Demographic Profile & Health Care Delivery System

Demographic Profile:

Uttar Pradesh is the most populous state with 199.6 million people and Lakshadweep the least populated with 64,429 people. The contribution of Uttar Pradesh (UP) to the total population of the country is 16.5% followed by Maharashtra (9.3%), Bihar (8.6%), West Bengal (7.6%), Andhra Pradesh (7.0%) and Madhya Pradesh (6.0). The combined contribution of these six most populous States in the country accounts for 55% to the country's population.

The state of Uttar Pradesh has an area of 240,928 sq. km. and a population of 199.6 million. There are 18 revenue divisions, 75 districts, 822 blocks and 107452 villages. The State has population density of 689 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 25.85 (against 20.02% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

It has been noticed in 2011 that the absolute increase in population is more in urban areas than in rural areas. The current Rural – Urban distribution is 68.84% & 31.16%. Level of urbanization has increased from 27.81% in 2001 to 31.16% in 2011. The proportion of rural population declined from 72.19% to 68.84% over this period. Between 2001 and 2011, the population of the country increased to 199.6 million (17.58 %), of which in rural areas the increase was of 90.4 million (12.1 %) and for urban areas the increase was 91.0 million (31.8 %).This spurt in population of urban areas in the country could be attributed to – Migration, natural increase and inclusion of new areas in 'Urban'

Service Delivery System:

In Health Infrastructure, the State has two Directorates each one is head by (i) Director General, Medical Health services, (ii) Director General, Family Welfare. All the health programmes are being implemented by both the Directorates. NRHM has a separate unit- "State Project Management Unit (SPMU)" for effective programme management of NRHM. Programme Managers, for each component of NRHM are designated as 'General Manager'. Most of the staff has been hired on contract; some have been brought on deputation. Programme management units (PMUs) have also been established in 18 divisional PMUs, 75 Districts PMUs and 820 Block PMUs. State Institute of Health & Family Welfare (SIHFW), Directorate of Family Welfare, Directorate of Medical Health and Directors (MH and FW) are involved in effective programme management.

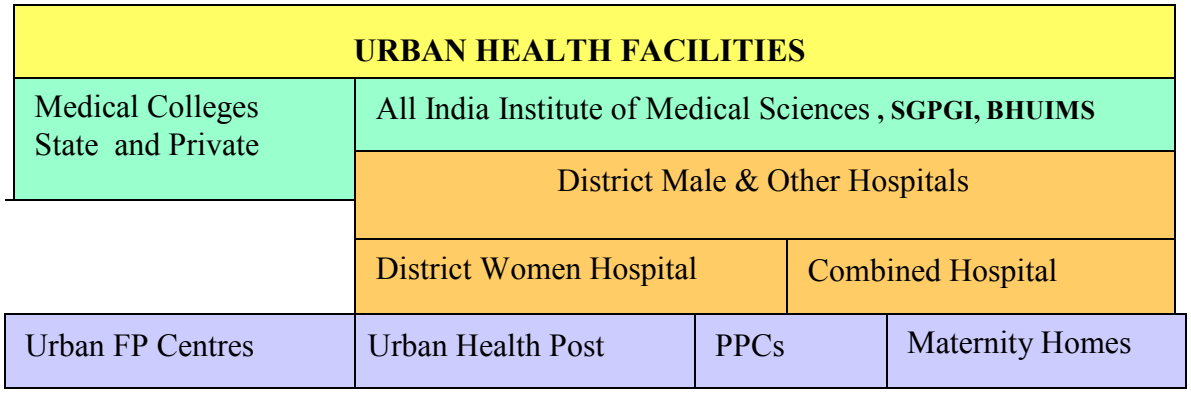
At Divisional level Additional Directors are providing leadership for implementation of programme and Divisional PMU is working as monitoring cell . In districts ,Chief Medical Officer is the in charge of health department and Chief Medical Superintendents of Male, Female and Combined hospitals are the heads of the hospitals.

Health services are being provided by District Male, Female and combined hospitals Community Health Centres, Primary Health Centres and Health Sub centre.

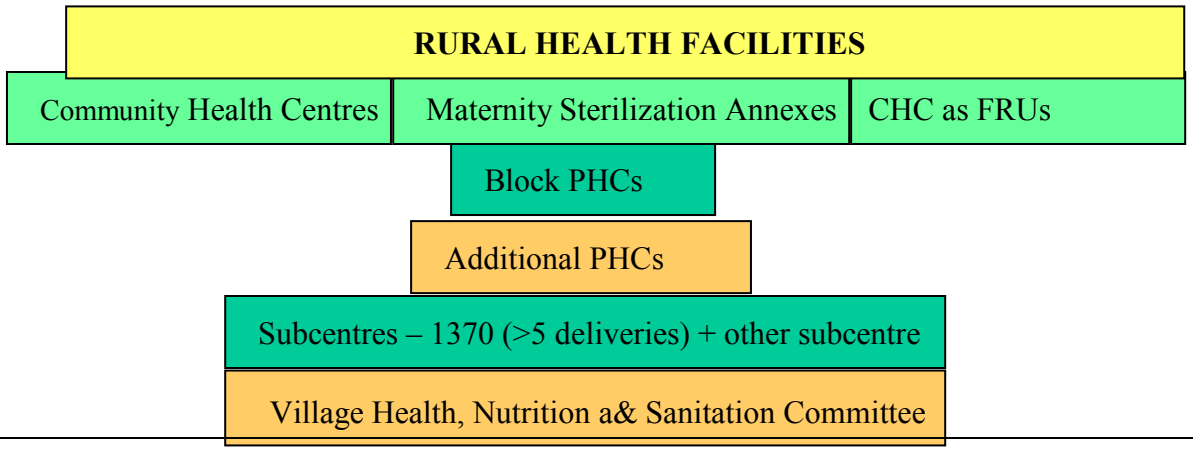
The health services are provided through a huge network of facilities both in urban and rural areas. Still the Urban Population in Uttar Pradesh has been Increasing rapidly in recent decades along with rapid urbanization .As per 2011 census, 4.44 crores persons are residing in towns and cities of Uttar Pradesh.

The health status of people in Uttar Pradesh is amongst the lowest in the country, especially for the urban poor. To improve the health status of the urban poor by provisioning of quality Primary Health Care services and decentralized health facilities it is pertinent to ensure one urban health post (UHP) per 50,000 populations having urban slum of 20000-30000 population in the city. Lot more needs to be done in this area as the number of operational UHPs/Centres is very less and unable to cater to the need of the urban slum population and reducing the work load of District Women Hospitals.

Health care network is poor in urban areas.



Health Infrastructure in Rural Areas :



Vision, Objectives & Structure of NRHM

Vision of NRHM:

National Rural Health Mission (NRHM) provided the strong, framework for implementation of primary level healthcare services by the Ministry of Health and Family Welfare (MoHFW) for the period, 2005-2012 and extended as II phase for the period – 2012-2017. NRHM is the response to the urgent need to transform the Indian Public Health System into an accountable, accessible and affordable system that provides quality services to its users.

NRHM operates as an omnibus broadband programme by integrating all vertical health programmes of the Departments of Health and Family Welfare including Reproductive & Child Health Programme and various diseases control Programmes. The NRHM has emerged as a major financing and health sector reform strategy to strengthen States Health Systems.

Objectives of the Mission:

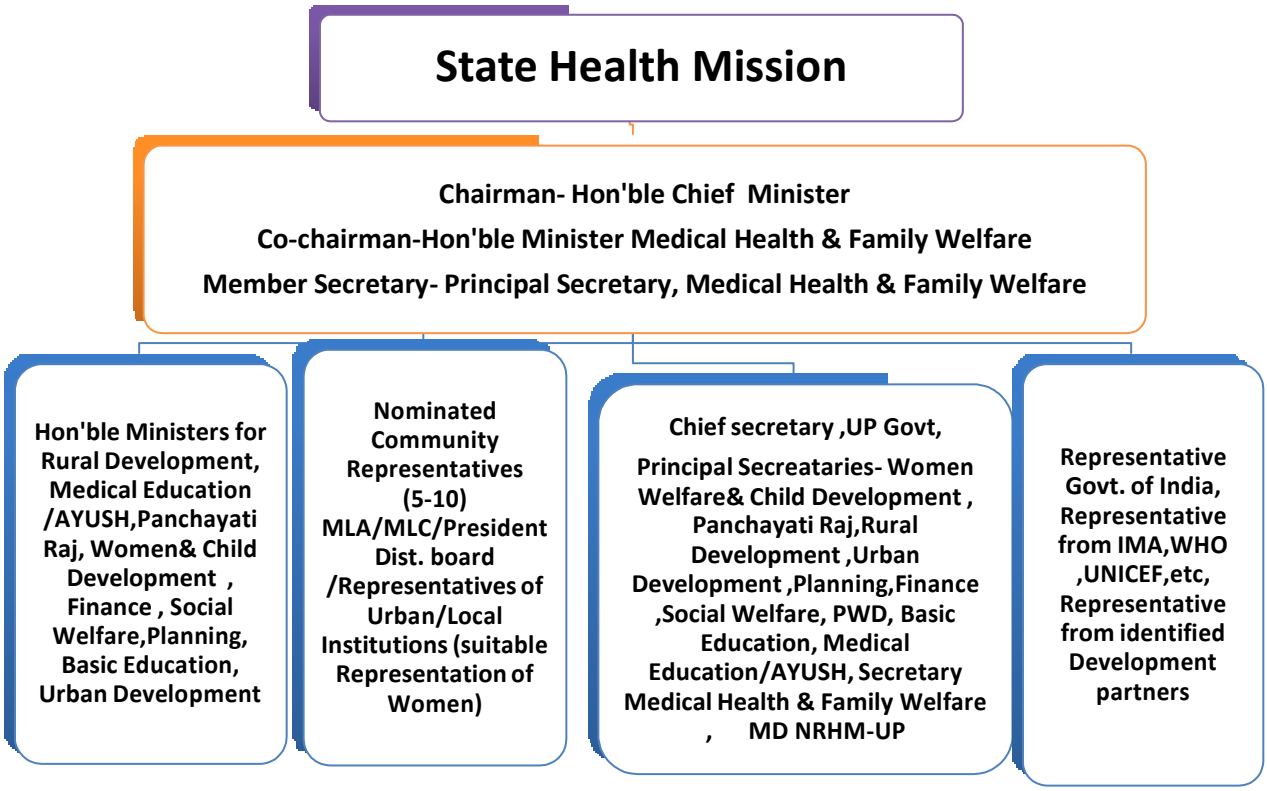
The aim of National Rural Health Mission is to ensure effective and quality healthcare, especially to the poor and vulnerable sections of the society. It is being implemented in the State with the aim of reducing Infant Mortality Rate & Maternal Mortality Ratio, ensuring Population Stabilization, Prevention & Control of Communicable & Non-communicable diseases. Significant progress has been made in terms of implementation of various activities under NRHM. A number of new schemes have also been launched over a period of time.

The overall objective of the State is to have the highest attainable standards (IPHS) of services at the public health institutions coupled with the recent technical advances in terms of well equipped facilities and adequate skilled manpower at every level.

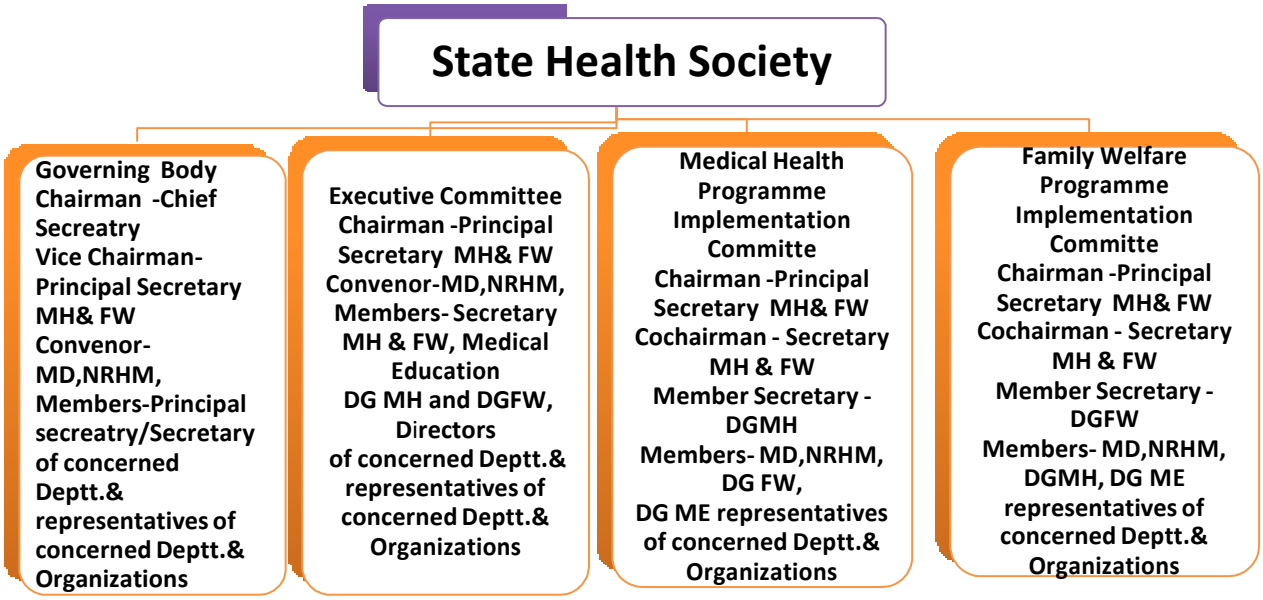
- Access to integrated comprehensive primary health care.
- Universal access to Public services for food, nutrition, sanitation, hygiene & public health care services.
- Reduction in maternal & child mortality.
- Prevention & control of communicable & non communicable diseases.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.
- Address inter-state and inter-district disparities.
- Time-bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary healthcare.
- To ensure the safety of the patient and of the healthcare worker.

Structure of Mission:

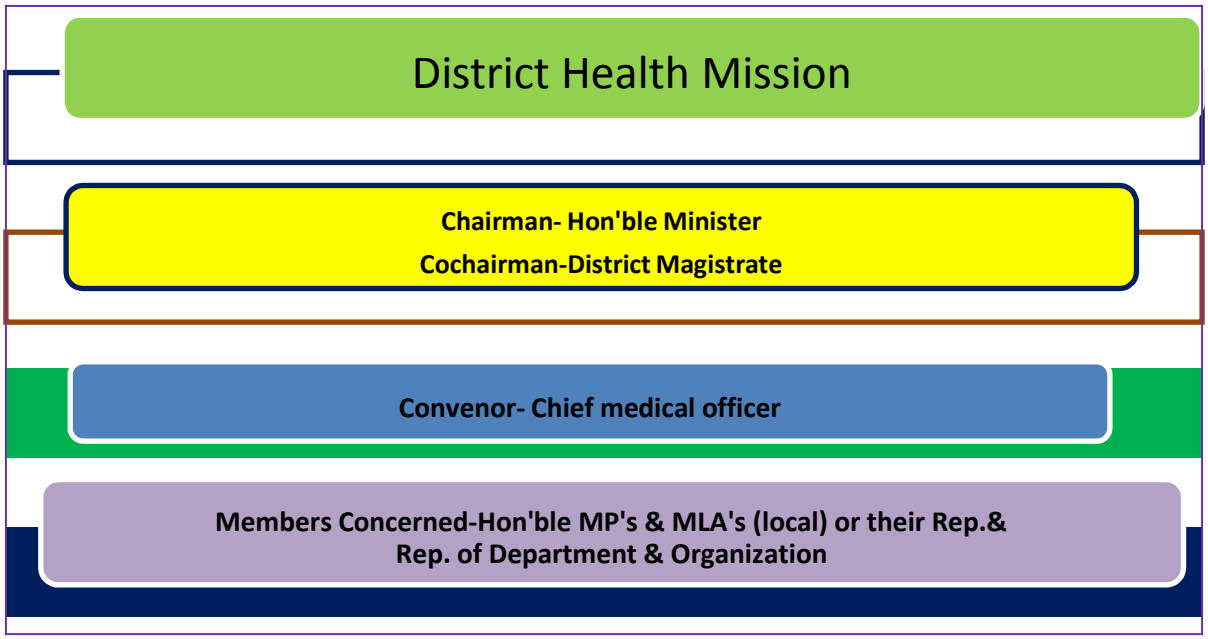
State Health Mission: State Government has set the State Health Mission headed by the Chief Minister for providing guidance to State Health Mission activities. Functions under the mission would be carried out through the State Health Society . Constitution of State Health Mission is given as below:

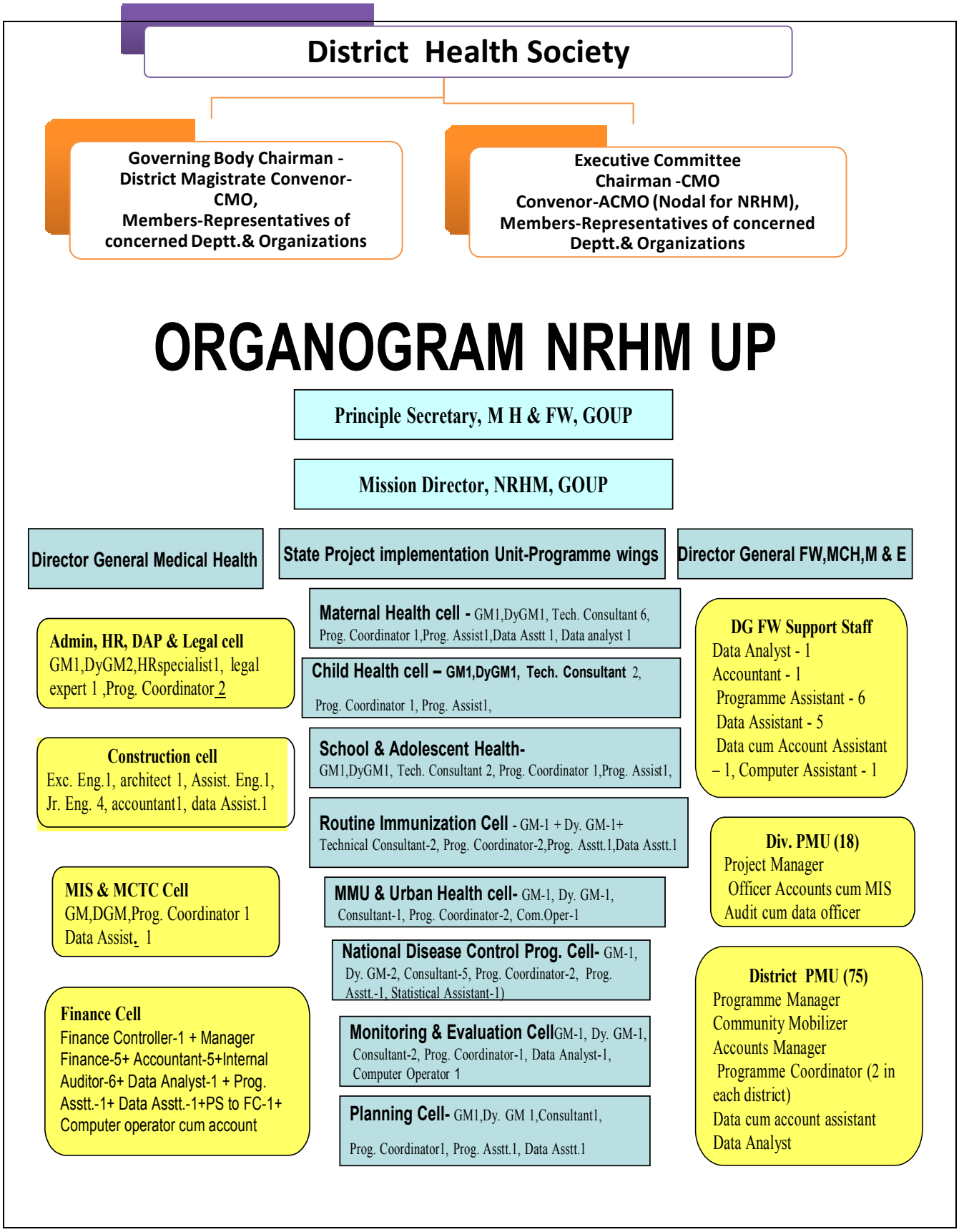


State Health Society: The State has merged existing State level vertical societies in the health sector and created an integral Society, called State Health Society. State Health Society has two bodies. Governing Body of the State Health Society is being headed by Chief Secretary. The rules/ by laws of State Health Society provide for a permanent secretariat headed by Mission Director and multidisciplinary team of experts and consultants to provide management support to mainstream implementing agencies. Secretariat of the State Health Society is also performing the function of State Health Mission.



District Health Mission: State has ordered merger of all District Level Vertical Societies into an integrated District Health and Family Welfare Society. District Health Mission shall guide the integrated District Health Society in Policy and operations.




District Health Society
Governing Body Chairman - District Magistrate Convenor- CMO, Members-Representatives of concerned Deptt.& Organizations
Executive Committee Chairman -CMO Convenor-ACMO (Nodal for NRHM), Members-Representatives of concerned Deptt.& Organizations
ORGANOGRAM NRHM UP
Principle Secretary, M H & FW, GOUP
Mission Director, NRHM, GOUP
Director General Medical Health
State Project implementation Unit-Programme wings
Director General FW,MCH,M & E
Admin, HR, DAP & Legal cell GM1,DyGM2,HRspecialist1, legal expert 1 ,Prog. Coordinator 2
Construction cell Exc. Eng.1, architect 1, Assist. Eng.1, Jr. Eng. 4, accountant1, data Assist.1
MIS & MCTC Cell GM,DGM,Prog. Coordinator 1 Data Assist. 1
Finance Cell Finance Controller-1 + Manager Finance-5+ Accountant-5+Internal Auditor-6+ Data Analyst-1 + Prog. Asstt.-1+ Data Asstt.-1+PS to FC-1+ Computer operator cum account
Maternal Health cell - GM1,DyGM1, Tech. Consultant 6, Prog. Coordinator 1,Prog. Assist1,Data Asstt 1, Data analyst 1
Child Health cell – GM1,DyGM1, Tech. Consultant 2, Prog. Coordinator 1, Prog. Assist1,
School & Adolescent Health- GM1,DyGM1, Tech. Consultant 2, Prog. Coordinator 1,Prog. Assist1,
Routine Immunization Cell - GM-1 + Dy. GM-1+ Technical Consultant-2, Prog. Coordinator-2,Prog. Asstt.1,Data Asstt.1
MMU & Urban Health cell- GM-1, Dy. GM-1, Consultant-1, Prog. Coordinator-2, Com.Oper-1
National Disease Control Prog. Cell- GM-1, Dy. GM-2, Consultant-5, Prog. Coordinator-2, Prog. Asstt.-1, Statistical Assistant-1)
Monitoring & Evaluation CellGM-1, Dy. GM-1, Consultant-2, Prog. Coordinator-1, Data Analyst-1, Computer Operator 1
Planning Cell- GM1,Dy. GM 1,Consultant1, Prog. Coordinator1, Prog. Asstt.1, Data Asstt.1
DG FW Support Staff
Data Analyst - 1
Accountant - 1
Programme Assistant - 6
Data Assistant - 5
Data cum Account Assistant – 1, Computer Assistant - 1
Div. PMU (18)
Project Manager
Officer Accounts cum MIS
Audit cum data officer
District PMU (75)
Programme Manager
Community Mobilizer
Accounts Manager
Programme Coordinator (2 in each district)
Data cum account assistant
Data Analyst

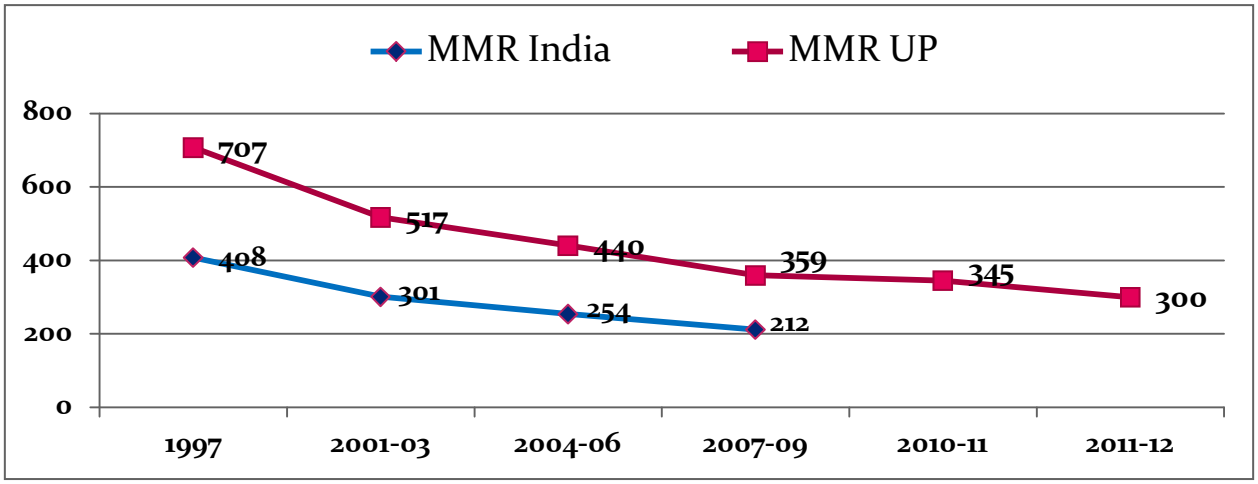
Goals & Achievement during 1st Phase of NRHM (2005-12)

Goals and Achievements during 1st phase (2005-12)

Sr. No.	Indicator	Unit	Status in the beginning 05-06		Targets for 2012		Achievement 2012	
			India	U.P.	India	U.P.	India	U.P.
1.	Infant Mortality Rate (SRS)	Per thousand	58	73	--	--	44	57
2	Maternal Mortality Rate (SRS)	Per lac live births	301 (01-03)	517 (01-03)	100	258	212 (07-09)	359 (07-09)
3	Total Fertility Rate (NFHS)	Per productive couple	2.9 (NFHS-2)	4.1 (NFHS-2)	2.1	2.8	2.7 (NFHS-3)	3.7 (NFHS-3)
4	Institutional Delivery	Percentage	40.9 (NFHS-3)	20.6 (NFHS-3)	70	70	72.9 (CES-2009)	62.1 (CES-2009)
5	Complete immunization	Percentage	54 (DLHS-III)	30.3 (DLHS-III)	100	100	61.0 (CES-2009)	40.9 (CES-2009)
6	Sex ratio (Census data)	Per thousand	927 (2001)	916 (2001)	935	924	916 (2011)	899 (2011)

Maternal Health:

Maternal Mortality in the state has continued to remain high for several decades but with introduction of several programme packages during last 15 years, the MMR has started declining. However there is still long way to go to achieve the declined objective for the state under NRHM programmes i.e. MMR 100/100000 live births.



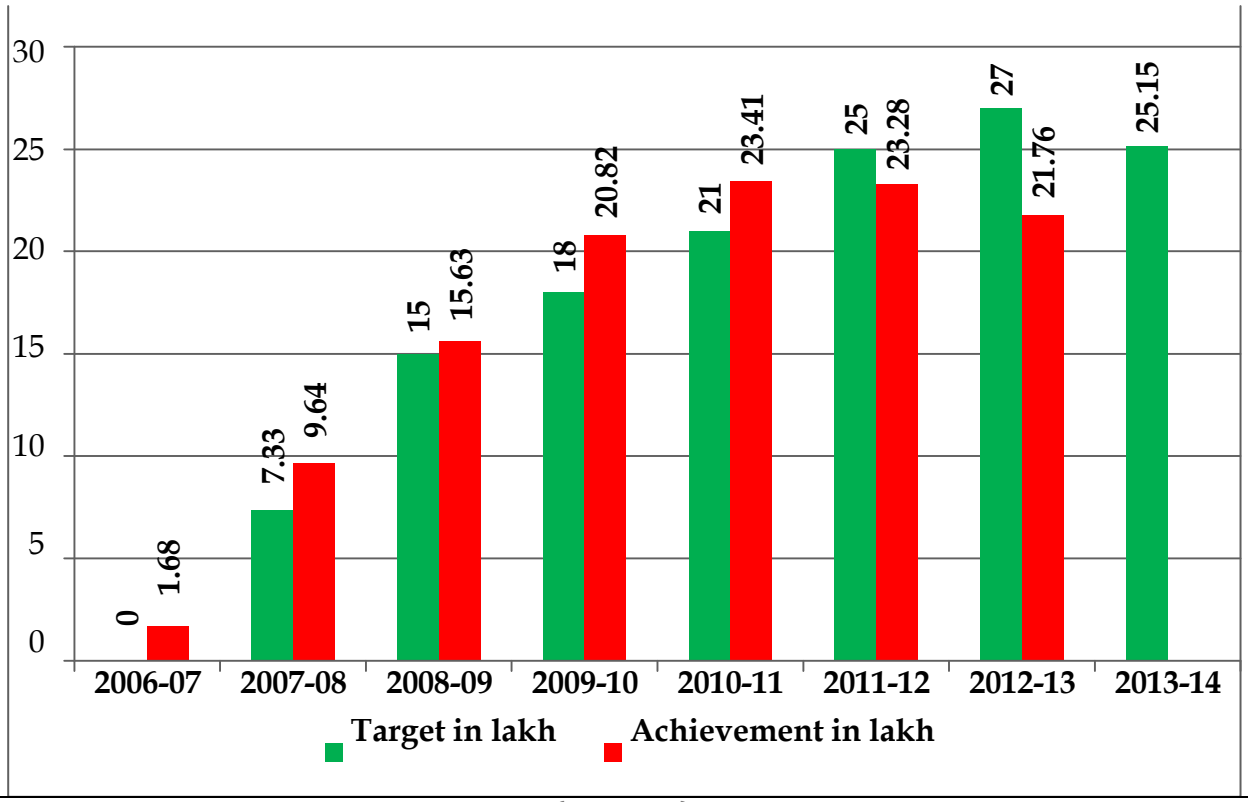
The implementation of focus interventions under NRHM such as Janani Suraksha Yojana has helped in increasing institutional deliveries and bringing down MMR. The affords have been made to operationalize more facilities such as FRUs and 24X7 BPHCs/CHCs, accreditation of Subcentres have also contributed in minimizing the tremendous case load of deliveries at District Women Hospitals.

State progress at a glance on key maternal health indicators is given below:

Indicators in %	DLHS III (2007-08)	CES (2009)	HMIS (2010-11)	HMIS (2011-12)
Any ANC	64.4	71.6	96.92%	88.6%
3 + ANCs	21.9	38.2	71.11%	68.5%
Full ANC	2.8	12.4	NA	NA
Institutional Delivery	24.5	62.1	43.59%	43.2%
Home Delivery	74.5		20.30%	27.5%
% of C-Sections out of total institutional deliveries				3.3%

Source: *NFHS III(2005-06)

Achievements: JSY achievement over the years



Specific Objectives	Specific Implementation strategy
Objective - 1	Strategy -1
To increase complete ANC from 2.8% to 40% (DLHS III)	Strengthening outreach services
Objective - 2	Strategy - 1 Implementation of JSY
To increase institutional delivery from 43.9% to 50% in Public sector	Strategy - 2 Support for Operationalization of L-1 MCH Centre (SC Delivery Points)
	Strategy -3 Operationalization of Level-2 MCH services at all BPHC and selected APHCs
Objective -3	Strategy - 1 Operationalization of FRU selected as L-3
To increase access to emergency obstetric care (increase C-Section Rate from 3.68% to 6 % in public sector**)**	Strategy - 2 Implementation of JSSK at all 132 functional FRUs
Objective -4	Strategy -1 Early detection through regular screenings in OPD and treatment at all district level facilities.
Reduce incidence of RTI/STI	Strategy - 2 Similar services at Sub district level (PHC/CHC) in 16 NACP HPDs
Objective -5	Strategy : 1 Making available Comprehensive Abortion Care services at all district level L-3 MCH centres
Reduce incidence of unsafe abortion	
Objective -6	Strategy -1 To ensure reporting of 40% of expected maternal deaths in the districts
Institutionalization of Maternal death Audit system	Strategy -2 To ensure maternal death Audit of 50% of the deaths reported
Objective -7	Strategy -1 Establishment of QAC at all levels
Improve Quality of services	Strategy -2 Improve quality of delivery services at all levels at all levels

Support to implement the JSSK schemes:

- Govt. order in support to Janani Shishu Suraksha Karyakram (JSSK) has been issued for total user free services at government facilities
- The state & district programme officers have been nominated and oriented
- In phase one JSSK implemented in 165 unit (all DWHs, all combined hospitals & CHCs designated as FRUs)
- Food facility is available in 134 facilities

From 2006 to 2010- Initially very good response. Institutional deliveries increased from 20.3% to 62.1% in 4 years.

>80% deliveries were accompanied by ASHAs

Contractual ANMs and staff nurses were provided

More number of Sub centers were accredited

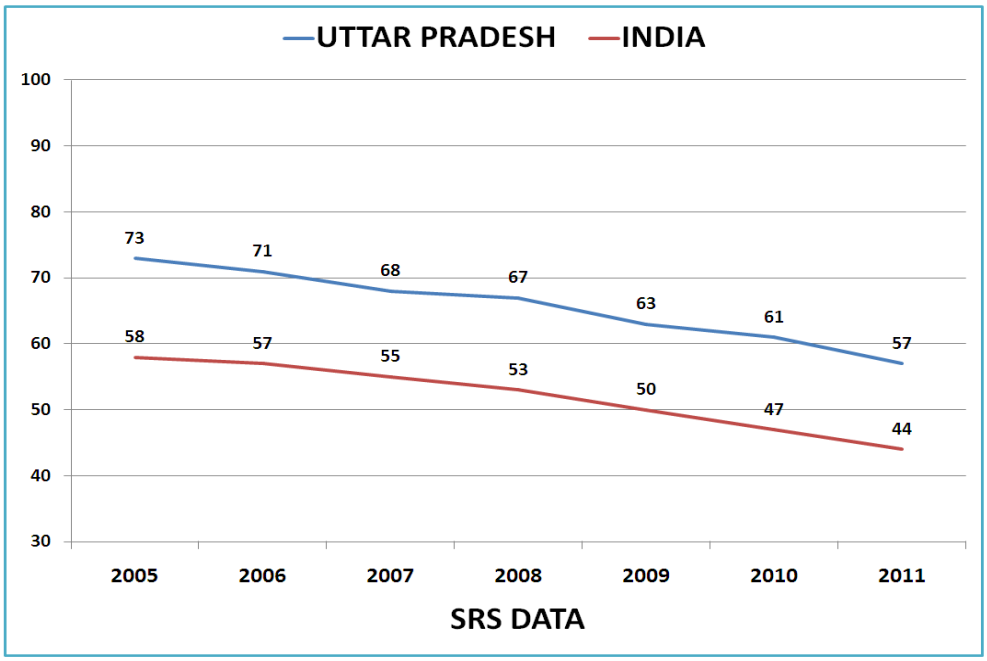
Focus on strengthening delivery facilities through RKS/Untied funds

2011 onwards- Fall in achievement started due to

- With increased load riders were inserted for payments- Photo identity proof made mandatory for Beneficiaries, ASHA incentives were restricted to their respective areas only
- CAG/CBI inquiry led to blocking of fund flow hence Institutional deliveries accompanied by ASHAs decreased
- MCTS enrolment of pregnant woman made mandatory for ASHA payments

Child Health :

Infant Mortality rate has been declining by 2 points every year since the inception of NRHM in the State. The fall was by 4 points between year 2008-09, but in the year 2010 it has declined by 2 points only. Again in the year 2010 -11 it has been decreased from 61 to 57 (4 points)



Child health indicators

Child Mortality	**Survey reference**				
	NFHS I	**NFHS II**	**NFHS III**	**SRS 2010**	**SRS 2011**
Neo Natal Mortality Rate	59.9/1000 LB	54.9/1000 LB	59.4/1000 LB	45/1000 LB	
Infant mortality Rate	69 (SRS 2007)	67 (SRS 2008)	63 (SRS 2009)	61 (SRS 2010)	57 (SRS 2011)
Under 5 Mortality		125/1000 LB	112/1000 LB	94/1000 LB	
Nutrition			**NFHS III**		
% of children (under 5 years) of age with anaemia			85.1		
% of children (under 5 years) who are underweight (< -3SD)			47.3		
% of children (under 5 years) who are severely wasted /SAM (< -3SD)			13.5		
Infant & Young Child Feeding			**DLHS III**	**NFHS III**	**CES 2009**
Children age <6 months exclusively breastfed			19.4	51.3	58.9
Children under 3 yrs. breastfed (within 1 hr after birth			15.4	7.2	15.6
Children (6-9 months) Complementary feeding			54.5	45.5	45.9
Diarrhoea & ARI			NFHS III	DLHS III	CES 2009
Children with Diarrhoea in the last 2 weeks who received ORS			12	17.3	29.2
Children with ARI or fever in the last 2 weeks who were given treatment at facilities			63.6	72.2	72.3
Vitamin A Supplementation			NFHS III	DLHS III	CES 2009
Percentage of children (age 9 months and above) received at least one dose of Vitamin A supplement			7.3	32.2	48.2

Achievements

Care of sick newborn:

- 7 Sick Newborn Care Units have been established to provide comprehensive management of the sick newborn, the efforts are being made to establish newborn Stabilization Unit (NBSUs) in all FRUs and Sick newborn Care units (SNCUs) in the district hospitals.

Sick Newborn care units in Lalitpur

Managing Children With Malnutrition

Status of Malnutrition in Uttar Pradesh - Like in other parts of India, malnutrition is an important public health problem in Uttar Pradesh. According to NFHS-3 (2005-06), 42% of children under three years are underweight (thin for their age), 52% of them are stunted (short for their age) and 19% are wasted (thin for their height). With specific reference to severe acute malnutrition (SAM), 5% of children below five years are severely malnourished. This means that there are over 13 Lakhs children below 5 years who suffer from severe acute malnutrition in the State. Total 6 NRCs have been established in 2010-11.

Child health Indicator under Malnutrition

Indicator	India	UP
Children under 3 years breastfed within one hour of birth (%)	23.4	7.2
Children age 0-5 months exclusively breastfed (%)	46.3	51.3
Children age 6-9 months receiving solid or semi-solid food and breastmilk (%)	55.8	45.5
Children under 3 years who are stunted (%)(chronically malnourished)	44.9	46.0
Children under 3 years who are wasted (%) (acutely malnourished)	22.9	13.5
Children under 3 years who are underweight (%)	40.4	47.3

Nutritional Rehabilitation centre in J.N. Medical College Aligarh

Immunization Programme

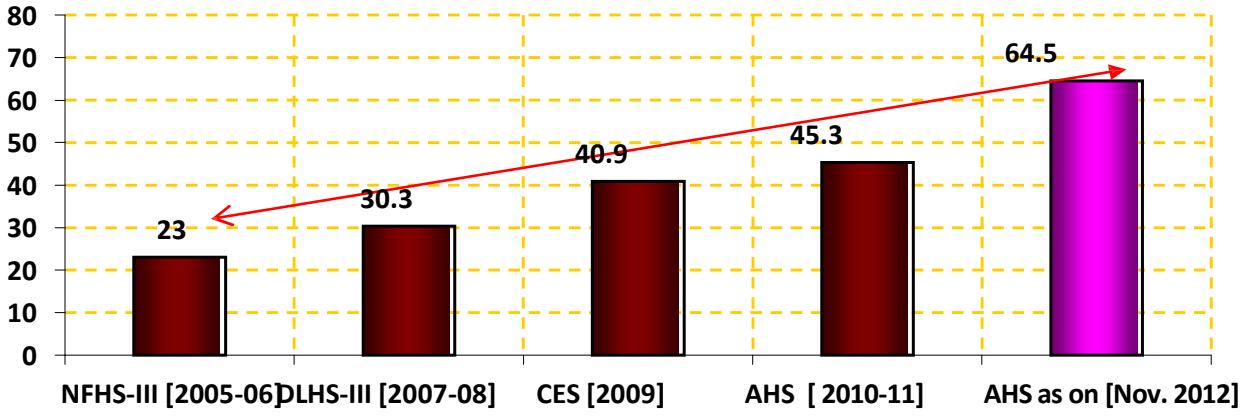
Routine Immunization Programme is the cornerstone of public health, world over. Vaccination was practiced in India since the early 1900s, especially against small pox, in late 1940's. In 1962, BCG inoculation was included in the National Tuberculosis Control Program. A formal programme under the name of Expanded Programme of Immunization (EPI) was launched in 1978. This gained momentum in 1985 under Universal Immunization Programme (UIP). UIP was merged in child survival and safe motherhood programme (CSSM) in 1992-93. Since 1997 immunization activities are an important component of Reproductive and Child Health (RCH) programme. A National Technical Advisory Group on Immunization (NTAGI) was set up in 2003, and a Midterm Strategic Plan (MTSP) developed in 2004. From April 2005, immunization is an important component of RCH-II under the National Rural Health Mission (NRHM).

In the state, the RI sessions are held for 2 days in a week – Wednesdays and Saturdays, thus 8 sessions per sub center per month are planned. The state proposes to hold 4-8 session in a month for any sub-centre as required according to its population and beside this immunization sessions are also being held in District Hospital, PPC, Urban Health Posts and outreach sessions in slums of big cities. Strategy aims to improve equity in access to immunization by targeting difficult-to-reach populations

State Level Coverage

Sl	Coverage	BCG	DPT	OPV	Measles	Fully Immunized
1.	**DLHS-3**	73.4	38.9	40.4	47.0	30.3
2.	**CES-2009**	76.4	58.1	53.9	52.8	40.9

JE vaccination has been included in 36 Districts in Routine Immunization and Hep. B vaccination is being implemented State since Oct 2011.



Steps taken for Improvement:

- Intensive micro planning and due lists have been prepared in all the Districts to cover left out and drop out children .
- Fixed sessions at facilities District Hospital (Male and Female), Combined Hospitals , CHCs, PHCs and Additional PHCs and UHPs
- Outreach sessions in outreach areas of Rural and Urban Slums
- Sessions in Urban Slums of 11 big cities and other cities having urban slum population
- Mobile sessions for vacant sub centre and Hard to reach areas
- Enlisting of all beneficiaries by "Pregnant Woman and Child Tracking Strategy" by ASHA, AWW and ANM
- Preparation of due lists of left out and dropout children
- Registration of PW and preparation of "Mother and Child Protection Cards"
- Registration and immunization of children (0-1year)
- ANM will collect relevant data in respect of all cases of pregnant women registered and children
- Computerization of all beneficiaries at Block level
- Maintenance of MCH registers and update of counterfoil
- Name wise Tally Sheet (Tracking formats) for beneficiaries in all RI sessions
- Routine Immunization Weeks

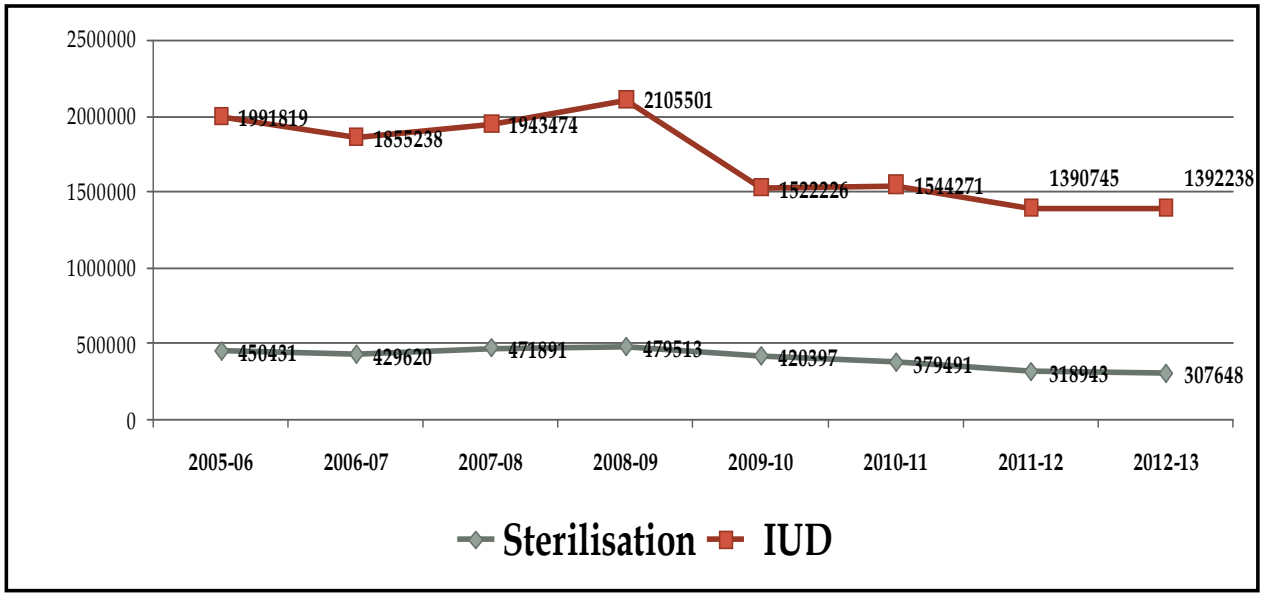
Family Planning Programme :

The Total Fertility Rate of the State is 3.7(NFHS III). The Population Policy of UP (2000) looks at the issues related to population stabilization and improvement of the health status of people, particularly women and children in a holistic manner. Total Fertility Rate (TFR) of Uttar Pradesh has declined from 4.1 to 3.7(NFHS 2 and NFHS 3). However; compared to the national average of 2.7, the rates are still very high. To enhance the performance of family Planning it is important to meet the desired unmet needs .The unmet need for spacing method has increased from 9% in 1998-99 to 12% in 2005-06.

As per the projections in the Population Policy of UP (2000), to reach the policy objectives of a replacement level of TFR of 2.1 by 2016, 12.1 Lakhs couples should be providing limiting method of family planning. In this endeavor UP is way behind.

Goals for Population Stabilization			
Target Area	**Baseline**	**Goals by 2012**	**Current status**
TFR	3.99%	2.8%	3.8 % (SRS 2009)
CPR	29.3% (NFHS 3)	44%	31.6 % (RHIS UP 2010)
Objectives to achieve goal			
CPR	25%	44%	43.6% (NFHS-3)
Sterilization	16.8%	31%	17.9%
Spacing	7.8%	13.2%	11.8%
Reduction of women reporting RTI/STI	34%	15%	20.5 (DLHS 3)

Achievement under Family Planning programme



Issues and Concerns

The following Constraints were noticed-

- Non availability of skilled service providers especially for NSV.
- Limited no. of facilities providing daily family planning services.
- Inadequate counseling of post partum and post abortion family planning services.
- Comprehensive spacing choices not reaching consistently to rural clients.
- Preference for male child has been a consistent barrier for TFR.
- Areas of missed opportunities did not trapped.

Following strategy has been adopted during the year to address the above mentioned issues.

- Deployment of family planning counselors to counsel women and address their concerns for small family norms along with counseling for adaptation of Post Partum family planning methods.
- Training of doctors and paramedical to provide special thrust on IUCD 380 A & post partum sterilization.
- Scaling up post partum IUCD 380-A programme to 30 centers covering 23 districts services.
- Scaling up No Scalpel Vasectomy. Strengthening of 3 Satellite Centers and one Centre of Excellence for Male Contraception (NSV) in the Medical Colleges of Lucknow, Meerut, Allahabad and Kanpur. Additional 2 centers are being proposed in District hospitals
- Partnership development for advocacy, leadership support with Population Foundation of India (PFI) and Scaling up partnership with RESPOND (engender health) from 9 to 15 districts, districts to promote NSV.
- UHI (Urban Health Initiative) is partnering for IEC/BCC activities by sharing 300 copies of films produced by JHU-CCP for promotion of Family planning methods, limiting and spacing both, to be used by FWCs in ANC Clinics and post partum wards.
- Implementation of BCC strategy for promotion and creating awareness related to family planning services including interpersonal communication, community engagement and mass media under NRHM.
- Involvement of private sector providers, accreditation of private facilities and service providers for family planning services.

Daily and Fixed day FP services:

All 51 District women hospitals, 15 DCHs and 66 FRUs (132) are providing female sterilization services on daily basis. In addition, 150 CHCs are providing fixed day services under "fixed day sterilization services" (ligation/abdominal tubectomy) are having a trained Gyn/ LMO preferably on Tuesdays and Fridays.

NSV camps in districts

Besides providing NSV services on regular basis, it is proposed that each district hospital will organize NSV camps.

Accreditation of Private centers /NGOs

In the year 2011-12, as accreditation was taken up by DHS very late in the year, only 38 private facilities were accredited for sterilization services in the state and around 4450 Sterilizations were compensated through them.

Post Partum Family Planning Services at Hospitals

Family Welfare Counselors: In view of large number of institutional deliveries under JSY scheme the Family Planning counselors were deployed, one per FRU to promote post partum family planning acceptance. 180 FWCs appointed in the last week of March 2011.

Promotion of Post Partum IUCD

Postpartum IUCD technique was piloted in the state at CSMMU, Lucknow in the year 2008-09 and doctors of District Women Hospital, Jhansi and Allahabad were trained in PPIUCD insertion technique through SIFPSA funds under technical supervision of JHIPIEGO, although Service delivery could not be started in that year. In the year 2010-11 standardization of the IEC material, follow up mechanism and reporting systems were developed and the programme implementation was expanded to Veerangana Avanti bai Mahila Chikitsalya, Lucknow as 4th center. In 2010-11 service delivery started in 4 centers after follow up. Support provided by trainers from CSMMU, Lucknow. In the year 2011-12, the programme was further expanded to 8 district women hospitals and 5 medical colleges (total 17 sites) and service providers could be trained from 11 sites (4 medical colleges and 7 DWH) (Table 1)and reporting on services delivery started from total 9 sites the achievement for the year 2011 – 12 was total of 735 PPIUCD

Pre-Conception, Pre-Natal Diagnostic Technique Act (PC&PNDT Act).

Sex ratio in the state is likely to create severe gender imbalance that can destroy the social fabric. It should also viewed both as child right issue (girls are killed either through sex selective abortions or die prematurely due to violence and neglect). Figures below indicate the trend in sex ratio over the years of India and Uttar Pradesh.

Year	1901	1911	1921	1931	1941	1951	1961	1971	1981	1991	2001	2011
India	972	964	955	950	945	946	941	930	934	927	933	940
UP	942	916	908	903	907	908	907	876	882	876	898	908

(Source: NRHM PIP- 2012-13)

But the results about the sex ratio among the children between ages 0 to 6 years have decreased remarkably at national as well as state level.

Year	Sex Ratio India	Sex Ratio UP
1991	945	927
2001	927	916
2011	914	899

National Programmes

Integrated Disease Surveillance Project (IDSP)

IDSP started in 2004 with support from World Bank, to improve and Integrated Disease Surveillance in pursuance of recommendations by high powered committees like Public Health System Committee, Technical advisory committee and committee of secretaries on Environmental Sanitation. In 2007 with Avian Influenza outbreak, human and animal components were added along with additional budget.

In Jan 2009 after detailed analysis of the situation, World Bank agreed to restructure the project and extend it for 2 years focusing on what can be achieved by the end of two years. Keeping this in mind PDOs (Project Development Objectives) was revised and a proposal for restructuring and extension of IDSP up to 2012 had been prepared.

The aim of establishing IDSP is to assist the Government to:

1. Survey a limited number of health conditions and risk factors.
2. Strengthen the linkages, data quality & analysis.
3. Improve lab support.
4. Train stakeholders in disease surveillance and action.
5. Coordinate and decentralize surveillance activities
6. Integrate Disease Surveillance at state and district level and involve communities specially Pvt. Sectors.

National Programme for control of blindness

India was first country to launch the National Programme for Control of Blindness in 1976. The goal of the programme was to reduce the prevalence of blindness. Out of the total estimated 45 million blind people (3/60) in the world, 7 million are in India and 1.85 million in Uttar Pradesh. This is due to the large population base and increased life expectancy. Every year 0.3% of the population, which means about 5.5 lac blind persons, are added to the total blind population. Out of 5.5 Lakhs total blind 3.5 Lakhs become blind every year due to cataract. As the number of cataract patient is reducing because of clearance of backlog, blindness due to degenerative diseases like diabetes and glaucoma and injuries related corneal opacities are increasing. The programme has to tackle emerging challenges

Goal – Prevalence rate of blindness in Uttar Pradesh is 1.0% (Survey-2004). Goal of the programme is to reduce prevalence rate of blindness to - 0.3% by the end of year 2020

Activities to achieve goal:

The main activities are - Cataract Surgery, School Eye Screening, Eye banking for keratoplasty and to treat Corneal Blindness. Other important activities are 'Management of diseases other than Cataract' such as Diabetic Retinopathy, Glaucoma management, Laser Techniques, Corneal Transplantation, Vitreoretinal Surgery and treatment of Childhood blindness)

National Leprosy Eradication Programme

In the National Leprosy Eradication Programme following main thrust areas have been identified during 12th Five Year Plan:

- Sustaining leprosy elimination at the state level
- Achieving elimination of leprosy i.e. prevalence of less than 1 case per 10,000 population in all the districts of the state
- Reduction in Grade-II disability through prevention of disability (POD) and reconstructive surgery of disabled persons affected by leprosy.

Performance under NLEP

SN	Indicators	2007-08	2008-09	2009-10	2010-11	2011-12
1.	No. of new cases detected (ANCDR/100,000)	31028 (15.9)	7577 (13.8)	27473 (13.4)	25509 (12.52)	24530 (12.03)
2.	No. of cases on record at year end (PR/10,000)	18254 (0.94)	16206 (0.81)	16484 (0.81)	15719 (0.77)	13939 (0.68)
3.	No. of Grade II disability among new cases (%)	471 (1.52)	555 (2.01)	594 (2.16)	645 (2.53)	671 (2.74)
4.	Treatment Completion Rate	91.32	91.26	92.81	93.1	94.78
5.	Reconstructive Surgery conducted	610	476	405	190	295

National Vector Borne Disease Control Programme

In the state of Uttar Pradesh, Vector borne diseases are a major public health problem. Malaria is prevalent in all 72 districts and a matter of concern in interstate border districts. Filaria continues to be endemic in 50 districts with a micro filarial rate of 1.5% and above, although there has been a steady decline in the cases in the last five years. Kala-azar is endemic in 4 districts of eastern UP, ie Kushi Nagar, Deoria, Ballia and Varanasi. In around 27 districts Japanese encephalitis is widespread and hyper endemic in 4 Districts viz Gorakhpur, Kushinagar, Deoria, Maharajganj. Rapid urbanization has contributed to the transmission of the Dengue in the state. Dengue is endemic in 54 districts and hyper endemic in 5 Districts viz Lucknow, Ghaziabad, Kanpur Nagar, Agra, G.B.Nager. Chikungunya, also caused by the Aedis mosquito is endemic in two districts viz Kanpur Nagar, Lucknow. Components of the Program

- Malaria Control Programme
- Filaria Control Programme
- Kala-azar
- Japanese Encephalitis
- Dengue & Chikungunya

National Goal

GOI in its National Health Policy (2002) had pledged commitment to reduce mortality on account of malaria by 50% by 2010 and efficient morbidity control and elimination of lymphatic filariasis by 2015.

Goals of NVBDCP

- Reduction in morbidity and mortality of all vector borne diseases.
- Prevention and Control of vector borne diseases by giving area specific priorities.
- Universal access to public health services and promotion of healthy life styles with the help of Integrated Vector Management.

NRHM Objectives

- Malaria: Annual Parasite Incidence of 1.3 and morbidity & mortality reduction rate 50% up to 2010, additional 10% by 2012.
- Filaria: Microfilaria Rate below by 1% in each endemic district. MDA Coverage more than 85% of population.
- Kala-azar: Cases less than 1 per 10,000 populations at sub district level.
- J.E.: Reduction in mortality rate by 50% taking the base of 2006.
- Dengue: Reduction in mortality rate by 50% taking the base of 2006.
- Chikungunya: Effective Control over Chikungunya morbidity.

Strategy for Prevention & Control of Vector Borne Diseases –

- Integrated Vector control (IRS, fish, Chemical & Bio-larvicide and Source Reduction)
- Early diagnosis & Complete Treatment
- Behaviour Change Communication
- Vaccination against J.E.
- No Specific drugs against Dengue, Chikungunya & J.E.
- Annual Mass Drug Administration for Lymphatic Filariasis Elimination

Objectives with their achievements having the base of 2005-06

Targets set by NVBDCP- NRHM	Achievements
Malaria morbidity and mortality reduction by 50 per cent by 2010	Malaria morbidity reduced by 36 percent and mortality reduced 100 percent by 2010.
Elimination of Falaria by 70 percent by 2010	Elimination of Falaria by 70 percent by 2010 is achieved.
Elimination of Kala-Azar by 2010	Elimination of Kala-Azar by 2010 is 80 percent achieved.
Reduction in Dengue mortality rate by 50 percent 2010	Reduction in Dengue mortality rate by 50 percent 2010, we achieved 80% so target is achieved
Effective control over Chikungunia morbidity	There are no cases of Chikungunia reported in last five years.

Objectives of the State

- Malaria Morbidity & Mortality reduction by 60% upto the year 2012 & 80% upto the year 2017.
- Elimation of Filaria by the year 2015 & 80% reduction upto the year 2012.
- Elimation of Kala-Azar by the year 2015 & 90% reduction upto the year 2012.
- Reduction of J.E. Mortality rate by 50% by 2017 having the base 2011.
- Reduction of Dengue Mortility rate by 50% by 2017 having the base 2011.
- Effective Control on Chikungunia Morbidity.

Malaria

Objectives

- To bring down annual incidence of malaria cases to less than 1 per 1000 at state level by the year 2017.
- To increase annual blood slides examination rate more than 10 per 1000 at state level by the year 2017.

Dengue & Chikungunia

Objective

- To reduce Dengue Mortality Rate by 50% by the Year 2017 having the base Year 2011.
- To reduce the incidence of Dengue & effective control on Chikungunia Morbidity.
- Strengthen the state wise surveillance mechanism for Dengue & Chikungunia
- Functional Sanctioned Surveillance Hospitals in all Endemic Districts/ Town/ Cities.
- Functional Rapid Response Teams in all the Endemic Districts.

As per guideline of GOI, the State of U.P. has established 22 Sentinel Surveillance Hospitals with Laboratory facilities, for enhancing the Dengue facility in the State. For backup support these institutes were linked with SGPGI, Lucknow, which has been identified as one of the Apex Laboratories in the Country with advanced diagnostic facility.

Strategy and Innovations Surveillance –

- Epidemiological Surveillance & Disease Management.
- Strengthening the existing surveillance.
- Strengthening referral surveillance.
- Epidemic preparedness & Rapid Response Team.
- Involvement of Private providers.
- Integrated Vector Management
- Effective Entomological Surveillance.
- Source reduction using Minor Engineering Method.
- Biological control, Larvicides (Biolarvicides).
- Larvicide (Chemical).
- Timly & Good quality of IRS is important & implemented with sound technical skill
- LLIN.

Operational Research Capacity Building-

- Training of ASHA in making Blood Smears.
- Training of ASHAs using Rapid Diagnostic Kit by MO/IC specified PHCs. Training of LTs of PHC in identifying Malaria parasite by Experts Pathologists & LTs.
- Training of Health Workers & Supervisors in making Solutions of Insecticides in using spray pumps & fogging machines by D.M.O.s & Malaria Inspector.

BCC/IEC activities -

- Information, Education & Communication before spraying and fogging operation about **precautions** to make it successful.
- Health Education Material supplied to ASHAs, Village Health Sanitation Societies, Health Sub Centres, P.H.C.s, C.H.C.s and other Govt Hospitals for proper display.

General Vector Control Strategy-

- Main strategy for control of vector borne disease is vector management.
- To control condition promoting mosquitoes breeding.
- One week day –Saturday to be made dry day (emptying over head tanks, coolers, defrost pans and plant pots etc.)
- Larvicide in open drains with stagnant water.
- Two round of IRS DDT -50% & three rounds of Malathian 25% WDP in High Risk Districts.
- Spray wages from state resource for technical skilled labours.
- Fogging by malathion technical at dawn and dusk.
- To control outdoor misquotes density in village affected with JE/AES (Larvicidal activity in morning).

Revised National Tuberculosis Control Programme

Goal – "Universal Access to TB Care", To ensure that all TB patients are registered and treated under the programme.

Objectives –

1. To achieve and maintain a cure rate of at least 85% among newly detected infectious (New sputum smear positive) cases
2. To achieve and maintain detection of at least 70% of such cases in the population

The State has identified priority areas for achieving the objectives planned

S.N.	Priority area	Activity planned under each priority area
1	Early identification of all infectious cases of TB	1 a) Improve integration with general health system and leverage field staff for home based case finding, improve communication and outreach
		1 b) Screening clinically and socially vulnerable groups for TB

S.N.	Priority area	Activity planned under each priority area
		1 c) Catch patients already diagnosed through better notification from all sources, better referral for treatment
2	To maintain 90% success rate for all new and 85% for re-treatment cases	2 a) Promptly and appropriately treating TB
		2 b) Making DOTS more patient friendly- more community DOT, better monitoring through Information Technology
		2 c) Improving partnerships between public and private sector
3	To scale-up treatment of Drug Resistant TB Cases	3 a) To achieve complete geographical coverage by end of 2012
		3 b) Strengthening of reference labs
		3 b) Strengthening of reference labs
4	To achieve decreased morbidity and mortality of HIV associated TB	4 a) Early, rapid TB diagnosis with high sensitivity tests for HIV-infected TB patients
		4 b) CPT/ART for all HIV-infected TB patients
		4 c) Full training coverage on intensified TB-HIV package, joint field visits of STC/UPSACS
	To improve outcomes of TB care in the private sector	5 a) Include lab. & pharmacies to detect patients at earliest points of care
		5 b) Increase involvement of private medical colleges
		5 c) Move from sensitization model to output-based contracting of services

National Iodine Deficiency Disorder Control Programme

Iodine Deficiency Disorders continue to be one of the major public health problems in India with around 200 million people estimated to be at risk. Uttar Pradesh with a population of 190 million is known to be IDD endemic and no district in the State is reported to be free from IDD. Iodine deficiency can be prevented by using salt that has been fortified with iodine. Iodine deficiency is particularly damaging during early pregnancy as it retards foetal brain development, resulting in a range of intellectual, motor and hearing deficits. Following disorders are associated with iodine deficiency:

- Goiter, Retarded mental & physical development
- Cretinism in children
- Repeated abortion & Still birth
- Poor school performance etc.

Magnitude of the problem in Uttar Pradesh State –

As per the NFHS-3, in Uttar Pradesh while 77 per cent of households are using iodized salt only 36% households use adequately iodized salt. Furthermore 23 per cent of the population in the state is using non-iodized salt, thus over twelve lakhs out of fifty-five lakh children born every year in the state are at a greater risk of not reaching their physical and mental development potential. The Coverage Evaluation Survey of 2009 shows the coverage with adequately iodised salt at 42.5%. NIDDCP focuses on the following:

- Survey and Resurvey every 5 years to know prevalence rate.
- Supply of only Iodized salt for human consumption (salt having 15 ppm Iodine at consumer level)
- Creating demand for Iodized salt especially in rural area.
- IEC & Health education

Goals & Objectives of state NIDDCP

- To bring down total Goiter rate (TGR) less than 10%
- To ensure 90% household consume Iodized salt by 2017 (15ppm Iodine at consumer level). Presently 77% of the households are consuming Iodized salt; only 36% households use adequately iodized salt.
- Supply of Iodized salt through Public Distribution System.

Physical Achievement under the programme –

- No kits were received from GOI in 2011. The testing results shared below are of the samples received directly from districts at IDD Cell and the sample report of USI Cells set up by UNICEF

SALT SUPPLY		
Year	**Allotment (Tonnes)**	**Supplies (Tonnes)**
2010 -11	777528	831861
2011-12	777528	443041 (upto Sep.2011)

National Programme for prevention control of deafness

National Programme for Prevention and Control of Deafness is newly introduced Programme which has been launched to prevent hearing impairments found in children.

The burden of deafness is relatively high in India with respect to world scenario.

As per estimate prevalence of severe to profound hearing loss is 291 per lac population (NSSO,
2001). 26.4 million of children in India are suffering from hearing loss which adversely effect their educational performance during their studies. Over 50 % causes of hearing impairment are preventable and 80 % of all deafness is avoidable by medical or surgical method.

Objective of the programme:

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

Long term objective: To prevent and control major causes of hearing impairment and deafness, so as to reduce the total disease burden by 25 % of the existing by the end of twelfth five year plan.

Phase wise coverage

YEAR 2006-2007- Gorakhpur & Barabanki
YEAR 2008-2009- Banda, Varansi and Lucknow.
YEAR 2009-2010- Agra ,Saharanpur and Moradadabad (included)
In Twelfth Five Year Plan we propose to add seven uncovered district under the programme in year2012-13 and ten to twelve districts each year subsequently.

Strategy

- Capacity building of District Hospital, Community Health Centre and Primary Health Centre.
- Identification of potential District hospital/ large hospital to provide preventive/screening / curative service on daily basis.
- To provide above services following action is proposed:

- Strengthening of district hospital in terms of equipment / instrument. Sound proof room for audiometry.

    - Adequate manpower will be ensured (one ENT specialist and one Audiologist at least at District level)
    - Skill development for service provider and paramedics
    - IEC for dissemination of information about availability of services / site/importance etc.

- Sensitization of service providers and paramedics PHN, MPW, CDPO, AWS, ASHA, teachers about NPPCD through training camps.
- Awareness generation in community through NGO, VHSC etc. through sensitization workshop with IEC support.
- Involvement of schools and ICDS for screening of children up to 14 years.
- The ENT department of CSMMU, Lucknow would be the Centre of Excellence which will support the programme in the state with provision of expertise for training as well as patient care and referral.

Proposed targets and strategy for Phase-II (2012-17)

Proposed Target for IInd Phase (2012-17)

Indicators	Current Status as per available data	Cumulative target for next five years	2012 -13	2013 -14	2014 -15	2015 -16	2016 -17
Maternal Mortality Ratio (MMR)	**359 (SRS- 2009)**	**200**	**310**	**280**	**250**	**225**	**200**
Infant Mortality Rate (IMR)	**57 (SRS -2011)**	**32**	**56**	**51**	**45**	**38**	**32**
Total Fertility Rate (TFR)	**3.7 (SRS -2009)**	**2.8**	**3.6**	**3.5**	**3.4**	**3.1**	**2.8**
Full Immunization	**40.9% (CES - 2009)**	**90%**	**50%**	**60%**	**70%**	**80%**	**90%**
Contraceptive Prevalence Rate (CPR)	**43.6% (NFHS- III)**	**53%**	**45%**	**47%**	**49%**	**51%**	**53%**
Institutional Delivery	**62.1% (CES – 2009)**	**85%**	**65%**	**70%**	**75%**	**80%**	**85%**

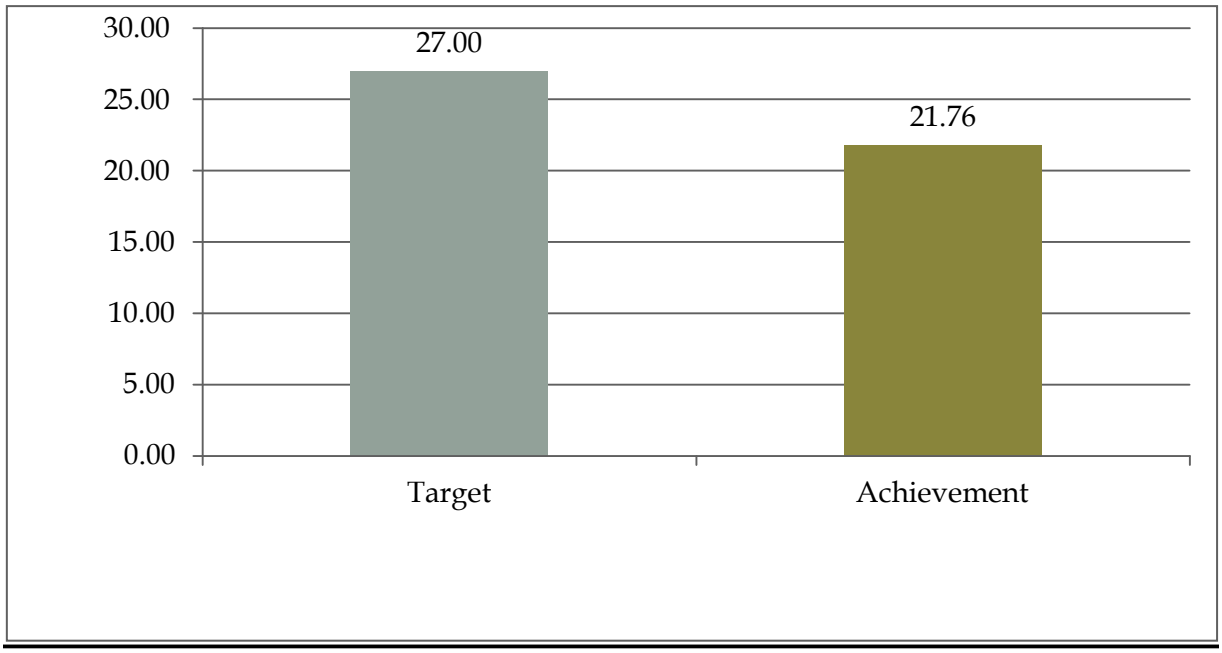
Service Delivery Targets

Indicators	DLHS-2 (2002-04)	DLHS-3 (2007-08)	CES -2009	State Targets		
				2012-13	2013-14	2014-15
Maternal Health						
Mothers who had 3 or more Ante Natal Check-ups	21.50%	21.80%	38.20%	4411778 (4 ANCs)	4813357 (4ANCs)	5227201 (4ANCs)
Institutional delivery in public health facilities (%)	22.40%	24.50%	62.10%	65%	70%	75%
Line listing and follow up of Severely Anaemic pregnant women (Nos.)	NA	NA	NA	76275	77538	78824

Child Health					
Full Immunization (%)	53.80%		50%	60%	70%
Line listing and follow up of Low Birth Weight babies RURAL Nos; (% of live births)			16% 707858	22% 991002	29% 1344931
Family Planning					
Female sterilizations (lakhs)	370478 (HMIS; 2010-11)		475000	550000	600000
Post-Partum sterilizations (lakhs)	42787 (HMIS; 2010-11)		55000	65000	75000
Male sterilizations (lakhs)	9013 (HMIS; 2010-11)		15000	20000	25000
IUD insertions (lakhs)	1570880 (HMIS; 2010-11)		1500000	1650000	1800000
Disease Control					
ABER for malaria (%)			To sustain the ABER at least about 10 %		
API for malaria (per 1000 population)			Surveillance may be improved in all the districts to obtain the real magnitude of Malaria		
Annualized New Smear Positive Detection Rate of TB%			72%-75%		
Success Rate of New Smear positive treatment initiated on DOTs %			85% - 88%		
Cataract operations(lakhs)			11.62		

Maternal Health

FY 2012-13



Strategy to increase JSY beneficiaries

- Increasing number of accredited sub-center
- Increasing no of beds by 8000
- Contractual HR (ANMs,SNs & Doctors) at all levels
- Incentives to ASHA has been linked with quality care and birth planning
- Free entitlements under JSSK to all pregnant women and JSY beneficiaries
- 108 ambulances for free transport from home to hospitals
- AADHAAR card linked payment system and payments through account payee cheques only being introduced
- More number of PHC, CHC are being made functional for deliveries

Janani Sishu Suraksha Karyakarm (2012-13)

To ensure no "Out Of Pocket expenses" for Pregnant Women & Newborn

- No user charges for pregnant women and newborn
- Free medicines and consumables
- Free essential investigations
- Free food for all admitted Pregnant women & JSY beneficiaries
- Free blood at all FRU- L-3 facilities

- **Free transport-**
  - from home to facility
  - Drop back from Facility to home
  - Referral to higher centers
- **Free treatment and referral of sick neonates.**
- **Grievance redressal system at all facilities.**

Free services started	Target for year 2012-13 (in lakhs)	Achievement (in Lakhs)	Achievement in %
Free diet	**15.53**	**6.61**	**43%**
Free treatment	**26.88**	**15.97**	**59%**
Free drop back	**16.35**	**3.49**	**21%**

Child Health-

Strategy to reduce IMR and U5MR :

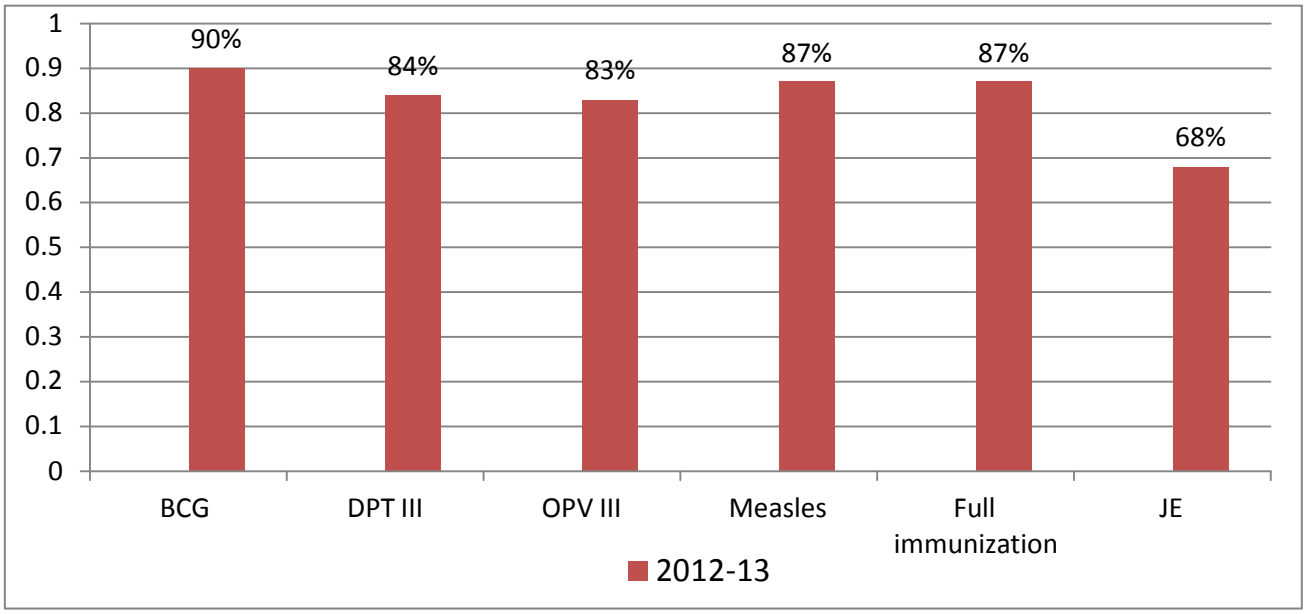
- Achieve the target of the NSSK training at functional delivery points
- Increase referral of the malnourished children to NRCs

Activity	Proposed	Functional
Sick Newborn Care Unit (SNCU)	**20**	**10**
Nutritional Rehabilitation Center (NRC)	**32**	**10**

Routine Immunization :

- 4 Special RI Weeks in 2012-13 to increase coverage in low coverage areas.
- 4 RI Weeks being conducted in 2013-14 also.
- Measles catch up campaign in all Districts, with 94 % coverage.
- Second dose of measles started in 2013-14.
- Training to all frontline workers planned in the year 2013-14.

Antigen wise Coverage of RI (2012-13)



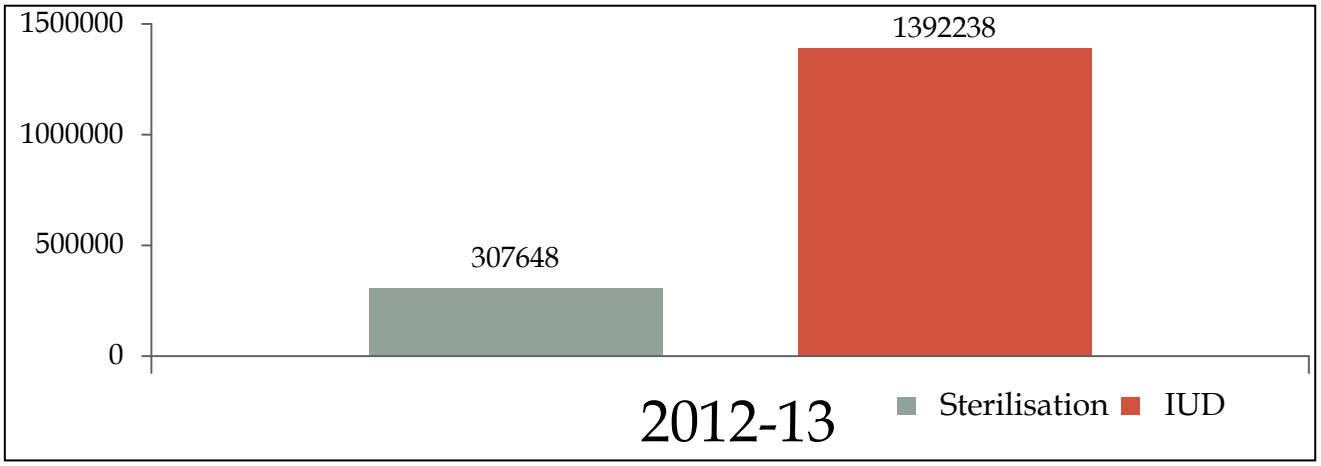
Family Planning programme:

NRHM Phase – II (2012-2017)

Outcome Indicators						
		2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**
TFR	3.8 **(SRS) 2007-09**	3.75	3.6	3.4	3.1	2.8

Output Indicators for Population stabilization							
Activity/ Monitor able Indicators		**Current status**	**Cumulative Targets for 2nd phase of NRHM 2**				
			2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**
1	Male sterilization	8,199	15000	20000	25000	30000	40000
2	Female sterilization	371237	450,000	450,000	450,000	450,000	450,000
3	IUDs	1543354	20 Lakhs	21 Lakhs	22 Lakhs	23 Lakhs	24 Lakhs

Achievement in 2012-13



PCPNDT Act (2012-13)

The 'Civil Registration Data' clearly shows that the sex ratio is declining in most of the commercially viable districts where ultra Sonography centers are in abundance indicating a direct correlation. Consequently, the strategies of the state now focus on these districts. Near about 4430 centers have been registered under the PCPNDT Act in the state. It is well known that it is difficult to regulate the private sector and therefore initiatives to monitor the implementation of the PC PNDT Act become even more essential. Given the above scenario, effective implementation of the PCPNDT Act together with social reform efforts including enhancing the value of a daughter is a significant step towards the prevention of female feticide. During year 2012 – 13, a State Level PCPNDT Cell has been established. Due emphasis has been given for inspection and Monitoring of all actionable points. Which are mainly focused on inspection visits to USG centers, documentation, filling cases, perusal in the court and action against defaulters.

No. of Registered centers	suspended centers	No. of Inspected centers	Inspection through False client	Court cases filed	Advisory committee Meetings held	Total No. Of Ultrasound machines	No of machines sealed
4620	316	5121	252	75	340	4566	73

National Disease Control Programme

National Program for Control of Blindness

- All the reports to be sent online.
- MIS training has been imparted to all the DPMs (Eye) of the state by the experts
- Online Reporting system is mandatory for NGO payments.
- Rates of Cataract Operation increased from Rs.750 to Rs.1000/operation to NGO.

National Leprosy Eradication Programme:

Following 8 objectives are set to achieve during the period of 5 years - 2012 -17

- Deployment of early case detection
- Improved case management
- Reduced stigma
- Sustained development of leprosy expertise
- Research supported evidence based programme practices
- Monitoring Supervision and Evaluation system improved
- Increased participation of persons affected by leprosy in society
- Ensured Programme management

Projected target for District level elimination i.e. PR < than1 per 10,000 population

Prevalence Rate	**Period wise details of the districts**						
	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
< 1	57	59	60	65	68	72	75
1 -2	13	12	15	10	7	3	0
2-5	2	1	0	0	0	0	0
> 5	0	0	0	0	0	0	0

State has also projected targets for Annual case detection rate(ANCDR), Number of cases on record at the end of the year (PR), Number of grade II disability among new case(%), Treatment Completion Rate(TCR) and Re-constructive Surgery.

Strategy:

- Ensuring improved early case detection; performance based ASHA incentive is there and special activities in form of 'Awareness creation and Active case detection Campaign' in 147 high endemic blocks having ANCDR more than 20 in35 high endemic districts.
- Programme ensures improved case management disability prevention provision of providing MCR footwear, aids appliances, supportive medicines, lab reagents and printing of records and reporting formats are there.
- Need based assistance to inmates of 72 Leprosy colonies in the state.screening camps in the districts and person found fit for RCS listed and referred to nearby Leprosy Care Centres in the state.
- In Urban leprosy Control programme 52 urban colonies have been covered the urban areas are categorized as Townships (40), Medium Cities I(2), Medium Cities II (8), Mega Cities (2) in which non government hospitals are involved, NGO participation is ensured, MDT drugs distribution is also ensured.

Revised National Tuberculosis Control Program

- All the districts of the State have been covered under Programmatic Management of Drug Resistant Tuberculosis in March 2013.
- Additional target for state Diagnostic Labs at 5 more sites (Agra, Aligarh, Bareilly, SGPGI, Lucknow, Meerut)
- Additional target for Specialised Drug Resistant TB Care centres will be made functional this year. eg. Etawah, Jhansi, Meerut, Basti, Aligarh, Allahabad & Gorakhpur approved by GoI.

Japanese Encephalitis(JE)/Acute Encephalitis Syndrome (AES)

- 10 bedded pediatric ICU in 10 hospitals of 9 districts (Gorakhpur, Kushinagar, Deoria, Maharajganj, Basti, Siddharthnagar, Sant Kabir Nagar, Behraich, Lakhimpur Kheri) and 100 bedded ICU ward at BRD Medical College Gorakhpur.
- The activities done by other department as follows:-
    - Jal Nigam department has established 12435 India Mark II hand pumps against target of 16888 India Mark II hand pumps up to June, 2013.
    - Jal Nigam department has also completed 54 percent of establishment of Tank Type Stand post (TTSP) against target of 2795 TTSP up to June, 2013.
    - Panchayati Raj Department has completed the construction of 53103 (41.56%) water sealed latrines against the fixed target of 127757.

OTHER IMPORTANT COMPONENTS OF NRHM PROGRAMME

Referral Transport/Emergency Medical Transport Services (EMTS)

An Effective perinatal referral transport service is critical for preventing maternal emergency care to reach an adequately resourced facility safely and well in time and condition that provides them a fair chance for survival and to receive treatment in time.

GoI has a mandate to establish a network of basic patient-care transportation ambulances whose objective would be to reach beneficiaries in rural areas within 30 minutes of receiving a call. Under NRHM

In view of the importance of access to ambulance services for reducing delays in access to care during various emergencies the ambulance services were started in all districts of UP. These services are basically of three types depending upon need and mode of operation.

1. "108" – EMTS
2. U.P. Ambulance Sewa
3. "102" Ambulance Sewa

Emergency Medical Transport Service (EMTS) "108"

- "108" EMTS sewa launched by Honorable Chief Minister on 14 Sep'2012.
- The ambulances under the scheme launched in phased manner and achieved target of total 988 ambulances on 10 Feb'2013.
- Total 3,39,274 patients (1,86,418 Pregnancy related, 47,235 Accidental cases) benefited by "108" Service till 31st Mar'2013.
- This service was utilized in Maha Kumbh, Allahabad and 33,341 patients benefited.
- Uttar Pradesh at present has a functional "dial 108" model, across all the districts, under Public Private Partnership (PPP) mode. This model cater to transporting patients in all kinds of emergencies, free of cost to all citizens.
- The objective is to provide immediate response during emergency with basic first aid to the patient and transport them to nearest government health facility. Total 988 Ambulances are functional till date

U.P. Ambulance Sewa

Under State Basic Ambulance Services: 972 ambulances are already functional in all the 75 districts of Uttar-Pradesh. These ambulances are used for inter facilities transport of patient, Sick New Born Children and for the purpose of drop back under Janani Shishu Suraksha Karyakram (JSSK).

"102" SEWA (not yet initiated, under consideration)

These ambulances are expected to serve transportation of pregnancy cases as well as neonatal cases from home to the health facility. State proposes to operate 1000. such ambulances (Yet to procure.). The required operational cost is (@Rs. 1,28,700.00 per ambulance per month including operation of centralized call center

Urban Heallth Programme

The Urban Population in Uttar Pradesh has been Increasing rapidly in recent decades along with rapid urbanization .As per 2011 census 4.44 crores persons are residing in towns and cities of Uttar Pradesh. The health status of people in Uttar Pradesh is amongst the lowest in the country, especially for the urban poor.

The health indicators among urban poor are significantly lower than in rural areas of the state. More than half of the urban poor women in UP are anaemic. High prevalence of anaemia contributes to high infant and maternal mortality, premature births and low birth weight babies. Only one in five urban poor women receives the recommended three antenatal checkups

Mere 24.4% of urban poor couples in UP use modern methods of contraception. This results in a large number of unwanted pregnancies and child births and deprives women to control their fertility and childbearing. Infectious diseases are more prevalent among the urban poor in Uttar Pradesh. The prevalence of medically treated TB (per 100,000 populations) is 532 as compared to 321 among average urban population and 425 in the state (NFHS 3).

Challenges

1. Lack of primary health care in urban areas
2. Poor quality care due to stretching of already constrained resources.
3. Ineffective Referral System from the community level to the second tier results in loss of trust in the public health care system making them turn to irrational treatments from unqualified providers.

Goals and Objectives

To improve the health status of the urban poors by provision of quality Primary Health Care services and decentralized health facilities by ensuring atleast one urban health post (UHP) per 50,000 populations having urban slum of 20000-30000 population in the city.

Target Population

- Poor & Under Served Population
- Inaccessible and Migrant Populations
- People live in temporary shelters
- People working in construction sites
- BPL people

Type of Services

Outpatient services, MCH services and referral service

134 Urban Health Post (UHP) established in different cities are providing primary health services to the urban poor. There are 45 Urban FP centers (17 Type II and 28 type III), lucknow has a urban project also. Besides that there are 7 Maternity homes in Lucknow and 2 in Varanasi, catering maternal child health services, reducing the client load on District Women Hospital.

Supporting Organizations: Urban Health Initiative (UHI) UHI supports Government of Uttar Pradesh in eleven cities (Agra, Aligarh, Allahabad, Gorakhpur, Bareilly, Kanpur, Varanasi, Moradabad, Mathura, Farrukhabad and Lucknow) through 21 local NGOs, with a network of 1,665 trained peer educators (on the USHA model), together working to serve poor communities in 1,705 urban slums. UHI aims to increase contraceptive use as a key intervention to reduce maternal and infant mortality. The over all objectives are as follows

i) To integrate family planning counselling and services with maternal, newborn, post partum, and post abortion services;

ii) To expand access to quality family planning services in health facilities;

iii) To test innovative private sector approaches to increase access to family planning;

iv) Create demand for sustained use of contraceptives and;

v) To increase funding, financial mechanisms, and a supportive policy environment to ensure continuity of family planning supplies and services for the urban poor.

UHI works in partnership with 122 facilities (public and private) to implement fixed day approach and strengthens counseling and interpersonal communication, at clinics and in communities through counselors and community based workers. It supports social marketing of condoms and pills, in nontraditional as well as traditional outlets. It uses mid-media and mass-media to market supplies and services and shape demand and practice for targeted groups.

Rashtriya Bal Swasthaya Karyakarm/Bal Swasthya Guarantee Yojana

Coverage: As per an estimate received from primary education department and middle education department, there are on an average 150 such schools in each block. Thus, the total no. of schools comes to about 1,47,895 and with an average of 200-250 children in each school, the estimated number of children to be covered under the scheme is about 4 crores. As per census report 2011, there are about 8.2 crore children of age group 2-18 years in the State. Out of these about 2.58 crore are in the urban area and 5.62 crore in rural areas. These 5.62 crore children are proposed to be covered under the scheme in a phased manner. In the first year it is proposed to cover about 1 Lakh schools and reaching out to about 2 crore children.

Three pronged programme strategy is mentioned below

1. Screening of School going children and preparing health card for each child Screening of non School going children and preparing health cards for each child
2. Health check up by dedicated medical team in schools on pre-fixed days and at VHNDs/SCs/ AWCs for non school going children as per micro plans
3. Referral of sick children and ensuring their treatment
4. At each CHC on a fixed day, one specialist camp will be organized every month where physician, surgeon, paediatrician and opthalmologist will be available to examine and advise the referred children.

Adolescent Health Programme

Nearly 25 percent of the population of Uttar Pradesh is adolescents (415 Lakhs). Of these approximately 200 Lakhs are adolescent girls. As per NFHS -3 adolescent girls getting married below 18 years of age are 59% and out of these 38% begin child bearing when less than 19 years of age. As per NFHS-3, teenage pregnancy is 14.3% and unmet need for contraception is 21%. Prevalence of Anaemia in this age group is about 49% and adolescents seeking treatment at health facilities is only 31%. There is poor awareness in this age group regarding different problems occurring such as RTI/STIs and way to address them. NFHS-3 data also indicates that there is poor knowledge regarding problems of unsafe sex, personal hygiene and nutrition. Only 33% of girls in age group of 15-19 years knew that condom can prevent HIV transmission and 36% males had heard of STDs.

Given the above scenario, the State under NRHM programme has planned to design and implement such projects that address and influence the health seeking behaviour of adolescents which will eventually determine mortality, morbidity, population growth and health in the community. This will also influence adolescents for delaying the age at marriage, reducing

teenage pregnancy, meeting unmet need of contraceptives, reducing incidents of RTI/STIs and reducing maternal deaths in this age group. Taking above mentioned situation into consideration, the state has implemented following schemes for adolescents in the State.

Establishing AFHS clinics* - During 2012-13, 36 AFHS clinics have been established in premises of Divisional Head Quarter level District Male and Female Hospitals. These clinics are providing services after Hospital working hours (2-5 p.m.), so that adolescents may reach there and get solution for their queries. One Counselor is recruited at each clinic.

A large percentage of adolescents in Uttar Pradesh do not go to the schools and are often in a more disadvantageous situation than those, who attend school. Hence, it is important that weekly Iron Folic Acid supplementation, Bi-annual de-worming and Family Life Education-with counseling on nutrition & personal hygiene should be incorporated for non-school going adolescent girls in the community under the adolescent health programme. This scheme was implemented during year 2012-13. the strategy envisages the two pronged strategy.

Programmes	Districts covered	Age Group	Target beneficiaries	IFA Distribution	De-worming distribution
Rashtriya Bal Swasthaya Karyakarm	75	2-18	Girls/boys	Yes	Yes
Menstrual hygiene scheme	13	10-19	Girls	Yes	Yes
SABLA scheme	22	10-19	Girls	Yes (non-school going girls)	Yes
AFHS Clinics* (2 in each district)	18	10-19	Girls / Boys	Yes	Yes

Quality Assurance for RCH services

Quality enhancement in health care has been recognized as an essential cornerstone for promoting equity and maximizing health gain. With the event of NRHM in the state of Uttar Pradesh, significant improvement has been made on multiple health indicators and promotional schemes for institutional deliveries have led to tremendous increase in utilization of public health facilities. The State now strives to address the issue of enhancing the quality of health care services rendered through establishment of Quality Assurance network at all level.

In continuation to our quest for delivering high quality health services, Quality Assurance Cell at State level has been established and State Quality Assurance Working

Groups have been formed. State is in process of finalizing the checklists as per GOI guideline with the help of GOI and NHSRC Officers which will be used by Quality Assurance working groups and other officers during field visit. Quality Assurance Cell at State level: Cell has been established under the chairmanship of Mission Director and a full time Deputy General manager has been appointed State Nodal Officer: Director, Medical Care Medical Health and Family Welfare Department U.P.

- State Working Groups: 4 State Working Groups have been formed , RCH services, NRHM Additionalties, Routine Immunization and National Programmes.
- Monitoring and Evaluation Cell for Quality Assurance Cell at State level has been established and State is in process of filling the posts for M&E cell . M& E cell at the State level will support Quality Assurance Cell.
- In order to establish and institutionalized Quality Assurance and improvement , Monitoring and Evaluation an attempt is being made by Government of Uttar Pradeh to set up a functional district quality assurance mechanism through District Quality Assurance cell . 18 Divisional and 75 District Quality Assurance Cells have been formed

Quality Assurance Cell Divisional and District level: To ensure the self driven quality improvement at PHC for improved quality of care, earlier we had planned to reach upto district level to assure the quality of services. With the support of Bill and Melinda Gates Foundation, State plan to take this initiative upto facility level at Block PHC.

Objective :

- Increase participation of all Stakeholders in a facility through development of Quality Teams
- Increase engagement with District Quality Assurance Cell to ensure achievement of District Health Plan.
- Orient Facility level Staff towards Quality Management System
- Motivate Facility level Staff to envision, plan and execute standard quality assurance paradigms like IPHS and Family Friendly Hospital Initiative
- Improve the quality of care provided to beneficiaries

Essential elements:

- District QA Cell workshop - Orienting district officials on facility solution levers
- Block Level workshops - Orienting block officials on facility solution.Creation of facility QA team – Monthly QA team meeting with recorded minutes
- Facility Assessment Toolkit – Standardized toolkit (paper/software based) for gap assessment and comprehensive facility assessment for readiness for IPHS and FFHI,
- Creation of Comprehensive Action Plan – Gap assessment and achievement monitored through monthly/Quarterly QA team meetings
- DQAC field visits – periodic engagement of DQAC with the facility to assess and monitor progress on comprehensive action plan.

Expected Outcomes:

- As a result of quality improvement, early identification of maternal and new born complication, stabilization and timely referral to appropriate facility
- IPHS and FFHI accreditation by state government

THE SOCIAL DETERMINANTS OF HEALTH

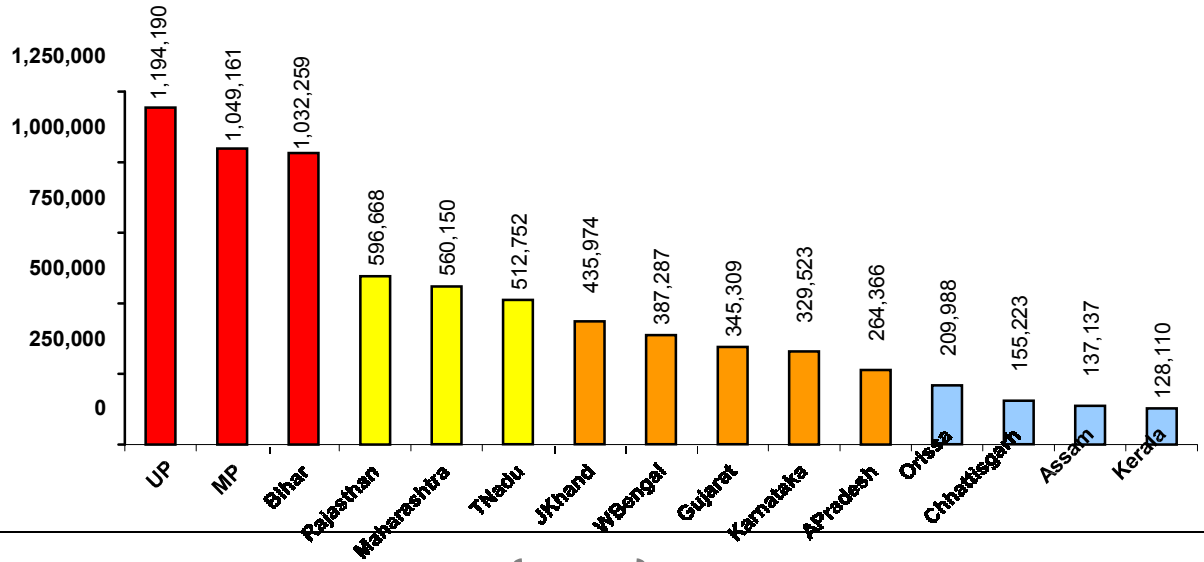
Nutrition

The persistence of malnutrition in India is a cause for serious concern. The Prime Minister has rightly referred to the prevailing situation as a "national shame". Malnutrition, particularly in the case of pregnant women leads to the birth of babies with a low birth weight. Such children suffer from many handicaps in later life, including impaired cognitive abilities.

We are far from achieving the goal set by Mahatma Gandhi at Noakhali in 1946, that the first and foremost duty of independent India should be to achieve freedom from hunger. To quote Gandhiji, "There are people in the world so hungry that God cannot appear to them except in the form of bread".

UP has many programmes for fighting malnutrition like Integrated Child Development Services (ICDS), School Noon Meal Programme. Nevertheless, the prevalence of both endemic and hidden hunger is not showing a downward trend. It is in this context that there is need for convergence and synergy among various programmes dealing with nutrition, drinking water, sanitation and primary health care.

60 percent of severely wasted children in India live in 6 states Malnutrition underlies up to half of under-five deaths.



In September 2012, the government of UP took a decision to set up Nutrition Mission in the state following a visit and recommendation by a team of young parliamentarians (Citizen's Alliance against malnutrition) in UP. The objective of Nutrition Mission is to reduce the proportion of moderate and severe malnourished children in the age group of 0 to 2 years in the State by having a dedicated focus on selected health and ICDS preventive and curative interventions.

It has been proposed that the Nutrition Mission be set up initially for a period of three years and subsequent decision be taken based on the results delivered by the Mission. UNICEF will be the lead technical partner in supporting the Nutrition Mission.

Nutrition Mission will be an autonomous flexible body which will liaise with Medical Health and Family Welfare department and ICDS for strengthening select interventions.

Under nutrition accounts for one third of under-five mortality. The following figures reveal the poor nutritional situation of children in UP.

- Only around 33% of under-3 children (1 out of every 3) being breastfed within one hour of birth (AHS-2011).
- Only around 18% of 6-35 months children (1 out of every 5) have been exclusively breastfed for at least six months(AHS 2011)
- About 96,000 under five children lost every year because of lack of optimal IYCF practices.
- Uttar Pradesh has around 1.3 million severe acute malnourished children. In UP there are about
- 95,000 child deaths per year as a result of severe acute malnutrition, or 260 deaths per day or 10-11 deaths per hour.
- Under-nutrition figures of Uttar Pradesh
  - ✓ Stunted (chronic under nutrition): 57% in UP, compared to 48% in India;
  - ✓ Wasted (acute under nutrition): 15% in UP compared to 20% in India.

Underweight (acute and chronic under nutrition): 42% in UP compared to 43% in India.More worrisome, the nutrition situation of children has not improved significantly over the last decade. For example, according to NFHS-3, there has only been a very slight 0.5 per cent annual decrease in the prevalence of underweight children over the past sixyears.

Convergence

As adolescents are in arena of various schemes of inline department there is enough scope of working in convergence to maximize outcome of the schemes being undertaken under Adolescent Reproductive and Sexual Health. State has already been working with few of them.

- **Village Health Sanitation and Nutrition Committee:** VHSNC members help in preparing village health plan and in organizing the periodical meetings of VHSNC.
- **Convergence with ICDS -** To address the issue of anaemia in adolescent age group it is being planned to provide IFA and De-worming tablets for non school going girls covered in districts under SABLA scheme. ANM & HV/ AYUSH lady will address issues of health, personal hygiene and nutrition arising in adolescent age group during quarterly Kishori Diwas with support of AWW. It will also be ensured to provide IFA and De-worming tablets to the beneficiaries.
- **Convergence with Uttar Pradesh State AIDS Control Society -** State will be working in convergence with UPSACS for establishment of AFHS clinics at ICTC and PPTCT in identified facilities so as to provide counseling to adolescents on specific issues pertaining to this age group and appropriate referral.

Other New Achievement in year 2012-13

FY 2012-13 has been a year of intense activity.

States have responded very positively to conditional ties and incentives, programme management has been strengthened with the appointment of nodal persons for each thematic areas and introduction of Score Cards, JSSK has made further inroads, RBSK has been initiated and Child Survival Summit at Mahabalipuram provided an opportunity to take stock of our achievements and reflect on the challenges ahead.

The Reproductive and Child Health Programme (RCH), under the umbrella of NRHM, addresses the issue of reduction of Infant Mortality Rate, Maternal Mortality Ratio and Total Fertility Rate through a range of initiatives. The most important of these is the Janani Suraksha Yojana, which has led to a huge increase in institutional deliveries within just four years, the number of beneficiaries rising from 9.64 lakhs per year during 2007-08 to 23.28 lakhs in the year 2011-12. In FY 2012 – 13 the annual achievement is 21.76 lakhs To cope with the tremendous increase in the work load of institutional deliveries the additional maternity bedded wings have been approved for construction. They are as follows:

- 100 bedded maternity wing in 50 District Hospitals
- 50 bedded Maternity wings in 12 CHCs
- 30 bedded Maternity wings in 78 CHCs.

Massive training of ANMs and staff nurses for safe delivery ensured through 2400 trained ANMs/SNs and training in 'management of sick children, to nurses, has also helped in a major way. In parallel to these efforts the up gradation of health facilities to provide emergency obstetric care and to improve access to Skilled Birth Attendants made a significant difference to health outcomes.

NRHM has also contributed by increasing the human resources in the public health sector, by up- gradation of health facilities and their flexible financing, and by professionalization of health management. State is trying to meet the huge gap in human resource by hiring the services of different levels of health providers (such as Gynaecologist, Pediatricians, Anaesthetist, ANMs, Lab. technicians etc.)

Disease Control Programmes have also shown considerable improvements. Polio is near Elimination and diseases like Tuberculosis, Neonatal Tetanus, Measles and even HIV have shown decreasing trends. However, Malaria continues to be a challenge. A number of newly emerging diseases like H1N1 have made it essential for us to strengthen surveillance and epidemic response capacities.

NRHM also aims at mainstream of AYUSH cadre of service providers who have very well out reach, so as to make the health services available in far flung rural areas.

Due attention has been given in improving the Health Management Information System HMIS. A separate division of Monitoring and Evaluation for quality Assurance has been developed during FY 2012-13, staff have been hired in form of data analyst, Project coordinator MIS, Consultant management and quality assurance etc. State has started operating HMIS and has started developing, analyzing performance reports from second quarter of the FY 2012-13.

The area of 'NGO participation', a greater engagement with the private sector is required to harness their resources for achieving public health goals. NRHM UP has a substantial focus on Public Private Partnership (PPP) component also. The state has active 'Developing Partner's Forum', the meeting of this forum help in allotting districts to the developing partners for specific activity, eg. The project of 'Urban Health Initiative' is working in urban slums of 11 districts of UP. HLFPPT with the assistance from State Innovations in FP Services Agency (SIFPSA) has developed a net work of Private Hospitals/Providers under the banner of Marry Gold Hospitals in UP for providing FP and RCH services.

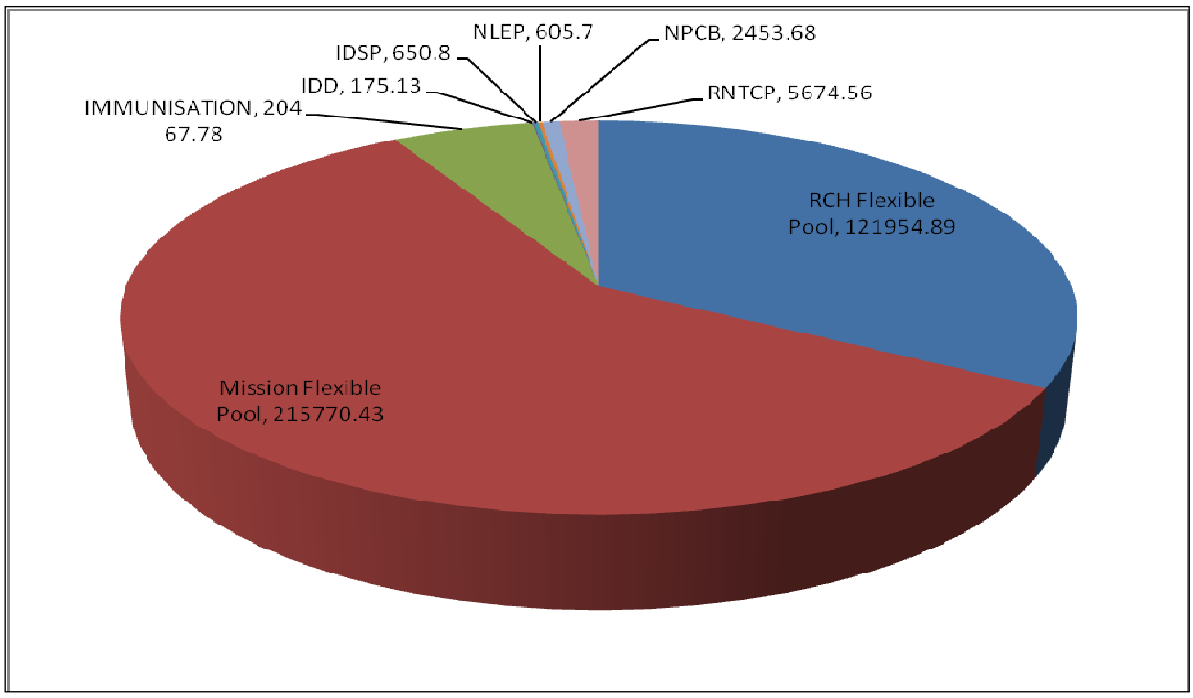
The current policy shift is towards addressing inequities, though a special focus on inaccessible and difficult areas and poor performing districts (45 high risk districts are in UP, out of which 19 have been selected as "**High Priority Districts"** on the basis of poor composite index).

Financial Progress 2012-13

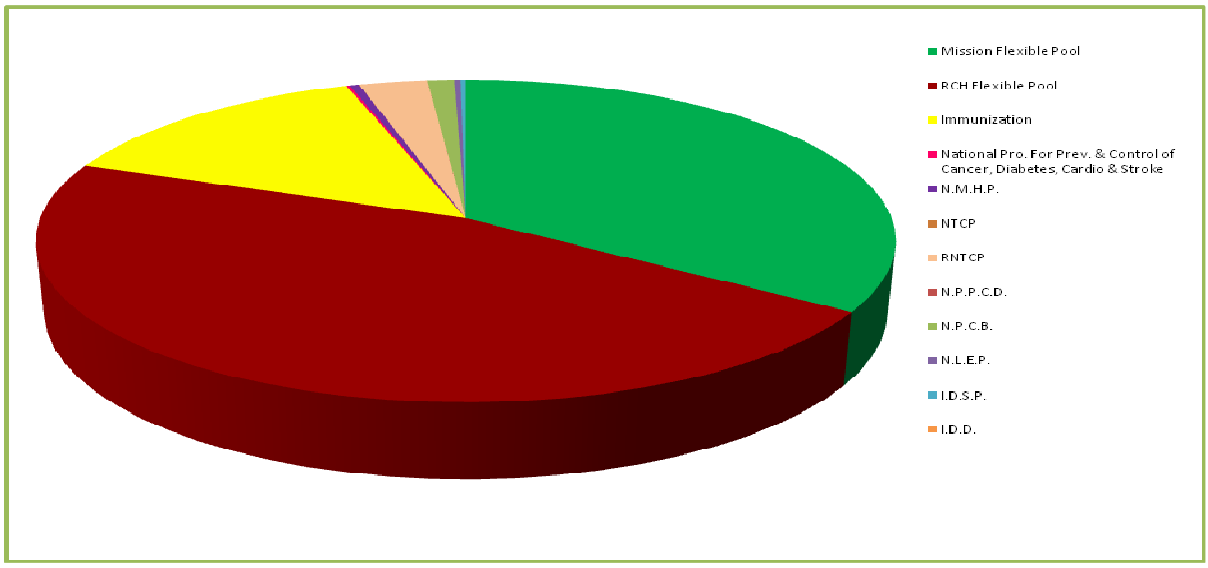
FINANCIAL PROGRESS UNDER NRHM FOR THE YEAR 2012 -13

FMR	Activities	Budget Allotted as per PIP (including SPIP)	Actual Expenditure	% Expenditure
A	RCH - TECHNICAL STRATEGIES & ACTIVITIES	121954.89	67470.6	55.32
B	Additionalities under NRHM	215770.43	49779.78	23.07
C	IMMUNISATION	20467.78	20646.83	100.87
D	IDD	175.13	0	0
E	IDSP	650.8	338.32	51.99
G	NLEP	605.7	387.78	64.02
H	NPCB	2453.68	1674.02	68.22
I	RNTCP	5674.56	4269.22	75.23
J	N.M.H.P		600.21	
K	N.P.P.C.D		3.68	
L	NTCP		7.21	
	National Program for		81.12	
	National Pro. for Prev.& Control of Cancer,Diabetes,Cardio & Stroke		199.61	
GT	Grand Total	371855.27	146928.09	39.51
	Infrastructure Maintenance (treasury Route)	63388	189855.26	299.51
	TOTAL	435243.27	336783.35	77.38

Total Approved Budget(In Lakhs) in PIP 2013



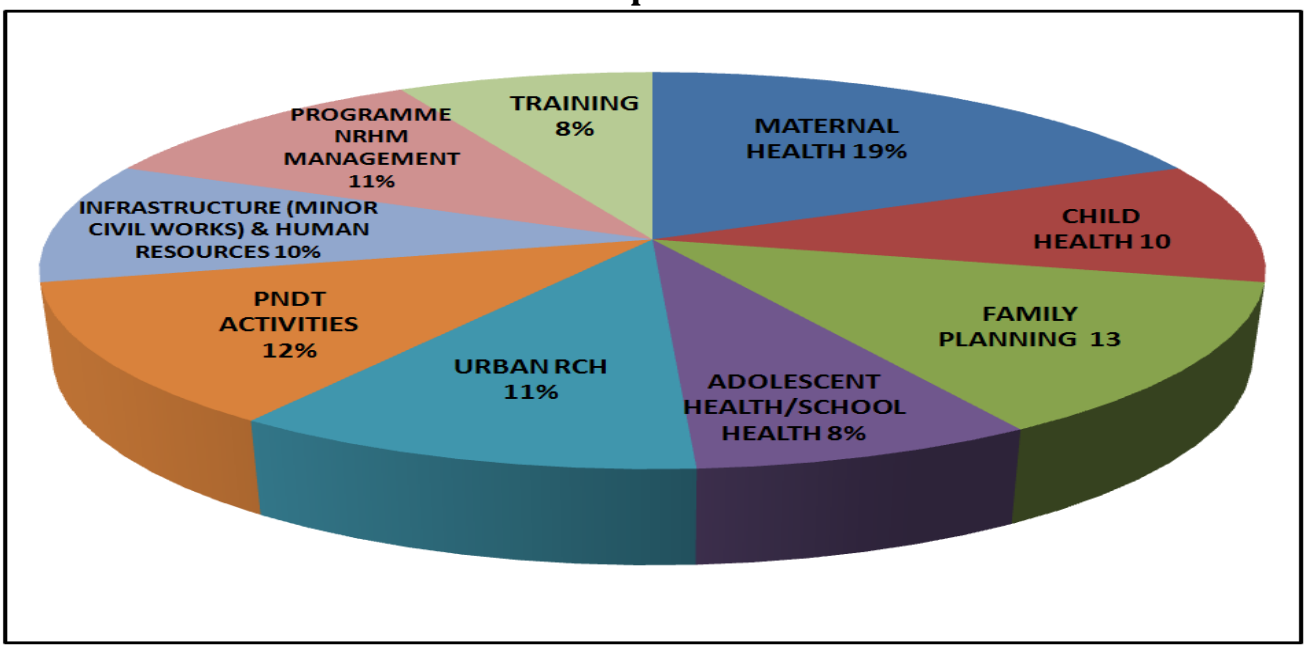
Total Expenditure (In Lakhs) in PIP 2013



Mission Flexible Pool	RCH Flexible Pool	Immunization	National Pro. For Prev. & Control of Cancer, Diabetes, Cardio & Stroke	N.M.H.P.	NTCP	RNTCP	N.P.P.C.D.	N.P.C.B.	N.L.E.P.	I.D.S.P.	I.D.D.
49779.78	6740.60	20646.83	199.61	600.21	7.21	4269.22	3.68	1674.02	387.78	338.31	0

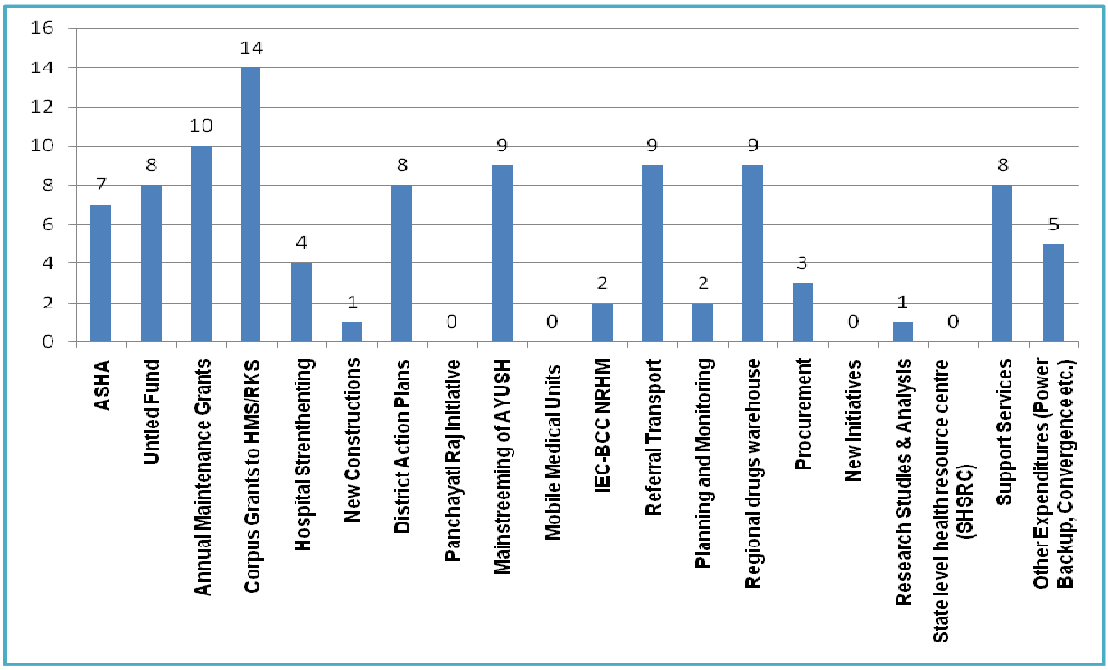
RCH Flexi pool

% of Expenditure against allotted budget in RCH Flexi pool 2012-13

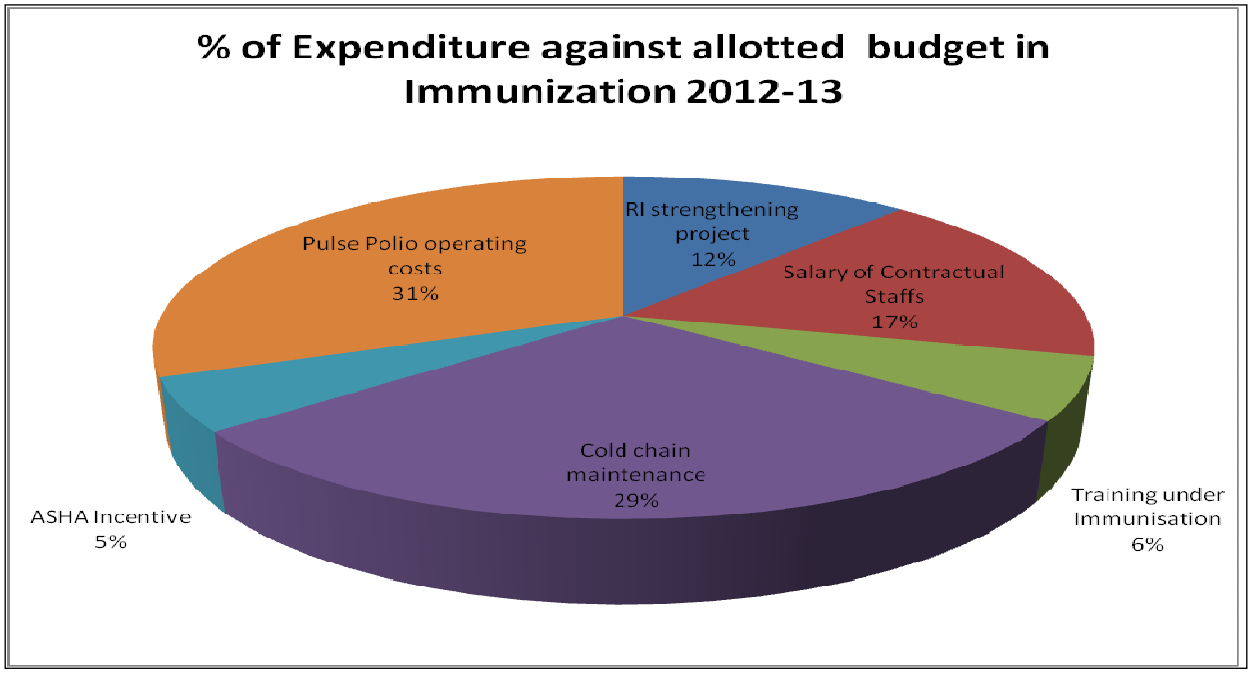


Mission Flexipool

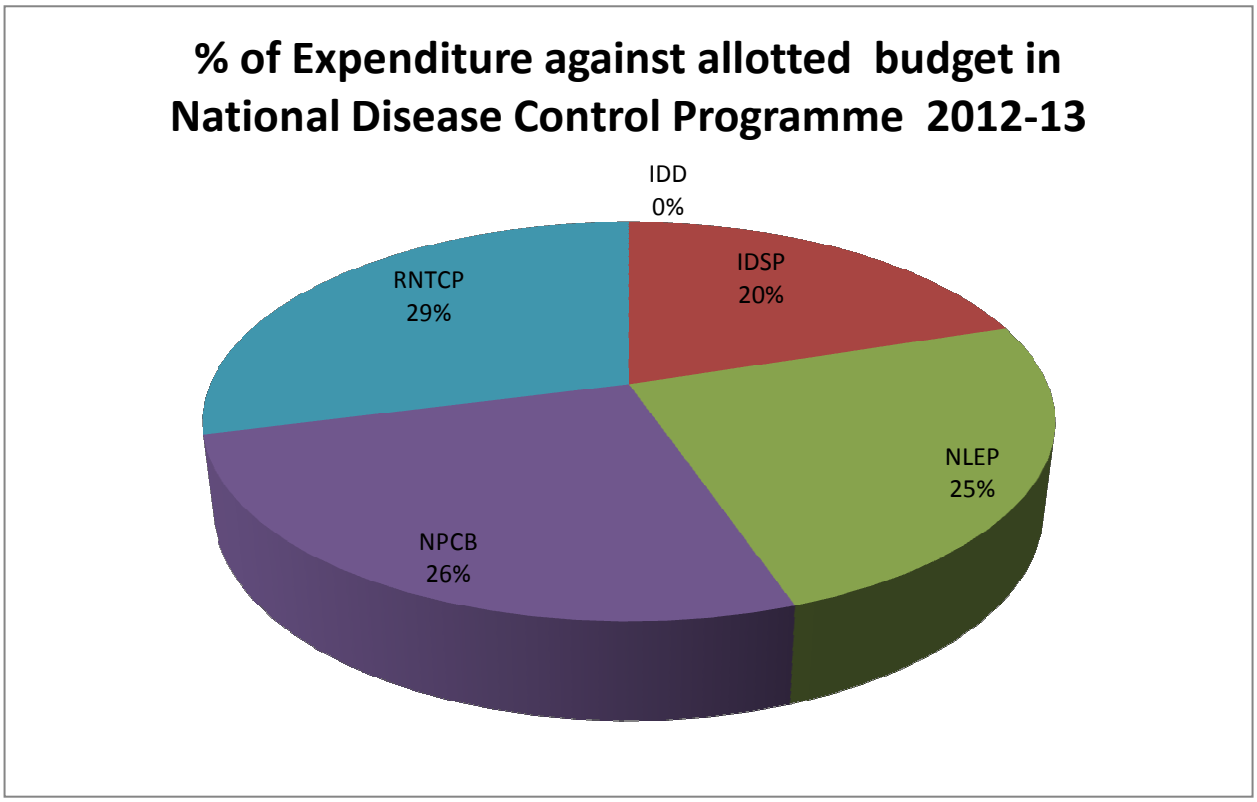
% of Expenditure against allotted budget in Mission Flexipool 2012-13



Immunization



National Disease Control Programme



New Initiatives for year 2013-14

Hausla:

- Aimed to give momentum to existing schemes by catalyzing momentum and inter-sectoral collaboration.
- **Objective :** Sharp reduction in maternal & infant mortality by delivering better health services in the spectrum of RMNCH+A (Reproductive, Maternal, Neonatal, Child and Adolescent health)
- **Scope :** All Districts. Special focus on 25 High priority Districts.
- **Launch** : Proposed on 15 July 2013.
- **Special efforts** :An year long Mass media campaign – airing messages through TV and Radio channels, to raise community awareness.

State Nutrition Mission

Mission being set up for a period of three years in the first phase

Objective of the Mission:-

- Reduce mild/moderate under nutrition among children below three years
- Reduce the prevalence of severe under nutrition in the state

Key Stakeholders:-

- National Rural Health Mission
- Department of Women and Child Development

Technical support from UNICEF

Initial funding support is being proposed by NRHM

- Governing Body has been formed under the Chairmanship of Hon'ble Chief Minister.
- Executive Body under the Chairmanship of Chief Secretary.
- Monitoring Committee under the Chairmanship of Principal Secretary Woman and Child Development and Health & Family Welfare.
- Implementation Committee under the Director General State Nutrition Mission

Proposed " 102 " Sew a :

- Operation of "102" ambulance sewa has been approved by Cabinet of Uttar Pradesh.
- Total 972 ambulances will be operated 24 X 7 through "102" toll free number, centralized call center and as per 'National Ambulance Guidelines'.
- In first phase 972 ambulances and in second phase 1000 ambulances will be made operational under this scheme.
- Looking at success of "108" EMTS sewa this services will also be operated through private service provider.

- Facility of transportation and drop back of pregnant women, sick new born (under JSY and JSSK) and Inter facility referral of severely ill patients will be provided to all rural and urban areas of state.

National Urban Health Mission

The Union Cabinet approved National Urban Health Mission (NUHM) as a new sub-mission under the over-arching National Health Mission (NHM). The structure would be:

- One Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population.
- One Urban Community Health Centre (U-CHC) for five to six U-PHCs in big cities.
- One Auxiliary Nursing Midwives (ANM) for 10,000 population.
- One Accredited Social Health Activist ASHA (community link worker) for 200 to 500 households.
- NUHM is approved for 5 years period; the Centre-State funding pattern will be 75:25.
- Fund allocated for UP : Rs. 235 cr. (Sep. 2013 – Mar 2014)
- **164 Cities with more than 50,000 population**
    - 9 Cities with more than 10,00,000 pop
    - 84 Cities with population between 1-10 lakh
    - 71 Cities with population between 50,000 -1 lakh
    - **5 District HQs with urban population of less below 50,000** Siddharthnagar, Mahrajganj, Kaushambi , Shrawasti &Amethi

Conclusion :

This 'Annual Health Report' provides valuable insights into proven approaches to reduce TFR, MMR, IMR in the state of UP. The major areas of operation/ interventions to achieve the desired goal of NRHM. The challenges the state is facing in operationalizing various vertical interventions, the convergence and synergy among various programmes dealing with nutrition, drinking water, sanitation and primary health care, the state has brought under the edges of NRHM to achieve the indicators under the Social Determinants of Health.

This 'Annual Health Report' is a report to the People on Health, examines the progress made in the health sector, identifies the constraints in providing universal access and provides options and future strategies. In terms of life expectancy, child survival and maternal mortality, Uttar Pradesh's performance has improved substantially & steadily. However there are wide divergences in the achievements across districts and there are also inequities based on rural urban divide.