of the existing burden by the end of 12th FYP (2012-17).
2. Decrease in the severity/ extent of ear morbidity or hearing impairment.
3. Improve service network/referral system for the persons with ear morbidity/hearing impairment.

Beneficiaries:

Individuals suffering from deafness, auditory diseases or injuries

Implementation Status in Delhi:

Data has not been published since 2018-19 in Directorate General of Health Services (DGHS) Annual reports and is available till 2017-18.

Table 32: Cases, surgeries and interventions for deafness from 2016-17 to 2017-18

Deafness	2016-17	2017-18	% change from 2016-17 to 2017-18
Total cases	13,517	10,664	-21%
Total surgeries	1,149	831	-28%
Total referrals for treatment	4,398	3,436	-22%

Inference:

Total cases of deafness fell from 13,517 in 2016-17 to 10,664 in 2017-18, number of cases requiring surgery also fell from 8.5% in 2016-17 to 7.8% in 2017-18.

[50] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1051&lid=606

1.2.6 National Programme for Healthcare of Elderly

Year:

2010

Background:

The National Programme for Health Care of the Elderly (NPHCE) is an articulation of the international and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP) adopted by the Government of India in 1999 and Section 20 of The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 dealing with provisions for medical care of senior citizens. [51]

Objectives:

1. To provide preventive, curative and rehabilitative services to the elderly persons at various levels of the health care delivery system of the country.
2. To provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an ageing population.
3. To strengthen referral system, to develop specialised human resources and to promote research in the field of diseases related to old age.
4. To build capacity of the medical and paramedical professionals as well as the care-takers within the family for providing health care to the elderly.
5. To promote the concept of active and healthy ageing.

Target:

No specific target mentioned.

Beneficiaries:

Adults above 60 years of age

Implementation Status in Delhi:

According to the Delhi Annual Report in 2018-19, general health care is being provided to all senior citizens on a preferential basis in most Delhi government hospitals and dispensaries. Sunday Clinics for Senior Citizens are running in 17 hospitals under Delhi government hospitals and daily Geriatric Clinics for senior citizens is running in 19 hospitals. Provision of separate queue for senior citizens at OPD, pharmacy, diagnostic facilities etc. has been established. The Senior Citizen Help Desk in most Delhi government hospitals has been set up at OPD. Screenings, training of staff, awareness generation etc. have also been organised by the Delhi government. In 2019-20[52] 11,35,216 elderly patients were reported in Delhi OPDs.

[51] https://www.nhp.gov.in/national-program-of-health-care-for-the-elderly-n_pg

[52] AR 2019-20 (delhi.gov.in)

1.2.7 National Programme for Palliative Care

Year:

2012

Background:

Palliative care is also known as supportive care which is required in the terminal cases of Cancer, AIDS etc. and can be provided relatively simply and inexpensively. Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources. It can be provided in tertiary care facilities, in community health centres and even in patients' homes. It improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support.[53]

The activities under this program would be carried out through the National Program for Prevention and Control of Cancer, CVD, Diabetes and Stroke. The programme also proposes provision of funds for establishing palliative care cells and palliative care services at the district hospitals.

Objectives:

1. Improve the capacity to provide palliative care service delivery within government health programs such as the National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Health Mission.
2. Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).
3. Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting the health care system.
4. Develop national standards for palliative care services and continuously evolve the design and implementation of the national program to ensure progress towards the vision of the program.

Target:

Availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of health care at all levels, in alignment with the community requirements.

Beneficiaries:

Beneficiaries of programmes like NPCDCS, NPHE, NACP, and NHM.

Implementation Status in Delhi:

No data of specific implementation was available in the public domain.

[53] https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1047&lid=609

1.2.8 Silicosis Control Programme

Year:

2010

Background:

Silicosis is caused by deposit of fine levels of dust due to silicon dioxide or crystallised silica in the lungs, leading to inflammation, breathing difficulties, and also autoimmune disorders, heart diseases, lung cancers caused due to it.[54] The Programme was started and implemented by the Delhi state government.

Objectives:

1. Reduction of new cases of silicosis in Delhi.
2. Capacity building of health care personnel.
3. Strengthening of diagnostic facilities in health care institutions.
4. Awareness generation in the community in silicosis prone areas.
5. Clinical care and rehabilitation of silicosis affected people

Beneficiaries:

Universal, with special focus on workers in high risk professions like construction, mining and quarrying, stone crushing and other industries

Target:

No specific target mentioned.

Implementing Status in Delhi:

According to the Delhi state government website awareness activities, surveys and clinical examinations are being conducted by the state government especially in vulnerable areas such as Lal Kuan, an active mining and quarrying area in Delhi.

[54]http://health.delhigovt.nic.in/wps/wcm/connect/doit_health/Health/Home/Directorate+General+of+Health+Services/National+Programmes

1.2.9 National Programme for Prevention and Control of Fluorosis

Year:

2008

Background:

Fluorosis is a disease caused by excess intake of fluoride through drinking water/food products/emission over a long period. Delhi implements the Programme for the prevention and control of fluorosis.

Objectives

1. To collect and assess data of fluorosis cases and reporting.
2. Monitoring areas where there is a suspicion of fluorosis such as surveillance in the community.
3. Comprehensive management of fluorosis in the selected areas through early detection, health detection and creation of awareness and medical management.

Target:

Not specified

Beneficiaries:

Universal

Implementation Status in Delhi:

Data is not being published since 2019-20 in Directorate General of Health Services (DGHS) Annual reports and is available till 2018-19.

1.2.10 Thalassemia Control Programme

Year:

1990

Background:

Thalassemia major is a genetic disorder that requires repeated and regular blood transfusion and iron chelation therapy for survival. Under the Thalassemia Control Programme, sessions are conducted for awareness, sensitisation and training of communities and medical/paramedical staff, with the aim to prevent thalassemia major birth. Emphasis is laid on awareness and screening procedure along with registration of thalassemia patients with the hospital/health facility. [55]

Objectives:

- Free testing facilities on all working days for public and referred persons from other health facilities.
- Free Safe Blood transfusion facilities to all thalassemia Patients through Leuco-Depleted Blood Transfusion sets on all days.
- Free regular supply of medicines for Iron Chelation to all patients.

Target:

Not specified.

Beneficiaries:

Thalassemia patients

Implementation status in Delhi:

Table 33: Age wise Deaths due to Thalassemia in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Thalassemia (D56)	2016	5	5	4	2	2	1	0	19
	2017	4	3	4	7	1	5	1	25
	2018	1	3	3	3	0	1	2	13
	2019	1	0	2	2	0	0	0	5
	2020	1	2	3	6	2	1	1	16

Inference:

Deaths due to Thalassemia increased by 220% from 5 in 2019 to 16 in 2020, of which maximum deaths (9) were in the age group of 15 to 44.

[55] http://web.delhi.gov.in/DoIT/DoIT_Planning/ph189.pdf

1.3. Mental Health Schemes

Mental health includes our emotional, psychological, and social well-being and is not just the absence of mental illnesses.

The table depicts the making and implementation of major programmes/schemes in Delhi

Government	Central	State	City
Central			
State	National Mental Health Programme		
City			

PROGRAMME MAKING PROGRAMME IMPLEMENTATION

SUSTAINABLE DEVELOPMENT GOALS

Target: *Promote mental health and well-being.*[1]

Status: *1,36,338 number of mental health cases in 2020-21*[2]

KEY FINDINGS[3]

- *The number of people accessing mental healthcare was 2,12,776 in 2019-20, which decreased by 36% to 1,36,338 in 2020-21.*
- *However, 46 deaths due to mental and behavioural disorders were reported in 2019 which decreased to 40 in 2020.*

[1] SDG Index, Niti Aayog [2] HMIS Data [3] Data from HMIS and Annual Reports of Registration of Births and Deaths in Delhi

1.3.1 National Mental Health Programme

Year:

1982

Background:

The National Mental Health Programme (NMHP)[56] was launched by the Central government keeping in mind the prevalence of mental illnesses in the community, and the absolute inadequacy of mental healthcare infrastructure in the country to cope with the increasing disease burden. It was recognised that persons with mental illness constitute a vulnerable section of society and are subject to discrimination; families bear disproportionate financial, physical, mental, emotional and social burden of providing treatment and care for their relatives with mental illness; persons with mental illness should be treated like other persons with health problems; and the environment around them should be made conducive to facilitate recovery rehabilitation and full participation in society.

The District Mental Health Programme was added to the Programme in 1996. The Programme was re-strategised in 2003 to include two schemes- the modernisation of state mental hospitals and up-gradation of psychiatric wings of medical colleges/general hospitals. The Manpower Development Scheme (Scheme-A and B) became part of the Program in 2009.

In 2017, the Mental Health Care Act was passed to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto. This Act superseded the previously existing Mental Health Act, 1987[57]. Delhi has an established State Mental Health Authority under the 2017 Act[58].

Objectives:

1. To make mental health services available, along with the other health services in the remote and rural population of the country.
2. To delegate various tasks and responsibilities to the suitable personnel in the general health services, in an appropriate way in case of mental health services.
3. To incorporate mental health services with other general health services and to make mental health service, an integral part of general health services.
4. To associate mental health knowledge and services, in social development schemes in general.
5. To ensure people's participation in delivering and developing mental health care services in the society.

[56] https://www.nhp.gov.in/national-mental-health-programme_pg
[57] https://nhm.gov.in/images/pdf/National_Health_Mental_Policy.pdf
https://nhm.gov.in/WriteReadDatas/pdf/programmes/NMHP/District_Level_Activities.pdf
[58] http://smhadelhi.org/pages.php?id=MTM=%20$&

Target:

1. Prevention and treatment of mental and neurological disorders and their associated disabilities.
2. Use of mental health technology to improve general health services.
3. Application of mental health principles in total national development to improve quality of life.

Beneficiaries:

Individuals afflicted by neuro-psychiatric disorders. According to Mental Healthcare Act 2017, "Mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence.

Implementation Status in Delhi:

Table 34: Reported Cases of Mental Issues in Delhi from 2018-19 to 2020-21

Cases	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Mental Health	2,36,201	2,12,776	-10%	1,36,338	-36%

Table 35: Age wise deaths due to mental health issues in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Mental and behavioural disorders (F01-F99)	**2016**	9	3	6	21	20	12	6	77
	2017	3	0	4	13	15	23	4	62
	2018	3	2	3	12	13	4	1	38
	2019	5	3	5	10	10	13	0	46
	2020	1	1	6	15	8	6	3	40
Suicide (X60-X84)	**2016**	0	0	3	2	1	0	0	6
	2017	0	0	1	5	3	0	0	9
	2018	0	1	3	5	3	1	0	13
	2019	0	0	2	25	4	2	0	33
	2020	0	1	18	32	5	0	0	56

Inference:

- The number of people accessing mental healthcare was 2,12,776 in 2019-20, which decreased by 36% to 1,36,338 in 2020-21.
- 46 deaths due to mental and behavioural disorders were reported in 2019 which decreased to 40 in 2020.
- However, deaths due to suicide are increasing continuously from 33 in 2019 to 56 in 2020.

1.4. Reproductive, Maternal, Newborn Child and Adolescent Health (RMNCHA+) Schemes

RMNCHA+ schemes comprise the following policy components, Maternal and Child survival, and Child and Adolescent Health, Reproductive and Sexual Health.

The table depicts the making and implementation of major programmes/schemes in Delhi

Government	Central	State	City
Central	Pradhan Mantri Surakshit Matritva Abhiyan		
State	• Pulse Polio Programme • Universal Immunisation Programme • Rashtriya Kishor Swasthya Karyakram • Janani Suraksha Yojana • Janani Shishu Suraksha Karyakram	• School Health Scheme • Family Welfare Services	
City			

PROGRAMME MAKING PROGRAMME IMPLEMENTATION

SUSTAINABLE DEVELOPMENT GOALS

Target: ***Reduce Maternal Mortality Rate to 70 by 2030 and Under 5 Mortality Rate to 25 by 2030.***[1]

Status: ***Maternal Mortality Rate was 252 and under-5 mortality was 20 (upto 1 year) in 2020.***[2]

KEY FINDINGS[3]

Child Immunisation

- *For full immunisation for Polio, at least 3 OPV and 2 IPV doses are required. Average number of children with OPV and IPV dosage decreased by 21% from 2,92,098 in 2019-20 to 2,30,454 in 2020-21.*
- *Of the vaccines covered under UIP for children (0 to 14 years), a high number of deaths were still reported due to tuberculosis (215 in 2020) and diarrhoea (56 in 2020).*

Infants

- *Most number of deaths of infants was caused due to Abdomen and Pelvic Pain (823 in 2020).*

[1] SDG India Index, Niti Aayog [2] HMIS Data [3] HMIS and Annual Reports of Registration of Births and Deaths in Delhi

Mother and Child

- *The number of Pregnant Women (PW) who registered for antenatal care decreased by 41% from 2018-19 to 2020-21.*
- *Further, the number of pregnant women who received 4 or more Antenatal Care (ANC) check-ups decreased by 31% from 2018-19 to 2020-21.*
- *Under Janani Shishu Suraksha Karyakram (JSSK), Infants given free medicines fell by 54% from 2018-19 to 2020-21 while it decreased by 37% for pregnant women. This may be because of the pandemic and the restriction associated with the lockdown.*

School Students

- *Number of girls and boys who registered for Adolescent Friendly Health Clinics (AFHC) has decreased from 2018-19 to 2020-21 - 53% for girls and by 62% for boys.*

Reproductive Health

- *Overall, the interventions listed under family planning heave decreased drastically for both men and women from 2019-20 to 2020-21.*
- *Female contraceptive interventions, made up an average of 99.66% of all family planning interventions from 2018-19 to 2020-21, whereas male contraceptive interventions only made up 0.34% of the total, showing a clear gender gap in family planning methods promoted.*

1.4.1 Pulse Polio Programme

Year:
1995

Background:
With the global initiative of eradication of polio following the World Health Assembly resolution in 1988, the Pulse Polio Immunisation Programme was launched in India in 1995. Children in the age group of 0-5 years were administered polio drops during the national and sub-national immunisation rounds (in high risk areas) every year. About 172 million children are immunized during each National Immunisation Day (NID)[59]. The WHO removed India from the list of countries with active endemic wild poliovirus transmission after India reported its last case in 2011[60].

Objectives:
The Pulse Polio Initiative was started with an objective of achieving hundred per cent coverage under Oral Polio Vaccine. It aimed to immunize children through improved social mobilisation, plan mop-up operations in areas where poliovirus has almost disappeared and maintain a high level of morale among the public.

Target:
The target of this programme is to reach every eligible child through the dual booth immunisation strategy and house to house immunisation component.

Beneficiaries:
All children up to five years of age.

[59] https://www.nhp.gov.in/pulse-polio-programme_pg#:~:text=About%20172%20million%20children%20are,country%20(25th%20May%202012)
[60] https://main.mohfw.gov.in/sites/default/files/18604854648148966448 1.pdf

Implementation Status in Delhi:

Table 36: Immunisations under Pulse Polio Programme from 2018-19 to 2020-21

Polio Immunisations	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Number of children administered Oral Polio Vaccine 0 (Birth Dose)	2,51,460	2,56,221	2%	1,82,639	-29%
Number of children administered Oral Polio Vaccine OPV1	3,17,830	3,07,453	-3%	2,47,137	-20%
Number of children administered Oral Polio Vaccine OPV2	2,97,365	2,98,484	0.4%	2,37,825	-20%
Number of children administered Oral Polio Vaccine OPV3	2,90,004	2,95,593	2%	2,29,104	-22%
Number of children administered OPV Booster	3,03,520	2,98,231	-2%	2,43,042	-19%
Number of children administered Inactivated Polio Vaccine 1 (IPV 1)	3,00,112	2,97,857	-1%	2,45,118	-18%
Number of children administered Inactivated Polio Vaccine 2 (IPV 2)	2,79,734	2,90,844	4%	2,28,315	-21%

Table 37: Age wise deaths due to Polio in Delhi from 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Acute Poliomyelitis (A80)	2016	0	0	0	0	0	0	0	0
	2017	0	0	0	0	0	0	0	0
	2018	0	0	0	0	0	0	0	0
	2019	0	0	0	0	0	0	0	0
	2020	0	0	0	0	0	0	0	0

Inference:

- For full immunisation for Polio, at least 3 OPV and 2 IPV doses are required. Average number of children with OPV and IPV dosage decreased by 21% from 2,92,098 in 2019-20 to 2,30,454 in 2020-21.
- However, it is a victory to witness as not even a single Polio death has been registered in Delhi since 2016 to 2020.

1.4.2 Universal Immunisation Programme

Year:

1985

Background:

The Immunisation Programme in India was introduced in 1978 as the 'Expanded Programme of Immunisation' (EPI) by the central government. In 1985, the programme was modified as the 'Universal Immunisation Programme' (UIP) to be implemented in a phased manner to cover all districts in the country by 1989-90. Through UIP, vaccination is provided free of cost against preventable diseases including diphtheria, pertussis, tetanus, polio, measles, tuberculosis, Hepatitis B, meningitis, pneumonia, Japanese encephalitis (JE) in JE endemic districts with introduction of newer vaccines such as rotavirus vaccine, adult JE vaccine, pneumococcal conjugate vaccine (PCV) and measles-rubella (MR) vaccines. [61]

Objectives:

1. Improve program service delivery for equitable and efficient immunisation services by all districts
2. Increase demand and reduce barriers for people to access immunisation services through improved advocacy at all levels and social mobilisation
3. Strengthen and maintain robust surveillance system for vaccine preventable diseases (VPDs) and adverse events following immunisation (AEFI)
4. Introduce and expand the use of new and underutilised vaccines and technology in UIP
5. Strengthen health system for immunisation program
6. Contribute to global polio eradication, measles, maternal and neonatal tetanus elimination.

Target:

Rapid Immunisation targets to vaccinate 27 million new born each year with all primary doses and 100 million children of 1-5 years with booster doses of UIP vaccines. In addition, 30 million pregnant mothers are targeted for TT vaccination each year.

Beneficiaries:

All eligible children and pregnant women, especially belonging to the lower socio-economic strata, those living in urban slums, rural areas, tribal and other hard to reach areas.

[61] https://www.nhp.gov.in/universal-immunisation-programme_pg

Implementation Status in Delhi:

Table 38: Deaths from Diseases of Vaccines under UIP for Age 0 to 14 from 2016 to 2020

Causes Of Death	Years	Upto 1 year	1 -4 years	5 - 14 years	Total
Acute Poliomyelites (A80)	2016	0	0	0	0
	2017	0	0	0	0
	2018	0	0	0	0
	2019	0	0	0	0
	2020	0	0	0	0
Acute Hepatitis B (B16)	2016	0	0	1	1
	2017	0	1	1	2
	2018	1	1	2	4
	2019	0	0	0	0
	2020	1	0	0	1
Tuberculosis (A15-A19)	2016	59	34	125	218
	2017	15	33	133	181
	2018	23	53	163	239
	2019	50	56	157	263
	2020	27	26	162	215
Diphtheria (A36)	2016	1	24	108	133
	2017	1	26	79	106
	2018	1	37	138	176
	2019	0	14	25	39
	2020	1	5	25	31
Whooping Cough (A37) Pertussis	2016	0	0	0	0
	2017	0	0	0	0
	2018	0	0	1	1
	2019	0	0	0	0
	2020	0	0	0	0
Tetanus (A33, A34, A35)	2016	7	2	6	15
	2017	7	0	8	15
	2018	6	0	4	10
	2019	6	2	2	10
	2020	3	1	1	5
Influenza (J10- J11)	2016	14	2	3	19
	2017	1	3	6	10
	2018	24	3	2	29
	2019	4	2	5	11
	2020	23	1	0	24
Measles (B05)	2016	1	6	2	9
	2017	2	0	0	2
	2018	1	3	2	6
	2019	2	0	0	2
	2020	0	0	0	0

Causes Of Death	Years	Upto 1 year	1 -4 years	5 - 14 years	Total
All Other Types Of Viral Diseases (A70-A74, A81, A87-A89,A95,B00-B02,B04,B06-B09 & B25-B34)*	2016	7	9	16	32
	2017	6	1	0	7
	2018	6	0	4	10
	2019	12	4	4	20
	2020	8	4	5	17
Diarrhoea and Gastroenteritis Of Presumed Infectious Origin (A09)	2016	51	12	5	68
	2017	29	14	5	48
	2018	44	19	5	68
	2019	66	29	7	102
	2020	36	14	6	56

Note: (*) - Includes Rubella and Mumps

Inference:

- Of the vaccines covered under UIP for children (0 to 14 years), a high number of deaths were still reported due to tuberculosis (215 in 2020) and Diarrhoea (56 in 2020).
- Deaths in children due to viral diseases that includes rubella and Mumps has decreased by 15% from 2019 to 2020.

1.4.3 Rashtriya Kishor Swasthya Karyakram

Year:

2014

Background:

In order to ensure holistic development of adolescent population, the central government launched Rashtriya Kishor Swasthya Karyakram (RKSK) for adolescents - male and female, rural and urban, married and unmarried, in and out-of-school with special focus on marginalised and underserved groups. The scope of the programme is wide and covers sexual and reproductive health (SRH), nutrition, injuries and violence (including gender based violence), non-communicable diseases, mental health and substance misuse. Key drivers of the program are community based interventions like outreach by counsellors; facility based counselling, social and behavior change communication and strengthening of Adolescent Friendly Health Clinics (AFHC) across levels of care. RKSK has been adopted in Delhi and aims to provide an amalgamation of Preventive, Promotive, Curative, Counseling and Referral services to adolescents. It includes a facility based component in the form of a programme called "DISHA"- the Delhi Initiative for Safeguarding Health of Adolescents. The outreach component under RKSK includes four activities namely Weekly Iron and Folic Acid Supplementation Program, Peer Education program, Adolescent Health Day, and Menstrual Hygiene Scheme[62].

Objectives:

1. Improve nutrition: Reduce the prevalence of malnutrition among adolescent girls and boys, reduce the prevalence of iron-deficiency anemia (IDA) among adolescent girls and boys.
2. Improve sexual and reproductive health: Improve knowledge, attitudes and behaviour, in relation to SRH; reduce teenage pregnancies, improve birth preparedness, complication readiness and provide early parenting support for adolescent parents.
3. Enhance mental health: Address mental health concerns of adolescents.
4. Prevent injuries and violence: Promote favourable attitudes for preventing injuries and violence (including Gender Based Violence) among adolescents.
5. Prevent substance misuse: Increase adolescents' awareness of the adverse effects and consequences of substance misuse.
6. Address NCDs: Promote behaviour change in adolescents to prevent NCDs such as hypertension, stroke, cardiovascular diseases and diabetes.

Target:

Increasing availability and access to information about adolescent health, increasing accessibility and utilisation of quality counselling and health services for adolescents and forging multi-sectoral partnerships to create safe and supportive environments for adolescents.

Beneficiaries:

Adolescents with a focus on marginalised groups

[62] http://health.delhigovt.nic.in/wps/wcm/connect/doit_health/Health/Home/Family+Welfare/Adolescent+Health

Implementation Status in Delhi:

Table 39: Implementation of RKSK from 2018-19 to 2020-21

Criteria	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Girls					
Number of girls registered in AFHC	1,18,421	1,10,523	-7%	55,904	-49%
Out of registered, girls who received clinical services	1,07,055	1,04,834	-2%	53,199	-49%
% of girls who received clinical services	90.4%	94.9%	4.5%	95.2%	0.3%
Out of registered, girls who received counselling	69,862	74,150	6%	42,778	-42%
% of girls who received counselling	59%	67.1%	8.1%	76.5%	9.4%
Boys					
Number of boys registered in AFHC	1,15,767	1,02,715	-11%	43,750	-57%
Out of registered, boys who received clinical services	1,08,773	99,425	-9%	41,430	-58%
% of boys who received clinical services	94%	96.8%	2.8%	94.7%	-2.1%
Out of registered, boys who received counselling	42,284	40,682	-4%	22,087	-46%
% of boys who received counselling	36.5%	39.6%	3.1%	50.5%	10.9%

Inference:

- Number of girls and boys who registered for Adolescent Friendly Health Clinics (AFHC) has decreased from 2018-19 to 2020-21 - 53% for girls and by 62% for boys.
- 95.2% of girls who registered in RKSK received clinical services, while 94.7% boys received clinical services in 2020-21.
- Counselling services are an important component under RKSK, the percentage of adolescents who received counselling out of the total who registered in AFHCs in the last three years is higher in girls (76.5%) than in boys (50.5%) in 2020-21.

1.4.4 School Health Scheme

Year:

1979

Background:

The School Health Scheme[63] is an initiative introduced at the school level to provide comprehensive health care to school children of Delhi state government and government aided schools. It involves key stakeholders such as: students, parents, teachers, schools, state department of education and public hospitals.

Objectives:

1. Promotion of Positive Health and Health Education.
2. Prevention including screening of school children for diseases, deficiencies and disabilities.
3. Early detection, diagnosis and treatment of common diseases, deficiencies and disabilities.
4. Referral and follow-up of children who require specialist attention at the nearest Delhi government dispensaries and hospitals.

Target:

To provide comprehensive health care to approx. 16 lakh school children of Delhi state government and government aided schools.[64]

Beneficiaries:

School children of Delhi state government and government aided schools.

Implementation Status in Delhi:

Table 40: Number of Referral Centres and OPD under School Health Scheme from 2017-18 to 2019-20[65]

Criteria	2017-18	2018-19	% change from 2017-18 to 2018-19	2019-20	% change from 2018-19 to 2019-20
School Health Clinics/Referral Centres	55	58	5%	60	3%
School Health Scheme Annual OPD Attendance	1,63,592	96,381	-41%	1,49,441	55%

Inference:

- The number of Referral centres under the scheme has increased marginally from 2018-19 to 2019-20.
- Number of students who received OPD service has increased by 55% from 96,381 in 2018-19 to 1,49,441 in 2019-20.

[63] http://web.delhi.gov.in/wps/wcm/connect/7ea357804c7e238981d0ad9843b21e62/REPORT_ANNUAL_13-14_25.1.16.pdf?MOD=AJPERES&lmod=1017877426&CACHEID=7ea357804c7e238981d0ad9843b21e62

[64] http://health.delhigovt.nic.in/wps/wcm/connect/doit_health/Health/Home/Directorate+General+of+Health+Services/School+Health+Scheme/

[65] AR 2019-20 (delhi.gov.in)

1.4.5 Janani Suraksha Yojana

Year:

2005

Background:

Janani Suraksha Yojana (JSY) is a "safe motherhood" intervention under the NHM. The objective of its implementation is to reduce maternal and neonatal mortality by promoting institutional deliveries among poor pregnant women[66]. It is a centrally sponsored scheme, which integrates the two components of cash assistance with delivery and post-delivery care. The scheme focuses on poor pregnant women in states that have less than 25% institutional delivery rates (named as Low Performing States or LPS). In addition to distribution of monetary assistance, the scheme aims at providing quality maternity services to pregnant women by preparing a micro-birth plan for efficient coordination of all childbirth related activities[67].

Objectives:

1. To collect all necessary documents from the beneficiary for eligibility under JSY.
2. To issue prescribed JSY Cards to beneficiaries by compiling all required information.
3. To provide for and /or aid the beneficiary in receiving at least four Antenatal Care (ANC) checkups to give health services including Injectable Tetanus (TT) and Iron Folic Acid (IFA) tablets.
4. To motivate the beneficiary towards an institutional delivery, either at a government health institution or at an accredited private health institution
5. To facilitate the opening of bank accounts for eligible JSY beneficiaries for the purpose of receiving the aforementioned JSY cash benefit.

Target:

To reduce the Maternal and Neonatal Mortality rate by promoting institutional deliveries among beneficiaries from BPL, SC and ST families in rural and urban areas.

Beneficiaries:

All SC/ST women, all pregnant women delivering in government facilities and accredited private facilities in Low Performing States, and BPL Pregnant women in High Performing States (HPS). Delhi is a HPS and hence only BPL women will be covered.

[66] https://nhm.gov.in/WriteReadData/l892s/97827133331523438951.pdf

[67] https://www.ilo.org/dyn/travail/docs/683/JananiSurakshaYojanaGuidelines/MinistryofHealthandFamilyWelfare.pdf

Implementation Status in Delhi:

Table 41: Infant and Maternal Mortality in Delhi from 2018-19 to 2020-21

Infant Mortality	2018-19	2019-20	2020-21	% change from 2018-19 to 2020-21
Live Births	2,82,190	2,83,719	2,05,448	-27%
Neonatal Deaths (upto 28 days)	3,609	3,276	3,189	-12%
Neonatal Mortality Rate (deaths per 1,000 live births)	12.8	11.5	15.5	21%
Infant Deaths (upto 1 year)	5,059	4,649	4,133	-18%
Infant Mortality Rate (deaths per 1,000 births)	17.9	16.4	20.1	12%
Maternal Deaths	572	484	518	-9%
Maternal Mortality Rate (deaths per 1,00,000 live births)	202.7	170.6	252.1	24%

Inference:

- Neonatal mortality has increased from 12.8 in 2018-19 to 15.5 in 2020-21. Infant mortality has increased from 17.9 per 1000 live births in 2018-19 to 20 deaths per 1000 live births in 2020-21.
- Maternal Mortality Rates have increased by 24% from 203 in 2018-19 to 252 in 2020-21. Delhi is still far away from achieving the target of 70 by 2030 according to Sustainable Development Goals.

Table 42: Top Causes of Infant Deaths in Delhi in 2020

Major Causes of death	Total Deaths upto 1 year of Age
Abdominal and pelvic pain (R10)	823
Septicaemia (A40-A41)	781
Slow fetal growth, fetal malnutrition and immaturity (P05- P07)	771
Hypoxia, birth asphyxia and other respiratory conditions (P20-P28)	693
Shock, not elsewhere classified (R57)	484
All other conditions originating in the perinatal period (P00-P04,P08,P29-P54,P56-P57,P60-P96)	416
Pneumonia (J12-J18)	297
All other symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R09, R11- R17,R19-R39,R41-R49,R51-R53,R58-R99)	179
All other congenital malformations, deformations, and chromosomal abnormalities, not elsewhere classified (Q00- Q04, Q06-Q18, Q30-Q34 & Q38-Q99)	174
Congenital malformations of the circulatory sytem (Q20- Q28)	148

Inference:

- Most number of deaths of infants was caused due to Abdominal and pelvic pain (823).
- 693 deaths due to Hypoxia and other respiratory diseases and 297 Pneumonia deaths have occurred in infants in 2020.

1.4.6 Janani Shishu Suraksha Karyakram

Year:

2011

Background:

Reducing maternal and infant mortality is a key role of Reproductive and Child Health (RCH) under the NHM. To enable this, the Government of India launched the Janani Shishu Suraksha Karyakram (JSSK) for the benefit of pregnant women who access Government health facilities for delivery. The scheme entitles all pregnant women delivering in public health institutions to a no-expense delivery (for both cesarean and natural deliveries), free drugs and consumables, diagnostics, blood tests, travel to and from the healthcare facility, and a balanced diet for the duration of their stay. Similarly, it entitles all sick newborns accessing public health institutions for healthcare till 30 days after birth.[68]

Objectives:

The objective of the JSSK Programme is that each and every pregnant woman and sick infant upto age of 1 year gets timely access to the health care system for the required antenatal, intra-natal, postnatal care, immunisation, and diagnostics free of cost.

Target:

To cover 1 crore pregnant women and sick newborns accessing the public health system every year.

Beneficiaries:

All pregnant women delivering in government health institutions in both rural and urban areas.

[68] https://www.nhm.gov.in/images/pdf/nrhm-updates/presentations/11th_sep/jssk_dc_mh.pdf

Implementation Status in Delhi:

Table 43: Antenatal Care and Deliveries in Delhi from 2018-19 to 2020-21

Indicators		2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Antenatal Care						
Total number of pregnant women (PW) registered for ANC		9,31,041	7,21,322	-23%	5,47,813	-24%
Out of the total ANC registered, number registered within 1st trimester (within 12 weeks)		3,35,500	3,27,469	-2%	2,40,174	-27%
Number of PW given TT1		2,97,500	2,32,814	-22%	2,08,497	-10%
Number of PW given TT2		2,35,993	1,85,663	-21%	1,58,186	-15%
Number of PW given TT Booster		41,742	37,120	-11%	34,128	-8%
Number of PW given 180 Iron Folic Acid (IFA) tablets		4,77,566	7,01,918	47%	4,29,123	-39%
Number of PW given 360 Calcium tablets		4,59,551	6,59,419	43%	4,44,836	-33%
Number of PW given one Albendazole tablet after 1st trimester		1,48,748	1,61,621	9%	1,19,821	-26%
Number of PW received 4 or more ANC check ups		4,07,668	4,07,582	-0.02%	2,83,160	-31%
Deliveries						
Number of Institutional Deliveries conducted (Including C-Sections)	Public	2,20,550	2,22,723	1%	1,61,520	-27%
	Private	50,935	52,438	3%	34,036	-35%
Number of Home Deliveries attended by Skill Birth Attendant (SBA) Doctor/Nurse /ANM)	Public	204	74	-64%	220	197%
	Private	0	0	-	0	-
Number of Home Deliveries attended by Non SBA (Trained Birth Attendant (TBA) /Relatives/etc.)	Public	12,028	11,046	-8%	10,970	-1%
	Private	0	0	-	0	-
Total	Public	2,32,782	2,33,843	0.5%	1,72,710	-26%
	Private	50,935	52,438	3%	34,036	-35%

Inference:

- The number of institutional deliveries to total deliveries has remained almost constant from 96.1% in 2019-20 to 94.6% in 2020-21, while the absolute number of institutional deliveries conducted in government facilities decreased from 2018-19 to 2020-21.
- With regards to antenatal care, the number of Pregnant Women (PW) who registered for antenatal care decreased by 41% from 2018-19 to 2020-21.

- While the number of pregnant women who received 4 or more ANC checkups decreased by 31% from 2018-19 to 2020-21, this was an average of 51% of total women who registered for ANC from 2018-19 to 2020-21.
- Number of Pregnant women out of total, given IFA tablets increased from 51% in 2018-19 to 78% in 2020-21.

Table 44: Services provided to Infants under JSSK in Delhi from 2018-19 to 2020-21

Services for Infants	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Free Medicines	33,892	26,874	-21%	15,459	-42%
Free Diagnostics	23,807	17,725	-26%	10,181	-43%
Free Home to facility transport	72	88	22%	205	133%
Inter facility transfers when needed	616	703	14%	464	-34%
Free Drop Back home	275	625	127%	482	-23%

Table 45: Services provided to Pregnant women under JSSK in Delhi from 2018-19 to 2020-21

Services for Pregnant women (PW)	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Free Medicines	2,37,705	2,20,358	-7%	1,49,429	-32%
Free Diet	1,54,173	1,40,087	-9%	1,01,666	-27%
Free Diagnostics	1,91,924	1,65,075	-14%	1,00,322	-39%
Free Home to facility transport	1,273	990	-22%	2,419	144%
Inter facility transfers when needed	6,481	6,985	8%	2,500	-64%
Free Drop Back home	2,806	1,472	-48%	731	-50%

Inference:

Infants given free medicines fell by 54% from 2018-19 to 2020-21 while it decreased by 37% for pregnant women. This may be because of the pandemic and the restriction associated with the lockdown.

1.4.7 Pradhan Mantri Surakshit Matritva Abhiyan

Year:

2016

Background:

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) was launched by the central government with an aim to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women every month. PMSMA guarantees a minimum package of antenatal care services to women in their 2nd and 3rd trimesters of pregnancy at designated government health facilities.[69]

Objectives:

1. Ensure at least one antenatal checkup for all pregnant women in their second or third trimester by an obstetrics and gynecology specialist/physician.
2. Improve the quality of care during antenatal visits. This includes ensuring provision of all applicable diagnostic services, screening for applicable clinical conditions, appropriate management of any existing clinical condition such as anemia, pregnancy induced hypertension, gestational diabetes etc., appropriate counselling services and proper documentation of services rendered, additional service opportunity to pregnant women who have missed antenatal visits.
3. Identification and line-listing of high risk pregnancies based on obstetric/ medical history and existing clinical conditions.
4. Appropriate birth planning and complication readiness for each pregnant woman especially those identified with a risk factor or a co-morbid condition.
5. Special emphasis on early diagnosis, adequate and appropriate management of women with malnutrition.

Target:

To ensure quality antenatal care to over 3 crore pregnant women in the country. A minimum package of antenatal care services would be provided to the beneficiaries on the 9th day of every month at the Pradhan Mantri Surakshit Matritva Clinics to ensure that every pregnant woman receives at least one checkup in the 2nd or 3rd trimester of pregnancy by a doctor.

Beneficiaries:

All pregnant women who are in the 2nd or 3rd trimesters of pregnancy.

Implementation Status in Delhi:

Refer to Janani Shishu Suraksha Karyakram for status of antenatal care in Delhi.

[69] https://pmsma.nhp.gov.in/about-scheme/

1.4.8 Family Welfare Services

Year:
1976

Background:
Family planning and welfare services for Delhi are managed as a part of the services offered by the Directorate of Family Welfare of the state government of Delhi. It coordinates with various agencies to provide contraceptives free of cost to beneficiaries. Hospitals and maternity homes also provide female and male sterilization services and post-partum contraceptive services.[70] Refer to Annexure 6 for details of the different contraceptive methods.

Objectives:
To facilitate provision of family planning services (contraceptives, female/male sterilization, counseling etc.)

Target:
No specific target mentioned.

Beneficiaries:
Universal

[70] http://web.delhi.gov.in/wps/wcm/connect/doit_health/Health/Home/Family+Welfare/Family+Welfare

Implementation status in Delhi:

Table 46: Family Planning methods (Female) adopted in Delhi from 2018-19 to 2020-21

Family Planning Female	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Number of Interval IUCD Insertions (excluding PPIUCD and PAIUCD)[71]	30,584	32,242	5%	11,038	-66%
Number of Postpartum (within 48 hours of delivery) IUCD insertions	40,904	57,634	41%	52,409	-9%
Number of Post Abortion (within 12 days of spontaneous or surgical abortion) IUCD insertions	3,915	4,696	20%	2,029	-57%
Number of IUCD Removals	12,761	12,441	-3%	6,288	-49%
Number of complications following IUCD Insertion	1,511	2,454	62%	1,222	-50%
Injectable Contraceptive-Antara Program- First Dose	13,753	18,893	37%	9,691	-49%
Injectable Contraceptive-Antara Program- Second Dose	4,235	7,042	66%	3,371	-52%
Injectable Contraceptive-Antara Program- Third Dose	1,621	3,720	129%	1,977	-47%
Injectable Contraceptive-Antara Program- Fourth or more than fourth dose	1,100	4,537	312%	4,447	-2%
Number of Combined Oral Pill cycles distributed	173,691	1,62,564	-6%	1,34,652	-17%
Number of Emergency Contraceptive Pills (ECP) given	28,782	30,611	6%	25,551	-17%
Number of Centchroman (weekly) pill strips distributed	28,209	62,597	122%	75,488	21%
No. of Tubectomies Conducted	17,032	17,652	4%	7,811	-56%
Failures following female sterilization	36	31	-14%	27	-13%
Deaths following female sterilization	1	0	-100%	0	-

[71] IUCD - Intrauterine Contraceptive devices, PPIUCD - Postpartum intrauterine contraceptive devices, PAIUCD – Post Abortion intrauterine contraceptive devices.

Table 47: Family Planning methods (Male) adopted in Delhi from 2018-19 to 2020-21

Family planning: Male	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Number of Condom pieces distributed	5,625,277	5,387,988	-4%	42,06,299	-22%
Number of Non Scalpel Vasectomy (NSV) / Conventional Vasectomy conducted	499	740	48%	77	-90%
Failures following male sterilization	2	1	-50%	1	0%
Deaths following male sterilization	0	0	0%	0	-

Inference:

- Overall the interventions listed under family planning heave decreased drastically for both men and women from 2019-20 to 2020-21.
- IUCD insertions for women show a 13% decrease from 2018-19 to 2020-21.
- With regards to sterilisations, vasectomies conducted have decreased by 85%, although the number of tubectomies is still much higher (7,811 tubectomies in 2020-21 as compared to 77 vasectomies)

Table 48: Percentage of female contraceptive interventions to male contraceptive interventions from 2018-19 to 2020-21

Total Contraceptives by Gender	2018-19	2019-20	2020-21
Total contraceptives	1,13,643	1,47,156	92,850
Female contraceptives	1,13,144	1,46,416	92,773
% of Female contraceptives to total	99.56%	99.50%	99.92%
Male contraceptives	499	740	77
% of Male contraceptives to total	0.44%	0.50%	0.08%

Note: The numbers do not include contraceptives distributed like condoms, oral pills and emergency pills since their usage cannot be determined.

Inference:

Female contraceptive interventions, made up an average of 99.66% of all family planning interventions from 2018-19 to 2020-21, whereas male contraceptive interventions only made up 0.34% of the total, showing a clear gender gap in family planning methods promoted.

Table 49: Number of Reproductive Tract/Sexually Transmitted Infections (RTI/STI) cases in Delhi from 2018-19 to 2020-21

RTI/STI Cases		2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Male	**Identified**	32,356	26,739	-17%	11,668	-56%
	Treatment Initiated	29,817	25,770	-14%	11,583	-55%
Female	**Identified**	170,627	154,354	-10%	81,227	-47%
	Treatment Initiated	158,063	147,990	-6%	78,919	-47%
Total	**Identified**	202,983	181,093	-11%	92,895	-49%
	Treatment Initiated	187,880	173,760	-8%	90,502	-48%

Inference:

- 86% of the total RTI/STI cases on average (from 2018-19 to 2020-21) were reported in females.
- This shows that the burden of sexually transmitted infections is concentrated towards females and has a direct relation to the misuse or failure to use effective contraceptives.
- On an average treatment was initiated for males in 96% of the cases and for females in 95% of the cases from 2018-19 to 2020-21.

Table 50: Number of Medical Termination of Pregnancy (MTP)/Abortions from 2018-19 to 2020-21

MTP	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
MTP up to 12 weeks of pregnancy	18,452	17,656	-4%	8,584	-51%
MTP more than 12 weeks of pregnancy	1,787	1,878	5%	896	-52%
Post Abortion/ MTP Complications Identified	135	211	56%	82	-61%
Post Abortion/ MTP Complications Treated	125	157	26%	71	-55%
Number of women provided with post abortion/ MTP contraception	9,978	12,451	25%	7,481	-40%

Inference:

- MTP's beyond 12 weeks of pregnancy has decreased from 2018-19 to 2020-21. Moreover, complications related to abortions have also decreased in the same period.
- This shows that efforts are being made to provide safe interventions for unwanted pregnancies. However, treatments for post abortion complications have also decreased. This is a shortcoming that needs to be addressed, as complications such as these can have long term consequences for the woman.

1.5. Nutritional Schemes

Nutrition is recognised as one of the most important social determinants of health. Malnutrition, especially micronutrient deficiencies, restricts survival, growth and development. It contributes to morbidity and mortality in vulnerable populations, resulting in substantial diminution in productive capacity in adulthood and consequent reduction in overall well-being.

The table depicts the making and implementation of major programmes/schemes in Delhi

Government	Central	State	City
Central			
State	• Integrated Child Development Services • Mid-Day Meal Scheme • National Iodine Deficiency Disorders Control Programme	Weekly Iron and Folic Acid Supplement Programme	
City			

PROGRAMME MAKING PROGRAMME IMPLEMENTATION

SUSTAINABLE DEVELOPMENT GOALS

Target: ***Reduce percentage of pregnant women aged 15 to 49 years who are anaemic (11g/dl) to 23.57% by 2030*** [1]

Status: ***26.2% of registered pregnant women reported anaemic (less than 11g/dl) in 2020-21*** [2]

KEY FINDINGS [3]

- *The number of tests conducted for anaemia have decreased by 55% from 2018-19 to 2020-21.*
- *However, proportion of severe anaemic to total tested has increased from 2.18% in 2018-19 to 3.62% in 2020-21.*
- *31% of total anaemia deaths in 2020 took place in age group 0-24 highlighting the importance of improving nutritional levels at a young age by strengthening overall food security schemes like ICDS and mid-day meal scheme.*
- *52% of total anaemia deaths in 2020 were reported in males.*
- *Majority deaths (68%) of malnutrition occurred in the age group of 0-4 years in 2020*
- *In 2019-20, from 6th to 12th class, 5,98,992 girls and 5,01,446 boys have been reported as given IFA tablets. However, this drastically decreased to 8,866 girls and 7,741 boys in 2020-21.*

[1] SDG India Index, Niti Aayog [2] HMIS Data [3] Data from HMIS and Annual Reports of Registration of Births and Deaths in Delhi

1.5.1 Weekly Iron and Folic Acid Supplement (WIFS) Programme

Year:

2013

Background:

Anemia is a serious public health challenge in India. The National Family Health Survey-3 (NFHS-3)[72] data suggests that anemia is widely prevalent among all age groups, and is particularly high among the most vulnerable – nearly 58 per cent among pregnant women, 50 percent among non-lactating women, 56 per cent among adolescent girls (15–19 years), 30 per cent among adolescent boys and around 80 per cent among children under 3 years of age and 70% below 5 years of age[73]. In young children, iron deficiency is due to increased iron requirement during periods of rapid growth. In addition, infant and toddler diets are often poor in bioavailable iron, particularly post weaning. Children who suffer from anemia have delayed psychomotor development and impaired performance; in addition, they have a 5–10 points deficit in intelligence quotient. Iron deficiency can cause significant central nervous system damage even in the absence of anemia. There seems to be a vulnerable period for these damages particularly between 9 and 18 months of age[74]. However, there is no evidence of implementation of the National Iron Plus Initiative for Anemia Control Programme of the central government. Instead Delhi has a WIFS programme that caters mainly to adolescents.

Objectives:

Weekly administration of iron and folic acid supplements to all students from Class 6th to 12th of Delhi government and aided schools.[75]

Target:

Weekly tablets to 13.82 lakhs Students (6th to 12th standards) in all 1,218 state government and aided schools in Delhi.

Beneficiaries:

Students from Class 6th to 12th of Delhi government and aided schools

Implementation Status in Delhi:

HMIS data shows that IFA tablets have also been provided to children and pregnant women under regular anganwadi services. This data has also been presented here along with that of adolescents to give a holistic picture of the problem and status of anemia control in Delhi.

[72] http://rchiips.org/nfhs/NFHS-3%20Data/VOL-1/India_volume_I_corrected_17oct08.pdf

[73] https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1024&lid=388

[74] https://nhm.gov.in/images/pdf/programmes/wifs/guidelines/Guidelines_for_Control_of_Iron_Deficiency_Anemia.pdf

[75] http://web.delhi.gov.in/wps/wcm/connect/doit_health/Health/Home/Directorate+General+of+Health+Services/School+Health+Scheme/WEEKLY+IRON+AND+FOLIC+ACID+SUPPLEMENTATION

Table 51: Anemia prevalence rate and interventions from 2018-19 to 2020-21

Anemia	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Number of Hb tests conducted	74,20,021	72,61,458	-2%	33,30,396	-54%
Out of the total number of Hb tests done, Number having Hb < 7 mg	1,61,984	1,90,798	18%	1,20,443	-37%
Number of children (6-59 months) provided 8-10 doses (1ml) of IFA syrup (Bi weekly)	10,199	13,086	28%	43,200	230%
Number of mothers provided full course of 180 IFA tablets after delivery	1,42,630	1,48,145	4%	99,187	-33%
Number of PW given 180 Iron Folic Acid (IFA) tablets	4,77,566	7,01,918	47%	4,29,123	-39%
Girls (6th -12th class) provided 4 IFA tablets in schools	NA	5,98,992	-	8,866	-99%
Boys (6th -12th class) provided 4 IFA tablets in schools	NA	5,01,446	-	7,741	-98%
Number of out of school adolescent girls (10-19 years) provided 4 IFA tablets at Anganwadi Centres	NA	6,383	-	0	-100%

Note: Anemia is measured by the Haemoglobin (Hb) level per decilitre of blood. For women, normal Hb levels range from 12.1 to 15.1gm/dl, and for men they range from 13.8 to 17.2gm/dl. Moderate anemia is characterised by Hb levels testing between 7.1-10.9gm/dl, and severe anemia is characterised by Hb levels testing below 7gm/dl[76].

Inference:

- The number of tests conducted for anemia have decreased by 55% from 2018-19 to 2020-21, also those tested severely positive has decreased by 26%.
- However, proportion of severe anemic to total tested has increased from 2.18% in 2018-19 to 3.62% in 2020-21.
- In 2019-20, from 6th to 12th class, 5,98,992 girls and 5,01,446 boys have been reported as given IFA tablets. However, this drastically decreased to 8,866 girls and 7,741 boys in 2020-21.

[76] https://www.nhp.gov.in/disease/blood-lymphatic/iron-deficiency-anemia#:~:text=Normal%20Hemoglobin%20Levels%3A%20Hemoglobin%20is,13.8%20to%2017.2%20gm%2Fdl

Table 52: Incidence of anemia in Pregnant Women in Delhi from 2018-19 to 2020-21

Anemia in Pregnant Women	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Number of PW registered for ANC	9,31,041	7,21,322	-23%	5,47,813	-24%
Number of PW having moderate anemia	2,86,165	2,90,041	1%	1,31,185	-55%
Number of PW having severe anemia	18,913	19,225	2%	12,221	-36%
% of PW with anemia to total PW registered	32.8%	42.9%	10%	26.2%	-16.7%
Number of treatments for PW having severe anemia	11,975	14,584	22%	10,557	-28%

Inference:

- The number of pregnant women tested positive for moderate anemia and severe anemia showed a decrease of 54% and 35% from 2018-19 to 2020-21.
- However, when compared to the total pregnant women registered for ANC the number of anemic cases reduced to 26% in 2020-21.

Table 53: Age wise number of deaths caused due to anemia in Delhi from 2016 to 2020

Cause of Death	Year	Sex	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Anemias (D50-D55, D57-D64)	2016	Male	15	36	49	66	57	29	9	261
		Female	16	25	36	64	44	29	3	217
		Total	**31**	**61**	**85**	**130**	**101**	**58**	**12**	**478**
	2017	Male	22	38	53	48	51	20	2	234
		Female	13	25	29	36	45	32	4	184
		Total	**35**	**63**	**82**	**84**	**96**	**52**	**6**	**418**
	2018	Male	32	44	60	94	87	45	7	369
		Female	23	22	38	63	54	34	7	241
		Total	**55**	**66**	**98**	**157**	**141**	**79**	**14**	**610**
	2019	Male	28	45	46	69	58	27	0	273
		Female	14	19	37	64	39	24	0	197
		Total	**42**	**64**	**83**	**133**	**97**	**51**	**0**	**470**
	2020	Male	17	33	31	69	59	36	1	246
		Female	11	26	26	65	53	41	1	223
		Total	**28**	**59**	**57**	**134**	**112**	**77**	**2**	**469**

Inference:

- There were 610 deaths due to anemia in 2018 which decreased to 469 in 2020.
- 31% of total anemia deaths in 2020 took place in age group 0-24 highlighting the importance of improving nutritional levels at a young age by strengthening overall food security schemes like ICDS and mid-day meal scheme.
- 52% of total anemia deaths in 2020 were reported in males.

1.5.2 Integrated Child Development Services

Year:
1975

Background:
Integrated Child Development Services (ICDS) Scheme is one of the flagship programmes of the Government of India as a response to the challenge of providing pre-school non-formal education on one hand and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality on the other. The beneficiaries under the Scheme are children in the age group of 0-6 years, pregnant women and lactating mothers[77]. It is implemented by the State Government through Anganwadi Centres. The Package of services provided by ICDS includes supplementary nutrition, Vitamin-A, Iron and Folic Acid, immunisation, health check-ups, referral services, treatment of minor illnesses, nutrition and health education to women, pre-school education of children in the age group of 3-6 years, and convergence of other supportive services like water supply, sanitation, etc.

Objectives:

1. To improve the nutritional and health status of children in the age-group 0-6 years
2. To lay the foundation for proper psychological, physical and social development of the child, to reduce the incidence of mortality, morbidity, malnutrition and school dropout
3. To achieve effective coordination of policy and implementation amongst the various departments to promote child development
4. To enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

Target:
The scheme is aimed at improving the health, nutrition and education of the target community.

Beneficiaries:
All children below 6 years of age, pregnant women and lactating mothers. Women in the age group of 15-44 years. Adolescent girls in selected blocks.

[77] https://darpg.gov.in/sites/default/files/ICDS.pdf

Implementation Status in Delhi:

Table 54: Underweight Newborns and Children from 2018-19 to 2020-21

Undernutrition	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Number of newborns weighed at birth	2,76,479	2,74,996	-1%	1,96,750	-28%
Number of newborns having weight less than 2.5 kg	57,336	59,981	5%	43,765	-27%
% of underweight newborns	20.7%	21.8%	1.1%	22.2%	0.4%
Severe Acute Malnutrition (SAM) reported in 0-5 years	4,043	3,675	-9%	1,105	-70%

Table 55: Age wise deaths due to malnutrition in Delhi for the years 2016 to 2020

Cause of Death	Year	0-4 Years	5-14 Years	15-24 Years	25-44 Years	45-64 Years	65 Years and Above	Not Specified	Total
Malnutrition (E40-E46)	**2016**	55	4	0	3	1	2	1	66
	2017	53	4	0	0	2	3	1	63
	2018	70	0	1	2	3	3	0	79
	2019	107	27	0	1	0	1	18	154
	2020	32	1	3	1	2	2	6	47

Inference:

- Number of children reported severe acute malnourished decreased from 4,043 in 2018-19 to 1,105 in 2020-21.
- Percentage of newborns found underweight also increased from 21.8% in 2018-19 to 22.2% in 2020-21.
- Majority deaths (32) of malnutrition occurred in the age group of 0-4 years - in 2020 68% of all deaths took place in this age group.

1.5.3 Mid-Day Meal Scheme

Year:

1995

Background:

Malnutrition is widely prevalent in India amongst growing children. Especially within children of the school going age group, nutritional deficiencies worryingly prevalent. Not only does malnutrition give rise to morbidity and mortality, but it also prevents a child from developing into a healthy, fully functional adult and has an adverse impact on learning levels[78]. Hence, the National Programme of Nutritional Support to Primary Education (commonly known as the Mid-Day Meal Scheme) was launched as a Centrally Sponsored Scheme on 15th August, 1995 with the objective to boost Universalisation of Primary Education by increasing enrolment, retention and attendance and simultaneously impacting on nutrition of students in primary classes.

Objectives:

1. Improving the nutritional status of children in classes I – VIII in government, local body and government aided schools.
2. Encouraging poor children, belonging to disadvantaged sections, to attend school more regularly and help them concentrate on classroom activities.
3. Providing nutritional support to children of primary stage in drought-affected areas.

Target:

The target of the scheme is to help improve the effectiveness of primary education by improving the nutritional status of all primary school children.

Beneficiaries:

All children studying in government, local body and government-aided primary and upper primary schools and the EGS/AIE centres (including Madarsa and Maqtabs supported under SSA of all areas across the country as of 2007)

Implementation Status in Delhi:

The scheme is being implemented in government schools in Delhi, but there is no data available regarding the quality of food provided.

[78] http://mdm.nic.in/mdm_website/#

1.5.4 National Iodine Deficiency Disorders Control Programme

Year:

1992

Background:

Iodine is an essential micronutrient required daily at 100-150 micrograms for normal human growth and development. Deficiency of iodine can cause physical and mental retardation, cretinism, abortions, stillbirth, deaf mutism, squint and various types of goiter.[79] The central government launched a 100% centrally assisted National Goiter Control Programme (NGCP) in 1962. In 1992 the NGCP was renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP) with a view of wide spectrum of iodine deficiency disorders. This programme provides for setting up of State Iodine Deficiency Disorder (IDD) Cells and state IDD labs. Delhi has its own IDD cell and IDD lab.

Objectives:

1. Surveys to assess the magnitude of IDD in the districts.
2. Supply of iodized salt in place of common salt.
3. Resurveys to assess iodine d eficiency disorders and the impact of iodized salt after every 5 years in the districts.
4. Laboratory monitoring of iodized salt and urinary iodine excretion.
5. Health Education and Publicity.

Target:

1. To bring the prevalence of IDD to below 5% in the country
2. To ensure 100% consumption of adequately iodized salt (15ppm) at the household level.

Beneficiaries:

All people residing in endemic and non-endemic areas for IDD.

Implementation Status in Delhi:

No data related to IDDs available in the public domain.

[79] https://dghs.gov.in/content/1348_3_NationalIodineDeficiency.aspx

1.6. Insurance Schemes

1.6.1 Ayushman Bharat- Pradhan Mantri Jan Aarogya Yojana

Year:
2018

Background:
Ayushman Bharat, a flagship scheme of Government of India, was launched as recommended by the NHP 2017, to achieve the vision of Universal Health Coverage (UHC). Ayushman Bharat adopts a continuum of care approach, comprising of two interrelated components, which are Health and Wellness Centres (HWCs)[80] and Pradhan Mantri Jan Aarogya Yojana[81]

The second pillar of Ayushman Bharat – the Pradhan Mantri Jan Aarogya Yojana (PMJAY) aims to provide secondary and tertiary hospitalisation care cover of Rs. 5 lakh per household per year for about 1,400 procedures at the public and private hospitals. While the primary and preventive care, along with the screening of suspected individuals will be provided at the AB-HWCs, the secondary and tertiary care will be provided at the public health facilities, the District Hospitals, Medical colleges and private hospitals empaneled by AB-PMJAY. Delhi has decided to implement the AB-PMJAY from 2020-21.

Objectives:
1. Disease prevention and health promotion to curb the increasing epidemic of non-communicable diseases.
2. Create a system of demand-led health care reforms that meet the immediate hospitalisation needs of the eligible beneficiary family in a cashless manner thus insulating the family from catastrophic financial shock.

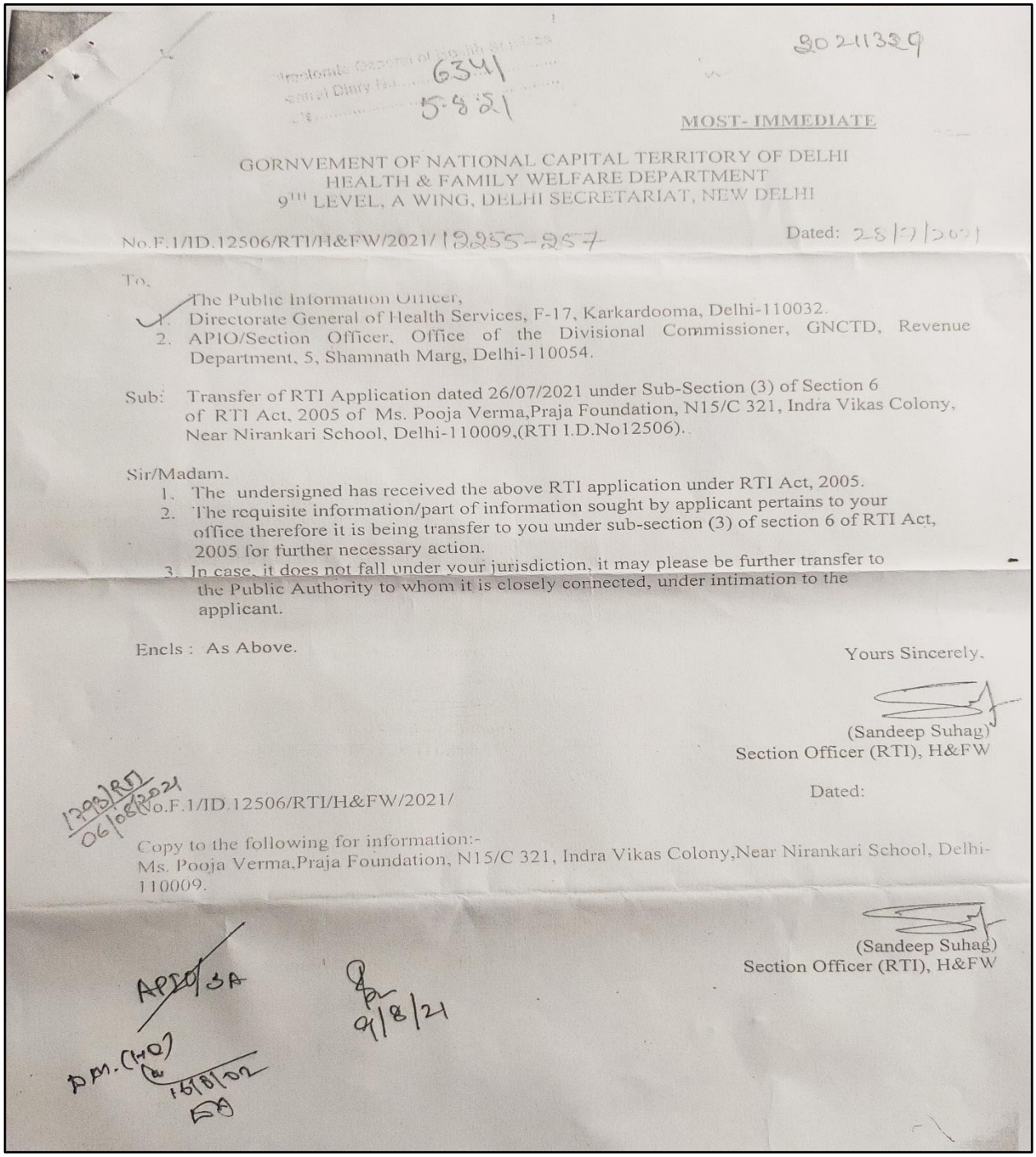
Target:
To provide medical care to 10.74 crore households in India

Beneficiaries:
PM-JAY has been rolled out for the bottom 40 percent of the poor and vulnerable population. In absolute numbers, this is close to 10.74 crore households. The inclusion of households is based on the deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas, respectively. This number also includes families that were covered in the Rashtriya Swasthya Bima Yojana (RSBY) but were not present in the SECC 2011 database. Even though PM-JAY uses the SECC as the basis of eligibility of households, many States are already implementing their own health insurance schemes with a set of beneficiaries already identified. Thus, States have been provided the flexibility to use their own database for PM-JAY. However, they will need to ensure that all the families eligible based on the SECC database are also covered. (Refer Annexure 7 for other Exclusions and Inclusions).

[80] https://ab-hwc.nhp.gov.in/
[81] https://pmjay.gov.in/

Implementation Status in Delhi:

In a response received from Health and Family Welfare Department to an RTI application, it was stated that the information is segregated and not available with single public authority. It was further transferred to DGHS and Revenue department.



9021329

Directorate General of Health Services
Central Diary No. 6341
5.8.21

MOST- IMMEDIATE

GORNVEMENT OF NATIONAL CAPITAL TERRITORY OF DELHI
HEALTH & FAMILY WELFARE DEPARTMENT
9TH LEVEL, A WING, DELHI SECRETARIAT, NEW DELHI

No.F.1/ID.12506/RTI/H&FW/2021/ 9255-257 Dated: 28/7/2021

To,

1. The Public Information Officer,
   Directorate General of Health Services, F-17, Karkardooma, Delhi-110032.
2. APIO/Section Officer, Office of the Divisional Commissioner, GNCTD, Revenue Department, 5, Shamnath Marg, Delhi-110054.

Sub: Transfer of RTI Application dated 26/07/2021 under Sub-Section (3) of Section 6 of RTI Act, 2005 of Ms. Pooja Verma,Praja Foundation, N15/C 321, Indra Vikas Colony, Near Nirankari School, Delhi-110009,(RTI I.D.No12506).

Sir/Madam,

1. The undersigned has received the above RTI application under RTI Act, 2005.
2. The requisite information/part of information sought by applicant pertains to your office therefore it is being transfer to you under sub-section (3) of section 6 of RTI Act, 2005 for further necessary action.
3. In case, it does not fall under your jurisdiction, it may please be further transfer to the Public Authority to whom it is closely connected, under intimation to the applicant.

Encls : As Above.

Yours Sincerely,

(Sandeep Suhag)
Section Officer (RTI), H&FW

1399/RTI
06/08/2021

No.F.1/ID.12506/RTI/H&FW/2021/ Dated:

Copy to the following for information:-
Ms. Pooja Verma,Praja Foundation, N15/C 321, Indra Vikas Colony,Near Nirankari School, Delhi-110009.

(Sandeep Suhag)
Section Officer (RTI), H&FW

APIO/SA

9/8/21

DM.(HQ)
16/8/02

2. Sustainable Development Goals

The Sustainable Development Goals (SDGs) is a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity. The Goal 3: Good Health and Well-being to ensure healthy lives and promote well-being for all at all ages. India adopted the SDG goals and the target on 2015 at the UN General Assembly

The year 2020 was the fifth anniversary of the adoption of SDGs**. The following components related to status of health in Delhi have thus been analysed based on the relevant SDG targets. This can showcase why there is a need for policy planning agencies to incorporate the SDG targets. So that stringent measures can be formulated to map how effective a programme implementation is carried out for various health preventions in Delhi and in the country. Also, we only have nine years left to achieve theses SDG goals, hence, it is imperative to plan, frame, make necessary changes and implement the new/existing schemes so that it aims to achieve the adopted SDG goals.**

Table 56: SDG Goal 3 targets adopted by India and their status in Delhi

Criteria	Parameters	Target	Status
Communicable Disease	Tuberculosis	0 TB cases/1 lakh population by 2030 under SDG and 0 TB cases/1 lakh population by 2025 under Revised National Tuberculosis Control Programme	**521 cases**/1 lakh population in 2020
	HIV	HIV incidence of 0/per 1,000 uninfected population	0.2/per 1,000 uninfected population
	Other Communicable/ Epidemics	End the epidemics of malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	**2,148 malaria cases** **7,040 dengue cases**
Non-Communicable Disease	Non-Communicable Disease	Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	The deaths due to diabetes has increased by 8% from 2015 to 2020 The deaths due to hypertension has decreased by 17% from 2015 to 2020
	Mental Health		**1,36,338** number of mental health cases
			Decrease in the number of deaths caused by mental and behavioral disorders by 48% from 77 in 2016 to 40 in 2020.

RMNCHA+	Neo-natal mortality	Reduce to at least as low as 12 per 1,000 live births	**16** (deaths per 1000 live births)
	Infant and Child Health	Under-5 mortality to at least as low as 25 per 1,000 births	**20** infant (upto 1 year) deaths per 1,000 births
	Maternal Health	Reduce Maternal Mortality Rate (deaths per 1,00,000 live births) to 70 by 2030 under SDG	**252** (deaths per 1,00,000 live births)
	Universal access to reproductive health-care services by 2030.	100% institutional deliveries out of the total deliveries reported	**94.59%** institutional deliveries
	Reproductive Health	Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	92,895 **Sexually Transmitted Infections reported** 99.92% **family planning interventions were targeted towards females.**
Nutrition	Micronutrient Deficiencies	Reduce percentage of pregnant women aged 15 to 49 years who are anaemic (11g/dl) to 23.57% by 2030 under SDG	**2% (12,221)** pregnant women **reported anaemic (less than 11g/dl)**

Note (*): Includes data of 6 MCD hospitals, 35 State hospitals, 11 districts of State CDMO, CAMO: NDMC- 4 out of 5, EDMC- 4 out of 5 and SDMC- 3 out of 5 received.

3. Recommendations

1. **Data Management:**

- Data on all the diseases and cases prevalent in the city should be maintained and analysed on a real-time basis. This will enable better methods to track the occurrence of diseases and ensure corrective measures are implemented to tackle them. Similarly, cause of death data can also help to identify the diseases that contribute to the deaths registered in the city and can allow for government to create targeted interventions.
- In all, there is a need for data-centric policy planning and programmes for all diseases like communicable and non-communicable diseases, mental health as well as programmes specific to mother and children.
- Respiratory diseases should be included in the NCD programmes as it caused by poor air quality and Delhi has always been on higher side of air pollution.
- Appropriate schemes and programme needs to implemented to reduce the increasing number of deaths in adolescent and working age group i.e. 15 to 64 years.

2. **Meeting SDG Target Should be Prioritised:**

- The SDGs provide specific targets that should be achieved to ensure good health and wellbeing of the citizens.
- Thus, all health policies and programmes must aim towards achieving the SDGs so that they can create specific milestones to ensure all epidemic like TB, malaria, HIV, etc. are eradicated by 2030.
- Additionally, with the help of data, the local government can track the status of health according to these targets and ensure corrective interventions are carried out.

3. **Medical Testing, Child Immunisation and School Health Checkups Should Be Amplified:**

- The pandemic brought about several restrictions that led to a decrease in the access to various healthcare services for diseases other than COVID 19.
- Thus, innovative measures must be undertaken to increase medical tests for all age groups for various diseases that are prevalent in the city, especially during the pandemic.

IV. Annexures

1. List of Municipal & Government Dispensaries and Hospitals

Sr. No.	Type	Dispensary name	Sr. No.	Type	Dispensary name
Central zone					
1	S	DGD Batla House	21	M	Defence Colony Urban Health Centre
2	S	DGD Delhi Sachiwalaya	22	M	Jangpura Polyclinic
3	S	DGD Garhi	23	M	Kalkaji Colony Hospital
4	S	DGD Molarband	24	M	Lajpat Nagar Colony Hospital
5	S	DGD Sangam Vihar D-1/36	25	M	Madanpur Khadar Allopathic Dispensary
6	S	DGD Sarai Kale Khan	26	M	Nizzamuddin Polyclinic
7	S	DGD Sriniwas Puri	27	M	Sarai kalen Khan Allopathic Dispensary
8	S	DGD Sunlight Colony	28	M	Sidharth Basti allopathic Dispensary
9	S	DGD Tajpur	29	M	Tuglakabad Dispensary
10	S	Seed PUHC Jasola Village	30	C	Darya Ganj
11	S	Seed PUHC Lal Quan	31	C	Andrews Gang
12	S	Seed PUHC Meetha Pur Extn	32	C	Jangpura
13	S	Seed PUHC Pul Prahladpur	33	C	Kalkaji - I
14	S	Seed PUHC Sangam Vihar B-Block	34	C	Kalkaji-II
15	S	Seed PUHC Sangam Vihar D-5/7	35	C	Kasturba Nagar-I
16	S	Seed PUHC Sangam Vihar F2/474	36	C	Kasturba Nagar-II
17	S	Seed PUHC Sangam Vihar H-16/413	37	C	Kidwai Nagar
18	S	Seed PUHC Tughlakabad	38	C	Lajpat Nagar
19	M	Badarpur Polyclinic	39	C	Sadiq. Nagar
20	M	Chest Clinic TB Hospital, Nehru Nagar	40	C	Sri Niwas Puri
City Sadar Paharganj					
1	S	DGD Ajmeri Gate	16	M	Depty. Ganj (F) Dispensary
2	S	DGD Chamelian Road	17	M	Goenka Road Dispensary
3	S	DGD Dujana House	18	M	Kashmere Gate dispensary
4	S	DGD Gali Guliyan	19	M	Lahori Gate Dispensary
5	S	DGD Gali Samosan	20	M	Lal Kuan Dispensary
6	S	DGD Hindustani Dawakhana	21	M	Lala Dulichand Bara Hindu Rao Polyclinic
7	S	DGD Motia Khan	22	M	Pratap Nagar Dispensary
8	S	DGD Nabi Karim	23	M	V.D. Clinic Roshnara road Dispensary
9	S	DGD Pul Bangash	24	M	Vivekanand Municipal Dispensary
10	S	DGD Sarai Rohilla	25	M	Vivekanand Polyclinic

City Sadar Paharganj					
11	S	DGD Suiwalan	26	C	Chitra Gupta Road
12	S	DGD Tis-Hazari	27	C	Minto Road
13	S	DGD Tis-Hazari-FAP	28	C	Chandni Chowk
14	M	Babasaheb Ambedkar Sadar Bazar Polyclinic	29	C	Pul Bangash
15	M	Chest Clinic SPM Marg	30	C	Lancer Road
Civil Line					
1	S	DGD Bhalswa Dairy	12	S	Seed PUHC Jagatpur
2	S	DGD Bhalswa JJ Colony	13	S	Seed PUHC Nathupura
3	S	DGD Jahangirpuri B Block	14	S	Seed PUHC Samta Vihar
4	S	DGD Jahangirpuri H Block	15	S	Seed PUHC Swarup Nagar
5	S	DGD Jharoda Majra	16	M	Badli Dispensary
6	S	DGD Majnu Ka Tila	17	M	Burari Polyclinic
7	S	DGD Mukandpur	18	M	GTB Nagar Polyclinic
8	S	DGD Mukhmailpur	19	M	Indra Nagar Dispensary
9	S	DGD Old Sectt	20	M	Siraspur Dispensary
10	S	DGD Timarpur	21	M	UHC/ Dhaka
11	S	DGD Wazirabad	22	C	Kingsway Camp
Karol Bagh					
1	S	DGD Anand Parbat	18	M	Jandhewalan Chest Clinic
2	S	DGD Baljit Nagar	19	M	Kirti Nagar Dispensary
3	S	DGD Budh Nagar	20	M	Maharaja agrsen Nigam Dispensary UHC WEA
4	S	DGD Gulabi Bagh	21	M	Naraina Dispensary
5	S	DGD Inderlok	22	M	Old Rajinder Nagar Dispensary
6	S	DGD Inderpuri, Near Mother Dairy	23	M	Pahar Ganj Dispensary
7	S	DGD Jai Dev Park	24	M	Ramesh Nagar Polyclinic
8	S	DGD New Ranjit Nagar	25	C	Pararganj
9	S	DGD Pahar Ganj	26	C	Dev Nagar
10	S	DGD Prem Nagar	27	C	Inder Puri
11	S	DGD Ranjit Nagar	28	C	Karol Bagh
12	S	DGD Regharpura	29	C	Naraina Vihar
13	S	DGD Shahzada Bagh	30	C	New Rajinder Nagar
14	S	DGD Tank Road	31	C	East Patel Nagar
15	S	Seed PUHC Sudarshan Park	32	C	West Patel Nagar
16	M	Chest Clinic Moti Nagar	33	C	Pusa Road
17	M	Dev Nagar Dispensary			
Keshav Puram					
1	S	DGD Ashok Vihar, H-Block	18	M	Azadpur Dispensary
2	S	DGD Gurmandi	19	M	Chest Clinic Gulabi Bagh
3	S	DGD Keshavpuram C-7 Block	20	M	Indra Gandhi Polyclinic

4	S	DGD Model Town	21	M	Jwala Heri Dispensary
5	S	DGD Paschim Puri	22	M	Nimri Polyclinic
6	S	DGD Paschim Vihar	23	M	Pitumpura Dispensary
7	S	DGD Sangam Park	24	M	Roop Nagar Dispensary
8	S	DGD Saraswati Vihar	25	M	Shakurbasti Dispensary
9	S	DGD Shakurpur	26	M	Singhalpur Dispensary
10	S	DGD Shalimar Bagh AC- Block	27	C	Rajpur Road
11	S	DGD Shalimar Bagh BB-Block	28	C	Shakti Nagar
12	S	DGD Wazirpur Industrial Area	29	C	Ashok Vihar
13	S	DGD Wazirpur J.J.Colony	30	C	Pitam Pura
14	S	Polyclinic Keshavpuram B-4 Block	31	C	Paschim Vihar
15	S	Polyclinic Pitam pura	32	C	Sunder Vihar
16	S	Polyclinic Wazirpur, PH-III	33	C	Tri Nagar
17	M	Atma Ram Gupta Poly clinic (Onkar Nagar PC)			
Najafgarh					
1	S	DGD Bamnoli	21	S	DGD Nangli
2	S	DGD Chhawla	22	S	DGD Pindwala Kalan
3	S	DGD Dhansa	23	S	DGD Raj Nagar Part-II
4	S	DGD Dindarpur Village	24	S	DGD Rawta
5	S	DGD Dwarka Court	25	S	DGD Sagarpur
6	S	DGD Dwarka Sector – 10	26	S	DGD Shahbad Md. Pur
7	S	DGD Dwarka Sector – 12	27	S	Seed PUHC Dharmpura
8	S	DGD Dwarka Sector – 19	28	S	Seed PUHC Gopal Nagar
9	S	DGD Dwarka Sector – 2	29	S	Seed PUHC Kakrola
10	S	DGD Dwarka Sector-14	30	S	Seed PUHC Qutub Vihar
11	S	DGD Dwarka Sector-17	31	S	Seed PUHC Ranaji Enclave
12	S	DGD Issapur	32	S	Seed PUHC Smalkha
13	S	DGD Jharoda Kalan	33	S	SPUHC Salhapur Khera
14	S	DGD Jhatikara	34	S	SPUHC Sitapuri
15	S	DGD Kanganheri Village	35	M	Bijwasan Chest Clinic
16	S	DGD Kapashera	36	M	Bijwasan Dispensary
17	S	DGD Mahipal Pur	37	M	Daulatpur Allopathic Dispensary
18	S	DGD Malik Pur Village	38	M	Gumenhera Allopathic Dispensary
19	S	DGD Mangla Puri	39	M	Issapur Allopathic Dispensary
20	S	DGD Mundela Khurd	40	C	Palam Colony
Narela					
1	S	DGD Bakhtawarpur	19	S	DGD Savda Ghevra
2	S	DGD Bawana	20	S	DGD Tikri Kalan
3	S	DGD Bhorgarh	21	S	Seed PUHC Begum Pur
4	S	DGD Darya Pur Kalan	22	S	Seed PUHC Kam Ruddin Nagar

5	S	DGD Harewali	23	S	Seed PUHC Nilothi
6	S	DGD Hiran Kudna	24	M	Alipur Polyclinic
7	S	DGD Holambi Kalan Ph-2	25	M	Bawana Polyclinic
8	S	DGD Jaunti	26	M	Begum Vihar Dispensary
9	S	DGD Katewara	27	M	Chest Clinic Narela
10	S	DGD Khera Kalan	28	M	Chest clinic Shahbad
11	S	DGD Madan Pur Dabas	29	M	Hamidpur Dispensary
12	S	DGD Majra Dabas	30	M	Karala Polyclinic
13	S	DGD Mundka	31	M	Mungeshpur Dispensary
14	S	DGD Nangloi	32	M	Narela Polyclinic
15	S	DGD Narela	33	M	Ram Roop Health Kanjhawala Polyclinic
16	S	DGD Nizam pur	34	M	Singhu Dispensary
17	S	DGD Rani Khera	35	M	Pooth Kalan Dispensary
18	S	DGD Sannoth			
New Delhi Municipal Council					
1	S	DGD Delhi High Court	10	C	North Avenue
2	S	DGD Patiala House Court	11	C	Pandara Road
3	S	DGD Supreme Court	12	C	President Estate
4	S	DGD Trade and Taxes, ITO	13	C	Telegraph Lane
5	C	Chanakya Puri	14	C	Dr. Z.H. Road
6	C	Constitution House	15	C	Pragati Vihar
7	C	Gole Market	16	C	Kali Bari Marg
8	C	Aliganj	17	C	South Avenue
9	C	Lodhi Road	18	C	Sidha Dispensary
Rohini					
1	S	DGD Jawalapuri	13	S	Seed PUHC Budh Vihar
2	S	DGD Kirari	14	S	Seed PUHC Chander Vihar
3	S	DGD Mangolpuri	15	S	Seed PUHC Inder Enclave - II
4	S	DGD Prashant Vihar	16	S	Seed PUHC Laxmi Vihar
5	S	DGD Rohini Court	17	S	Seed PUHC Nihal Vihar
6	S	DGD Sector-13, Rohini	18	S	Seed PUHC Prem Nagar II
7	S	DGD Sector-8, Rohini	19	S	Seed PUHC Prem Nagar III
8	S	DGD Sultanpuri	20	M	Chest Clinic Choudhary Desraj
9	S	Polyclinic Rohini, Sector 4	21	M	Lala Hans Raj Gupta, Rohini Polyclinic
10	S	Polyclinic Sector-18, Rohini	22	M	Nangloi Polyclinic
11	S	Polyclinic Sector-2, Rohini	23	C	Rohini
12	S	Seed PUHC Aman Vihar			
Shahadra North					
1	S	DGD Arvind Nagar	21	S	Seed PUHC Chandu Nagar
2	S	DGD Ashok Nagar	22	S	Seed PUHC Chauhan Patti
3	S	DGD Babarpur	23	S	Seed PUHC Kabir Nagar

4	S	DGD Bhagirathi Vihar	24	S	Seed PUHC Nehru Vihar
5	S	DGD Durgapuri	25	S	Seed PUHC New Mustafabad
6	S	DGD Gokulpuri	26	S	Seed PUHC Old Mustafabad
7	S	DGD Jhilmil	27	S	Seed PUHC Rajiv Nagar/Shri Ram Colony
8	S	DGD Johripur	28	S	Seed PUHC Shaheed Bhagat Singh
9	S	DGD Khajoori Khas	29	S	Seed PUHC Shiv Vihar Phase -II
10	S	DGD Maujpur	30	S	Seed PUHC Shiv Vihar Phase -V
11	S	DGD Nand Nagri Extension	31	S	Seed PUHC Sonia Vihar 0 Pushta
12	S	DGD New Seemapuri	32	S	Seed PUHC Sonia Vihar 4.5 Pushta
13	S	DGD Old Seemapuri	33	S	Seed PUHC Zafrabad-1
14	S	DGD Saboli	34	M	Allopathic Dispensary, Brahmpuri
15	S	DGD Seelampur	35	M	Allopathic Dispensary, Karawal Nagar
16	S	DGD Shiv Vihar Tiraha	36	M	Allopathic Dispensary, Yamuna Vihar
17	S	DGD Yamuna Vihar	37	M	Allopathic Dispensary, Harsh Vihar
18	S	Seed PUHC Amar Colony	38	C	Dilshad Colony
19	S	Seed PUHC Bhagirathi Vihar	39	C	Bhajan Pura
20	S	Seed PUHC Brahmpuri			
Shahadra South					
1	S	DGD Bank Enclave	22	S	DGD Vasundhara Enclave
2	S	DGD Bhola Nath Nagar	23	S	Seed PUHC Ghazipur
3	S	DGD Chander Nagar	24	S	Seed PUHC New Ashok Nagar
4	S	DGD Dilshad Garden	25	S	Seed PUHC Rajbir Colony
5	S	DGD Geeta Colony	26	S	Seed PUHC, Jheel
6	S	DGD Himmat Puri	27	M	Allopathic Dispensary, EDMC HQ
7	S	DGD I.P. Extension	28	M	Allopathic Dispensary, Kasturba Nagar
8	S	DGD Jagat Puri	29	M	Allopathic Dispensary, Khureji Khas
9	S	DGD Kalyan Puri	30	M	Allopathic Dispensary, Patparganj
10	S	DGD Karkardooma	31	M	Jheel Khureji Dispensary
11	S	DGD Karkardooma Court Complex	32	M	Polyclinic Shahdara
12	S	DGD Laxmi Nagar	33	M	SPM Chest Clinic, Patparganj
13	S	DGD Mayur Vihar, PH-III (Kondli)	34	M	West Azad Nagar Dispensary
14	S	DGD Mandawali Fazal Pur	35	M	Chest Clinic Shahdara
15	S	DGD Mayur Vihar	36	C	Shahdara, Mansrover Park
16	S	DGD Mukesh Nagar	37	C	Krishana Nagar
17	S	DGD New Lahore Shastri Nagar	38	C	Laxmi Nagar
18	S	DGD Pandav Nagar	39	C	Mayur Vihar
19	S	DGD Shashi Garden	40	C	Shahdara
20	S	DGD Suraj Mal Vihar	41	C	Ghaziabad
21	S	DGD Trilok Puri			

South					
1	S	DGD Begum pur	24	C	Sidha Unit
2	S	DGD Ber Sarai	25	C	Pushp Vihar
3	S	DGD Chatterpur	26	C	Hauz Khas
4	S	DGD Chirag Delhi	27	C	Laxmibai Nagar
5	S	DGD Dakshinpuri	28	C	Moti Bagh
6	S	DGD Jonapur	29	C	Munirka
7	S	DGD Kalkaji	30	C	MB. Road
8	S	DGD Khanpur	31	C	Malaviya Nagar
9	S	DGD Madangir	32	C	Netaji Nagar
10	S	DGD Moti Bagh (Shastri Market)	33	C	Nauroji Nagar
11	S	DGD Rajokri	34	C	Nanakpura
12	S	DGD Saket	35	C	R.K. Puram-I
13	S	DGD Saket Court Complex	36	C	R.K. Puram-II
14	S	Seed PUHC Aya Nagar	37	C	R.K. Puram-III
15	S	Seed PUHC Jawahar Park	38	C	R.K. Puram-IV
16	S	Seed PUHC Neb Sarai	39	C	R.K. Puram-V
17	S	Seed PUHC Sangam Vihar	40	C	R.K. Puram-VI
18	M	Madangir Allopathic Dispensary	41	C	Sarojini Nagar-I
19	M	Masjid Moth Polycllinic	42	C	Sarojini Nagar-II
20	M	Munirka Polyclinic	43	C	Sarojini Nagar Market
21	M	Primary Health Centre Mehrauli	44	C	CBI Colony
22	M	Primary Health Centre, Fateh Pur Beri	45	C	M&G. Hospital, R.K. Puram
23	C	Sarojini Nagar			
West					
1	S	DGD Bakkarwala	18	S	DGD Tilak Vihar
2	S	DGD Baprolla	19	S	DGD Tilangpur Kotla
3	S	DGD Basant Gaon	20	S	DGD Vikas Puri
4	S	DGD Chowk handi	21	S	Seed PUHC Mansa Ram Park
5	S	DGD Janak puri (A-4A)	22	S	Seed PUHC Mohan Garden
6	S	DGD Janak puri(C4B)	23	M	Maharaja Agarsen Polyclinic
7	S	DGD Jeevan Park	24	M	Rajouri Garden Allopathic Dispensary
8	S	DGD Khyala	25	M	Subhash Nagar Allopathic Dispensary
9	S	DGD Madipur	26	M	Tilak Nagar Colony Hospital
10	S	DGD Mayapuri	27	M	Uttam Nagar Dispensary
11	S	DGD Nangal Raya	28	C	Hari Nagar
12	S	DGD Nangli Jalib	29	C	Janak Puri-1
13	S	DGD Nawada	30	C	Janak Puri-2
14	S	DGD Raghubir Nagar	31	C	Nangal Raya
15	S	DGD Ram Dutt Enclave	32	C	Rajouri Garden
16	S	DGD Shiv Vihar	33	C	Tilak Nagar
17	S	DGD Tihar Jail Complex			

Sr. No.	Type	Hospital name	Sr. No.	Type	Hospital name
Central zone					
1	S	Nehru Homeopathic Medical College & Hospital			
City Sadar Paharganj					
1	S	Aruna Asaf Ali Govt. Hospital	5	S	Maulana Azad Institute of Dental Sciences
2	S	Govind Ballabh Pant Hospital (GBPH)	6	S	Sushrut Trauma Centre
3	S	Guru Nanak Eye Centre	7	M	Girdharilal Maternity Hospital
4	S	Lok Nayak Hospital	8	M	Kasturba Hospital
Civil Line					
1	S	Babu Jagjivan Ram Hospital	4	M	MVID Hospital
2	S	Poor House Hospital	5	M	Rajan Babu TB Hospital
3	M	Hindu Rao Hospital			
Karol Bagh					
1	S	Aacharyashree Bhiksha Hospital	3	S	Dr. N. C. Joshi Hospital
2	S	Ayurvedic & Unani Tibbia College and Hospital	4	S	Sardar Vallabh Bhai Patel Hospital
Keshav Puram					
1	S	Attar Sain Jain Hospital	3	S	Deep Chand Bandhu Hospital
2	S	Bhagwan Mahavir Hospital			
Najafgarh					
1	S	Chaudhary Brahm Prakash Ayurved Charak Sansthan	2	S	Rao Tula Ram Memorial Hospital
Narela					
1	S	Maharishi Balmiki Hospital	2	S	Satyawadi Raja Harish Chandra Hospital
New Delhi Municipal Council					
1	C	Lady Hardinge Medical College	2	C	Dr. Ram Manohar Lohia Hospital
Rohini					
1	S	Dr. Baba Saheb Ambedkar Hospital	2	S	Sanjay Gandhi Memorial Hospital
Shahadra North					
1	S	Delhi State Cancer Institution	4	S	Jag Parvesh Chander Hospital
2	S	Guru Teg Bahadur Hospital	5	S	Rajiv Gandhi Super Speciality Hospital
3	S	Institute of Human Behaviour and Allied Sciences (I.H.B.A.S.)	6	M	Swami Dayanand Hospital
Shahadra South					
1	S	Chacha Nehru Bal Chikitsalaya	3	S	Lal Bahadur Shastri Hospital
2	S	Dr. Hedgewar Arogya Sansthan			

South					
1	S	Dr. B. R. Sur Homoeopathic Medical College & Hospital	4	C	Safdarjung Hospital & VMCC
2	S	Institute of Liver & Biliary Sciences	5	C	All India Medical Sciences
3	S	Pandit Madan Mohan Malviya Hospital			
West					
1	S	Central Jail Hospital	4	S	Guru Govind Singh Hospital
2	S	Dadadev Mother & Child Hospital	5	S	Janakpuri Super Speciality Hospital
3	S	Deen Dayal Upadhyay Hospital			

2. Registration of Births and Deaths Act 1969

- Provides for registration of births and deaths and for matters connected.
- 'Source of demographic data for socio-economic planning, development of health systems and population control' *(as per 2012 Training Manual for Civil Registration Functionaries in India, Office of Register General of India, Ministry of Home Affairs, Government of India).*

Medical Certification of Causes of Death (MCCD)

The Registration of Births and Deaths Act, 1969 (RBD Act, 1969) came into force in **Delhi** w.e.f. 1st July, 1970. The Act aims at compulsory accounting of vital events which results in the issuance of certificates as well as generation of valuable data for plan and policy formulation on health sector. The Delhi Registration of Births and Deaths Rules, 1970 has also been notified w.e.f. 1st January 1971. Further, these rules have been modified as per direction of Registrar General India in December, 1999 and came into force w.e.f. 1st January, 2000. Directorate of Economics & Statistics, Govt. of N.C.T. of Delhi also functions as the Office of Chief Registrar (Births & Deaths) for the N.C.T. of Delhi. **The actual registration of Births & Deaths in Delhi is done by five local bodies viz North/South/East Delhi Municipal Corporations, NDMC and Delhi Cantonment Board through the registration offices spread under their respective jurisdictions**. Each local body has the provision of Additional Chief Registrar (Birth & Death) to coordinate for smooth and effective functioning of registration work of vital events occurred in the respective jurisdictional area. The registration office/zone under the local body is headed by Registrar (B&D).

MEANING OF MCCD: Medical Certification of cause of death is a record of the cause of death i.e. the disease, abnormality or injury which has directly or indirectly contributed to the death of a person. Death often results from the combined effect of two or more conditions. Sometimes these conditions may be related or un-related. When the conditions are related the under lying cause of death is the disease or injury which initiated the sequence of events. All other conditions of death other than the underlying cause of death are termed as antecedent and immediate cause of death. The system of medical certification of cause of death provides cause specific mortality profiles which is a key indicator for analysing the health trends of population in a scientific manner. The analysis of causes of deaths in different age groups has immense value to the public health planners/administrators, medical professionals, epidemiologists and research workers etc.

Source:
http://www.delhi.gov.in/wps/wcm/connect/f18afe0043c31f83863fff115eec0808/MCCD+Report+2016.pdf?MOD=AJPERES&lmod=1859733220&CACHEID=f18afe0043c31f83863fff115eec0808

FORM NO. 4

(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

(Hospital In-patients. Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital .....

I hereby certify that the person whose particulars are given below died in the hospital in Ward No.....

on ..... at .....AM/PM

NAME OF DECEASED					
Sex	Age at Death				For use of Statistical Office
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female					

CAUSE OF DEATH		Interval between onset and death approx.
I Immediate cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.	(a) ..... due to (or as a consequences of)	
Antecedent cause Morbid conditions, if any, giving rise to the above cause, stating underlying conditions last	(b) ..... due to (or as a consequences of)	
II Other significant conditions contributing to the death but not related to the disease or condition causing it	(c)	

Manner of Death How did the injury occur?

1. Natural 2. Accident 3. Suicide 4. Homicide
5. Pending investigation

If deceased was a female, was pregnancy the death associated with? 1. Yes 2. No

If yes, was there a delivery? 1. Yes 2. No

Name and signature of the Medical Attendant certifying the cause of death

Date of verification.....

SEE REVERSE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum..... S/W/D of Shri .....

R/O ..... was admitted to this hospital on .....

and expired on .....

Doctor .....

(Medical Supdt.
Name of Hospital)

FORM NO.4A
(See Rule 7)
MEDICAL CERTIFICATE OF CAUSE OF DEATH
(For Non-Institutional deaths. Not to be used for stillbirths)
To be sent to Registrar along with From No.2 (Death Report)

I hereby certify that the deceased Shri/Smt/Kum..... son of/wife of/daughter of .....resident of .....was under my treatment from ..... to ..... and he/she died on .....at.....A.M./P.M.

NAME OF DECEASED					For use of Statistical Office
Sex	Age at Death				
	Age in completed years	If less than 1 year, age in Months	If less than one month, age in days	If less than one day, age in Hours	
3. Male 4. Female					
CAUSE OF DEATH				Interval between onset & death Approx	
I. Immediate cause State the disease, injury or complication which Caused death, not the mode of dying such as Heart failure, asthenia, etc.			(a) ..... due to (or as consequences of)	....	.....
Antecedent cause Morbid conditions, if any, giving rise to the above Cause, stating underlying conditions last			(b)..... due to (or as consequences of)	.....	.....
II.			(c).....	.....	.....
Other Significant conditions contributing to the Death but not related to the diseases or conditions causing it.			....	.....	.....

If deceased was a female, was pregnancy the death associated with? If yes, was there a delivery? 1. Yes 2. No	1. Yes	2. No

Name and Signature of the Medical Practitioner certifying the Cause of Death.
Date of Verification:.....

SEE REVERSE FOR INSTRUCTIONS

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum..... S/W/D of Shri..... R/O..... was under my treatment from.....to.....and he/she expired on .....at .....A.M./P.M.

Doctor:.....
(Signature and address of Medical Practitioner/Medical attendant with Registration No.)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

Directions for completing the form

Name of deceased: To be given in full. Do not use initials. If deceased is an infant, not yet named at time of death, write 'Son of (S/o)' or 'Daughter of (D/o)', followed by names of mother and father.

Age: If the deceased was over 1 year of age, give age in completed years. If the deceased was below 1 year of age, give age in months and if below 1 month give age in completed number of days, and if below one day, in hours.

Cause of Death: This part of the form should always be completed by the attending physician personally.

The certificate of cause of death is divided into two parts, I and II. Part I is again divided into three parts, lines (a) (b) (c). If a single morbid condition completely explains the deaths, then this will be written on line (a) of Part I, and nothing more need be written in the rest of Part I or in Part II, for example, smallpox, lobar pneumonia, cardiac beriberi, are sufficient cause of death and usually nothing more is needed.

Often, however, a number of morbid conditions will have been present at death, and the doctor must then complete the certificate in the proper manner so that the correct underlying cause will be tabulated. First, enter in Part I(a) the immediate cause of death. This does not mean the mode of dying, e.g., heart failure, respiratory failure, etc. These terms should not be appear on the certificate at all since they are modes of dying and not causes of death. Next consider whether the immediate cause is a complication or delayed result of some other cause. If so, enter the antecedent cause in Part I, line (b). Sometimes there will be three stages in the course of events leading to death. If so, line (c) will be completed. The underlying cause to be tabulated is always written in last in Part I.

Morbid conditions or injuries may be present which were not directly related to the train of events causing death but which contributed in some way to the fatal outcome. Sometimes the doctor finds it difficult to decide, especially for infant deaths, which of several independent conditions was the primary cause of death; but only one cause can be tabulated, so the doctor must decide. If the other diseases are not effects of the underlying cause, they are entered in Part II.

Do not write two or more conditions on a single line. Please write the names of the diseases (in full) in the certificates as legibly as possible to avoid the risk of their being misread.

Onset: Complete the column for interval between onset and death whenever possible, even if very approximately, e.g., "from birth" "several years".

Accidental or violent deaths: Both the external cause and the nature of the injury are needed and should be stated. The doctor or hospital should always be able to describe the injury, stating the part of the body injured, and should give the external cause in full when this is shown. Example : (a) Hypostatic pneumonia; (b) Fracture of neck of femur; (c) Fall from ladder at home.

Maternal deaths: Be sure to answer the question on pregnancy and delivery. This information is needed for all women of child-bearing age, even though the pregnancy may have had nothing to do with the death.

Old age or senility: Old age (or senility) should not be given as a cause of death if a more specific cause is known. If old age was a contributory factor, it should be entered in Part II. Example : (a) Chronic bronchitis, II old age.

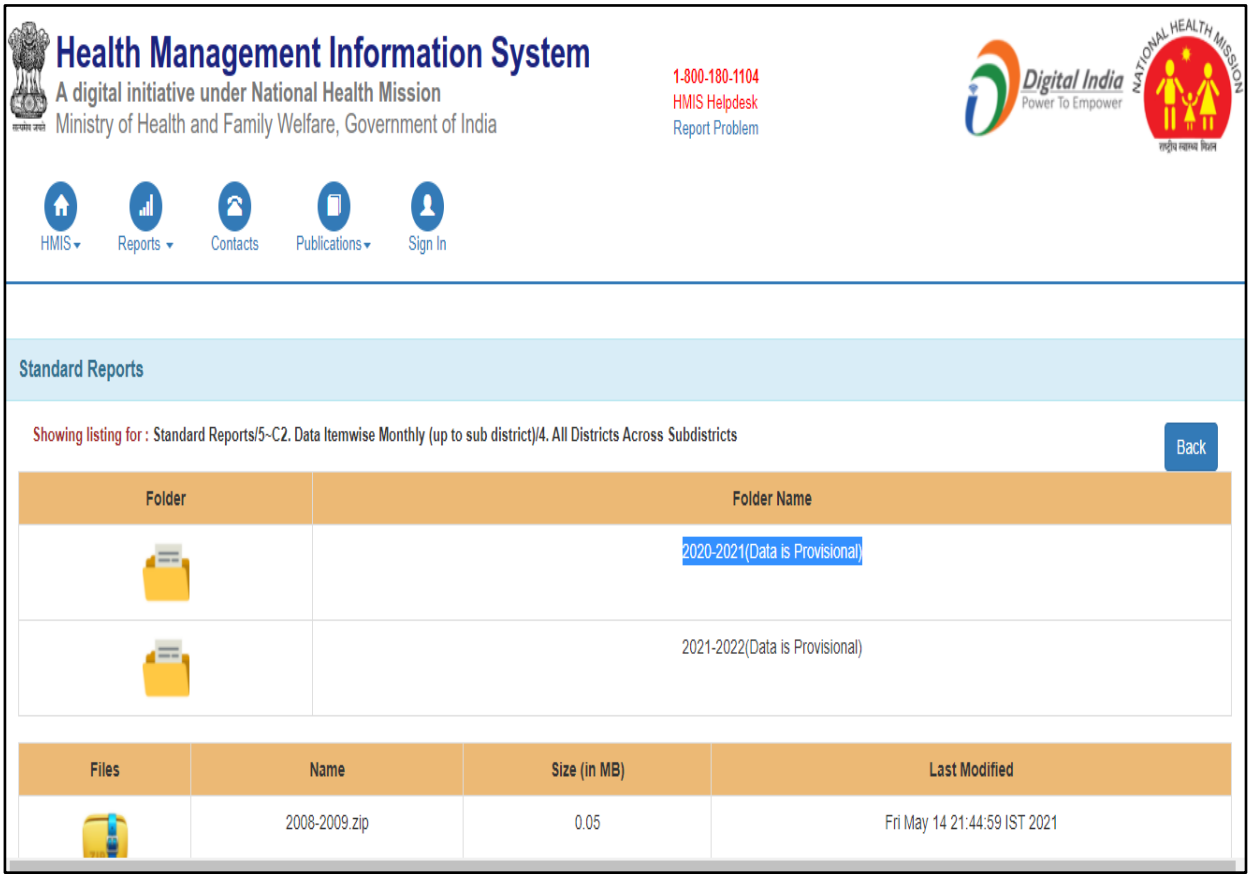
Completeness of information: A complete case history is not wanted, but, if the information is available, enough details should be given to enable the underlying cause to be properly classified.

Example: Anaemia – Give type of anaemia, if known. Neoplasm – Indicate whether benign or malignant, and site, with site of primary neoplasm, whenever possible. Heart disease – Describe the condition specifically; if congestive heart failure, chronic on pulmonale, etc., are mentioned, give the antecedent conditions. Tetanus – Describe the antecedent injury, if known. Operation – State the condition for which the operation was performed. Dysentery – Specify whether bacillary, amoebic, etc., if known. Complications of pregnancy or delivery – Describe the complication specifically. Tuberculosis – Give organs affected.

Symptomatic statement: Convulsions, diarrhea, fever, ascites, jaundice, debility, etc., are symptoms which may be due to any one of a number of different conditions. Sometimes nothing more is known, but whenever possible, give the disease which caused the symptom.

Manner of Death: Deaths not due to external cause should be identified as 'Natural'. If the cause of death is known, but it is not known whether it was the result of an accident, suicide or homicide and is subject to further investigation, the cause of death should invariably be filled in and the manner of death should be shown as 'Pending investigation'.

3. Health MIS


Health Management Information System
A digital initiative under National Health Mission
Ministry of Health and Family Welfare, Government of India
1-800-180-1104
HMIS Helpdesk
Report Problem
Digital India
Power To Empower
NATIONAL HEALTH MISSION
HMIS
Reports
Contacts
Publications
Sign In
Standard Reports
Showing listing for : Standard Reports/5~C2. Data Itemwise Monthly (up to sub district)/4. All Districts Across Subdistricts
Back
Folder
Folder Name
2020-2021(Data is Provisional)
2021-2022(Data is Provisional)
Files
Name
Size (in MB)
Last Modified
2008-2009.zip
0.05
Fri May 14 21:44:59 IST 2021

4. Health Indicators Adopted by India under Sustainable Development Goals, SDG India Index Baseline Report, 2018

The National Context

National aspirations for economic growth cannot be achieved without a healthy and productive population. Economic and social advancements can neither be secure nor sustainable unless sufficient investments are made to protect and promote the health and well-being for all, at all ages. Thus, maintaining good health is important for individuals to lead a better life and is critical for a nation's development.

While sustained efforts have to be made for India to achieve the targets set under Goal 3, the country has made impressive gains on key indicators. The maternal mortality ratio has declined to 130 in 2014-16 from 254 in 2004-06. Under 5 mortality rate in 2015-16 was 50, down from 74 in 2005-2006 . ***Ayushman Bharat*** and ***POSHAN Abhiyan*** are two of the most comprehensive and recent programmes of the Government of India to promote good health.

India SDG Index – Goal 3

To measure India's performance on the Goal of Good Health and Well-being, five national level indicators have been identified, which capture four out of the 13 SDG targets for 2030 outlined under this Goal. These indicators have been selected based on availability of data at the national level and to ensure comparability across States and Union Territories (UTs).

3.1	**3.2**	**3.3**	3.4	3.5	3.6	3.7
3.8	3.9	3.a	3.b	3.c	3.d	

NATIONAL INDICATORS USED

SDG GLOBAL TARGET	INDICATOR SELECTED FOR SDG INDIA INDEX	NATIONAL TARGET VALUE FOR 2030
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	1. Maternal Mortality Ratio	70
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	2. Under-five mortality rate per 1,000 live births	11
	3. Percentage of children aged 12-23 months fully immunized (BCG, Measles and three doses of Pentavalent vaccine)	100
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	4. Annual notification of Tuberculosis cases per 1 lakh population	0
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	5. Number of governmental physicians, nurses and midwives per 1,00,000 population	550

5. Child Immunisations from 2018-19 to 2020-21

Table 57: Total Immunisations in Delhi from 2018-19 to 2020-21

Vaccines	2018-19	2019-20	% change from 2018-19 to 2019-20	2020-21	% change from 2019-20 to 2020-21
Child Immunisation					
Vitamin K1 (Birth Dose)	1,88,843	2,05,791	8.97%	1,52,583	-25.86%
BCG	2,93,105	2,90,204	-0.99%	2,13,953	-26.27%
DPT1	13,791	12,007	-12.94%	8,141	-32.20%
DPT2	9,348	8,118	-13.16%	5,710	-29.66%
DPT3	8,102	7,507	-7.34%	4,934	-34.27%
Pentavalent 1	3,09,913	3,03,665	-2.02%	2,47,661	-18.44%
Pentavalent 2	2,94,111	2,96,126	0.69%	2,38,789	-19.36%
Pentavalent 3	2,88,645	2,94,431	2.00%	2,31,411	-21.40%
OPV 0 (Birth Dose)	2,51,460	2,56,221	1.89%	1,82,639	-28.72%
OPV1	3,17,830	3,07,453	-3.26%	2,47,137	-19.62%
OPV2	2,97,365	2,98,484	0.38%	2,37,825	-20.32%
OPV3	2,90,004	2,95,593	1.93%	2,29,104	-22.49%
Hepatitis-B0 (Birth Dose)	2,33,124	2,43,103	4.28%	1,76,323	-27.47%
Hepatitis-B1	11,822	9,966	-15.70%	6,613	-33.64%
Hepatitis-B2	8,011	7,084	-11.57%	4,620	-34.78%
Hepatitis-B3	6,863	6,906	0.63%	3,972	-42.48%
Inactivated Polio Vaccine 1 (IPV 1)	3,00,112	2,97,857	-0.75%	2,45,118	-17.71%
Inactivated Polio Vaccine 2 (IPV 2)	2,79,734	2,90,844	3.97%	2,28,315	-21.50%
Rotavirus 1	11,586	2,00,446	1630.07%	2,46,842	23.15%
Rotavirus 2	8,747	1,53,907	1659.54%	2,36,956	53.96%
Rotavirus 3	6,408	1,22,344	1809.24%	2,27,267	85.76%
Child Immunisation (9-11months)					
Measles and Rubella (MR)- 1st Dose	2,56,286	3,09,272	20.67%	2,40,598	-22.21%
Measles 1st dose	48,408	5,436	-88.77%	7,305	34.38%
JE 1st dose	43	286	565.12%	94	-67.13%

Child Immunisation (After 12 months)					
Measles and Rubella (MR)- 1st Dose	10,694	12,032	12.51%	12,082	0.42%
Measles-1st dose	3,184	1,659	-47.90%	918	-44.67%
Child Immunisation (16-24 months and booster)					
Measles and Rubella (MR)- 2nd Dose	15,137	2,74,712	1714.84%	2,34,272	-14.72%
Measles 2nd dose	10,315	8,919	-13.53%	7,960	-10.75%
DPT 1st Booster	3,02,650	2,98,570	-1.35%	2,44,717	-18.04%
OPV Booster	3,03,520	2,98,231	-1.74%	2,43,042	-18.51%
Measles, Mumps, Rubella (MMR) Vaccine	2,66,228	19,873	-92.54%	6,695	-66.31%
Typhoid	2,54,312	20,117	-92.09%	3,03,346	1407.91%
Immunisation Sessions					
Immunisation sessions planned	1,39,825	1,32,664	-5.12%	85,875	-35.27%
Immunisation sessions held	1,35,927	1,28,664	-5.34%	81,614	-36.57%
Number of Immunisation sessions where ASHAs were present	79,826	81,768	2.43%	48,534	-40.64%

6. Major Types of Contraceptive Methods

Intrauterine Contraceptive Devices (IUCDs):
A small flexible, plastic device, usually with copper, is inserted into the womb by a qualified medical practitioner, after menstruation, abortion, or 4-6 weeks after delivery. It prevents the fertilized egg from settling in the womb. Copper ions have spermicidal activity. It is 95–98% effective, does not interfere with intercourse and can be removed when pregnancy is desired. It may cause heavy bleeding in some women. Pelvic inflammation in women, especially those exposed to STDs, may occur. Sometimes the IUD loosens and detaches and hence should be checked periodically. It may increase risk of ectopic pregnancy. It is unsuitable for women with cervical or pelvic infection, uterine fibroids, heavy menstruation, or unexplained vaginal bleeding. Two popular contraceptive devices used are *CuIUCD 380A (10 Years) and CuIUCD 375(5 years).*

Injectable Contraceptive-MPA (Under Antara Programme):
It is a hormonal contraceptive method for women that prevent pregnancy for three months. It prevents monthly ovulation, thickens cervical mucus thus blocking sperms from meeting eggs and makes implantation of fertilized eggs difficult. It needs to be administered every 3 months. It can easily be administered in the arms, thighs or buttocks. The date of subsequent dose may be remembered from the MPA card provided. It is a long-term effective, reversible method of contraception, suitable for breastfeeding women (after 6 weeks of childbirth) and does not require daily attention.

Chhaya (Centchroman):
Chhaya is a non-hormonal, non-steroidal, once a week contraceptive pill. Chhaya prevents implantation of fertilized egg in the uterus. For the first three months two pills are to be taken every week. From 4th month one pill has to be taken every week. The first pill can be taken on the first day of the menstrual cycle or any other day provided pregnancy has been ruled out. Chhaya is an effective reversible method of contraception. It is safe for women of all age groups and breastfeeding women, even immediately after childbirth. Return to fertility on stopping the pills is also prompt.

ECP (Emergency contraceptive pill):
This Method of Contraception that is used within 72 hours of unprotected intercourse to prevent pregnancy also called "Morning after" or post-coital contraception. The Government of India guidelines for Emergency Contraception recommend use of Levonorgestrel (progestogen only) NG 0.75 mg as a "dedicated product" for effective emergency contraception. The Drug Controller of India has approved only Levonorgestrel for use as ECP. It prevents pregnancy by inhibiting or delaying ovulation, altering the survival mucosa, altering the endometrial leading to impair endometrial receptivity to implantation of fertilizing egg. Any woman can use emergency oral contraception if she is not already pregnant. The ECPs should be taken as soon as possible after unprotected intercourse. Only one tab of 1.5 mg or two tabs of 0.75 mg stat should be taken within 72 hours after intercourse.

Male Sterilisation (Vasectomy):
A permanent surgical method in which the vasa deferentia which carry the sperms from the testes to the penis, are blocked. This prevents the sperms from being released into the semen at the time of ejaculation. It is a simple and reliable method not requiring hospitalization. Contrary to popular belief, it does not affect health; neither does it interfere with intercourse.

Female Sterilisation (Tubectomy):
Tubal ligation or tubectomy is a surgical procedure for female sterilization in which the fallopian tubes are permanently blocked or removed. This prevents the fertilization of eggs by sperm and thus the implantation of a fertilized egg. Tubal ligation is considered a permanent method of sterilization and birth control. Tubectomy is however likely to have more risks and complications as compared to vasectomy.

7. Criteria for Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana

Exclusions of Medication: Out- patient care, Individual diagnostics (for evaluation), Drug rehabilitation program, Cosmetic related procedures, Fertility related procedures, Transplants involving organs etc.

Beneficiary Inclusions: In Urban areas include occupational criteria such as Rag pickers, Beggars, Domestic workers, Street vendors, Cobbler, hawkers, Construction workers, Plumbers, Masons, Painters, Welders, Sweepers Sanitation workers, Mali, Home-based workers, Artisans, Handicrafts workers, Tailors, Transport workers, Drivers, Conductors, Helpers, Rickshaw pullers, Shop workers, Assistants, Peons, Attendants, Waiters, Electricians, Mechanics, Assemblers, Repair workers, Washer-men, Chowkidar. All eligible families are identified with valid Yellow, Orange, Antyodaya, and Annapurna ration card (irrespective of date of issue of Ration Card or the inclusion of the beneficiary's name therein) coupled with any Photo ID proof.