CHAPTER – XI

MEDICAL AND PUBLIC HEALTH

"The real wealth of a nation is its people and the purpose of development is to create on enabling environment for people to enjoy long, healthy and creative lives".

The First Human Development Report,1990

The importance of health and its implications for human development have been obvious since time immemorial. India suffers from a high morbidity ;burden with high fatality rates. Widespread infectious diseases and rising chronic non-infectious diseases along with large disparity in access to health care service plague the Indian health system. The health system in India as it exists today has been inherited from the colonial rule. Health planning in India after independence was modelled on the recommendations of the Bhore Commendations of the Bhore Committee report, which focused on decentralisation of the health service to reach the entire population and integrating preventive, curative and promotive health services. The concept of primary health care became the basis of Indian health planning.

2. The initiative in the health sector in U.P. during the last two decades have been in pursuance of India's health policy commitment, the health infrastructure has developed along the same lines, with a hierachical network of health centres. The state, therefore, has a large public sector health infrastructure . However, only 9 percent of the people actually make use of this facility for treatment of ordinary ailments and have to depend mostly on private health care. Unfortunately, a vast majority of these private sector providers consist of quacks and faith healers. This is a sad statement on the state of public health infrastructure in U.P. Some of the major strengths of the health sector are as under:-

- Primary Health Centers (PHC's) 3640 with 4463 Doctors.
- Sub-Centers 18565 with 19388 ANM's in position Community Health Centers (CHC's) 340 with 1549 specialists/Doctors.

3. The State has one of the highest incidences of infant and maternal mortality in entire country. The incidence of blindness, tuberculosis, leprosy, and maternal morbidity is also high. Large proportions of babies are under-weight. Meaning thereby that existing maternal and child care facilities or not upto desired level and need to be improved . Moreover, AIDS seems to be raising its ugly head. By the end of July 2000 there were 259 full-blown cases of AIDS and 889 persons had already tested sero-positive.

4. Innovative solutions, however, offer hope. It is observed that infant and maternal morbidity show a direct relationship with non-availability of trained medical attention at the time of delivery. Here too, trained medical attention is important only because it has a direct relationship with a hygienic environment and the use of basic essentials like a rust free blade for cutting the umbilical cord. Sensitisation of people towards basic hygiene practices such as the use of soap and clean blade can help in overcoming the mortality challenge. The low cost "Dai Kit" can perform wonders. In fact, Civil Society interventions in different parts of the state stand testimony to be a

fact that small interventions have worked to the benefit of the people . Such interventions, although still limit in terms of geographical and overall impact, have led to significant improvement in quality of care in general and MCH and population stabilisation in particular.

- The sex ratio in Uttar Pradesh has declined from 882 in 1981 to 876 in 1991. However it increased to 898 in 2001. Among the states sex ratio is highest in Kerala (1058). The notable point is that the gap in sex ratio between India and Uttar Pradesh in 1951 was 38 which reduced to 35 as per 2001 census.
- The average life expectancy at birth for women (54.5 years) in Uttar Pradesh is lower than the male expectation of life (56.8 years) whereas at national level this figure is slightly higher for females (59.4 years) than the males (59 years).
- Life Expectancy estimates ;for various regions did not show much difference in life expectancy. Western, Central and Eastern regions had uniform life expectancy of 62 years, while Bundelkhand had lower figure at 60.3 years.
- Among the districts, Ballia and Kanpur Nagar were the districts with highest life expectancy at birth of 74.4 and 74.3 respectively, Ghaziabad followed them at 70.1 years. In the western region, thus, Ghaziabad had the highest life expectancy followed by Agra and Meerut. These districts have a high proportion of urban population. The lowest life expectancy in this region was in the largely rural and backward tracts of Budaun (51.8), Shahjahanpur (56) and Etah (56.3)
- In the central region the urban-industrialised Kanpur Nagar had the highest life expectancy followed by Lucknow (69.5). Hardoi (53.6), Rae Bareili (56.7) and Fatehpur (58.8) had the lowest life expectancy.
- In the eastern region Ballia had the highest life expectancy followed by Ghazipur (68.3), Gorakhpur (66.7) and Mau (66.5). Seven districts had a life expectancy below 60 years, lowest being 54.4 in Bahraich. It needs to be mentioned that the eastern region has the highest number of districts and it houses the largest chunk of UP's population.
- Of the five districts in the Bundelkhand region, Jhansi had the highest life expectancy of 62.5 years, while Lalitpur had the lowest figure of 57.3 years.

5. The largest number of districts with lower life expectancy lay in eastern UP. Another important observation is the lower life expectancy of females. This shows the poor status of females in the state, which is affecting their well being. Females actually have a lower life expectancy than males, while biologically they should have a higher life expectancy. Only seven districts show a female life expectancy higher than male life expectancy. Females thus face discrimination almost universally throughout the sate and therefore share a much larger burden of mortality ;than would naturally accrue to them.

- The IMR in Uttar Pradesh decreased from 100 per 1000 live births in NFHS-I (1990-92) to 87 per 1000 live births in NFHS-2. U.P. had the highest level of IMR than any State except Meghalaya. By 1999 the IMR in UP had declined only to 84. Thus, though the state shows a decline in IMR over time, the IMR has always been higher than the national average.

- District level estimates of IMR are prepared on the basis of the population census and are only available for 1991. In that year the Census estimate for the state IMR was 99. The proportion of children born, not surviving till one year is more than three times higher in districts with the highest infant mortality rates, compared to districts with the lowest rate . Districts with the lowest IMRs are in the Eastern, and Western regions of the state, while districts with the highest IMRs are in the Western, Central and Eastern regions of the state. Badaun, which had the highest infant mortality rate in both 1981 and 1991, lies in the Western region of the state. The dispersion of poor health states districts across all of the UP's regions, except the Hill region, now part of Uttaranchal State, is a characteristic feature of Uttar Pradesh.
- The district wise pattern shows uniformly high CMR across the state, highest being in Basti (205) and lowest in Ballia (61). Districts with high CMR were generally the same as those with high IMR. Rampur, Badaun, Etah, Firozabad, Barielly, Pilibhit, Shahjahanpur and Kheri in western UP, Sitapur, Hardoi, Raebareli and Fatehpur in central UP, all districts of Bundelkhand, and Pratapgarh, Allahabad, Bahraich, Gonda, Basti, Siddarthnagar, Maharajganj and Mirzapur in eastern UP were the districts with high CMR. Ghaziabad, Agra, Gorakhpur, Mau, Ghazipur and Ballia were the districts with lowest CMR below 100. Female CMR was much higher than male CMR as in the case of IMR.
- The National Family Health Survey (1998-99) shows that 52 percent of children below three years of age are underweight and 56 percent are short for their age or stunted. This compares unfavourably with the national level estimates of 47 and 46 percent respectively.
- The proportion of fully vaccinated children is higher in urban than in rural areas. Immunisation against TB (BCG) was highest at 57.5% , followed by polio (42.3%), measles (34.6%) and DPT (33.9%) . In the case of both polio and DPT, immunisation is fairly high for the first dose but subsequently drops sharply till the final dose. Thus, only a small proportion of the population completes the full course of vaccination. Only 16% of the children were fully vaccinated by age of 12 months, which means that a fourth of the fully vaccinated children did not receive their vaccination within the given time frame of 12 months from birth. Female children with 19% full immunisation, received lower priority in vaccination as compared to male children (24%).
- The number of maternal deaths is very high in Central, Western and Eastern UP. The regional variation is in the line with the social status of women in these regions (RCHS 1998-99).

Population Policy of Uttar Pradesh 2000

6. The population growth rate between 1991 and 2001 works out to be 2.3percent as against 2.29 percent during 1981-91, which has been faster than all-India being 1.95 percent and 2.13 percent respectively. Hence along with the desired step up in the pace of development, it is equally important to have effective check on the population growth because of the fact that unless population growth is checked, enourmous developmental efforts may prove to be meaningless.

7. The objective of the population policy is to improve the quality of the people of Uttar Pradesh with unequivocal and explicit emphasis on sustainable development measures and actions. Population stabilization and improvement of the health status of people. particularly women and children, are essential prerequisites to sustainable development.

8. The main objective of the population policy is to reach replacement level of fertility of 2.1 by 2016 . For this purpose, the contraceptive prevalence rate by modern methods must increase from 22 present in 1998-99 to 52 percent in 2016. Fertility and contraceptive behaviour are inextricably inter-linked to infant and child mortality. To achieve population stabilization, there is an urgent need to reduce the infant mortality rate and also the maternal mortality ratio. The specific objectives of the Population Policy are given below:

(1) (1) Mean Age Marriage for women to increase 19-5 years by 2016. This will be achieved by increased awareness about legal age at marriage. Panchayats will maintain records of all marriages.

(2) (2) Reduction in Total Fertility Rate from 4.3 in 1997 to 2.6 in 2011 and further to replacement level of fertility of 2.1 in 2016.This will be achieved through increased use of contraceptive. Unmet need to be reduced from 56 percent in 1998-99 to 10 percent in 2016. Increase the average age of the mother at the birth of her first child from the current 18 years to 21 years by 2016.

(3) (3) Reduction in Maternal Mortality by improving ANC coverage from 46 percent in 1997 to 90 percent in 2016 and increased Tetanus Toxide (TT) coverage.

- Increase deliveries by trained personnel
- Increase institutional deliveries
- Reduce anaemia among mothers, Eliminate severe anaemia among all women by 2011
- Strengthen the systems to identify pregnant mothers at risk and referral system to attend to high risk cases.

(4) (4) Reduction in Infant and Under Five Mortality

- Increasing complete immunization of children from 42 percent in 1997 to 69 percent in 2006, to 85 percent in 2011, and to all children in 2016.
- Increase the use of oral re-hydration salts among children suffering from diarrhoea.
- Eliminate severe malnutrition among children by 2011
- Reduce the incidence of acute respiratory infections (ARIs) among children.
- Ensure that 50 percent of all children receive all required doses of vitamin A by 2006 and 90 percent by 2016 .

Reduce RTI/STI and AIDS prevalence and incidence

9. The infrastructure for health care in Uttar Pradesh is extremely inadequate. In 1991 the number of hospitals in the state were only 6.6% of the total hospitals in the country and the number of dispensaries in 1989 was 6.2% of the total dispensaries in the country. In 1991 the beds available in the hospitals work out to 2930 persons per bed. This is the highest figure amongst all the states in the country (except Bihar). The PERFORM survey estimates that in the public sector the number of Government hospitals, CHC/PHC and Sub-centres was 24930 . Of these twelve thousand were located in eastern region, 6000 in Western and 1135 in the Bundelkhand. The public sector providers include ANMs, Anganwari workers and village health guides. Their number for Uttar Pradesh as a whole was estimated at 8793.8. There were 37822 such providers in the eastern region, 30216 in the western region, 16024 in central region and 3000 in the central region and 3000 in the Bundelkhand

Private Sector

10. A large network of private providers exists along with a large number of public sector providers. The total number of private sector doctors is estimated at 1,57,259 (Registered and unregistered all inclusive) The Dai's (TBAs) are estimated at 1, 12,259 (Trained and untrained) Commercial outlets including medical shops, pharmacies etc. number about 6,98,000. Unlike the distribution of public sector providers, the highest concentration of the private providers is in the western region with 2952 institutions, 65401 doctors and 47945 dais. The distribution of health providers understandably has strong bearing on the health care in U.P. Regions with lower concentration of medical providers (in proportion to population) have lower maternal and child health care coefficient and higher unmet need for family planning services.

11. The total number of allopathic doctors was 23730 and 18400 were in the private sector. A large number of the doctors in the state actually belong to Homeopathic and Ayurveda /Unani doctors 2329 . Lucknow with three thousand nine hundred approximately allopathic doctors has the highest number of doctors in the entire state. A large number of these doctors (3735) are actually in the private sectors. Interestingly the records of the relevant councils suggest that in some of the districts the number of private practitioners is extremely low.

Civil Society Intervention in the Health Sector of U.P.

12. In Uttar Pradesh NGOs seem to be playing a very significant role in the Health Sector of the State. Across the state in almost all the economic regions of the state NGOs have made some significant intervention. Some of the important NGOs which are active in the health sector are The Hunger Project, Lokarpan, Sakhi, Manav Seva Sansthan etc. It needs to be mentioned that NGO movement received a significant boost after the formation of SIFPSA (State Innovations in Family Planning Services Project Agency). Other important agencies which are making a significant contribution in terms of institutional financial support are CRS North India, CARE and Prema etc.

13. The impact of NGO intervention can be gauged from the fact that in the area where Lokarpan is working it is found that:

- Around 81% of the mothers have been provided Anti Natal Care (ANC) coverage . In the NGOs non-intervention area the coverage was only 54%.

- 89% of the children were vaccinated. However, in the non-intervention area only 65.5% are vaccinated.
- Interestingly, the ratio between ANMs visit in the NGO and non-NGO area is 3.58: 2.27. The implications are very significant The ANM is a government functionary, her frequency of visit in the NGO area is found to be almost 35% better than the non-NGO area.

14. Similarly , it is found that the Hunger Project started working in the Brahmpur block of Gorakhpur district in 1996 (received financial support from SIFPSA). The area has recorded a complete transformation in terms of health sector statistics. The block now has one lowest IMR in the entire- district (Before the start of the project this block had one of the highest prevalence of mortality conditions and IMR). this significant upward movement of Brahmpur block on all heath indicators, in a span of four years is a classic example of NGO and Public sector partnership

ALLOPATHY

15. The population of urban areas has substantially increased during the past two decades. Keeping in view the growing population of urban areas, a policy decision was taken in the Sixth Plan period to provide 200 bedded district hospitals in each district having population upto 10 Lakh, 300 bedded district hospitals in each district having population above 10 Lakh and 500 bedded district hospitals at divisional headquarters where medical college does not exist. But in the Ninth Five Year Plan period, it has been experienced that the status of the urban slum dwellers is worse than that of the rural population. A target for the establishment of 100 urban primary health centers has already been proposed for the year 2001-02. The efforts are also being made to link these primary health centers with the existing infrastructure.

16. **Sub-Centres:** Sub-centers are the most peripheral govt. service units providing primary health care services to the rural population of the State. According to the prescribed norms, one sub center is established over 5000 rural populations in plains and 3000 population in tribal & Bundelkhand and difficult areas. In the State, on the basis of these norms, establishment of 20509 sub-centres is needed but so far only 18565 sub-centres are functioning, out of which 6612 are in the govt. buildings while buildings of 499 sub-centres are under construction. Therefore, the gap of the establishment of 1944 sub-centres and the construction of 11953 sub-centres buildings for still remains including under construction.

17. **Primary Health Centres:** It is also a very important govt. health institution in the rural areas where the community comes in direct contact with the Medial Officer for getting the medical care service. The population norms for the establishment of Primary Health Centres is one for every 30,000 rural population in plains and one in every 20,000 rural population in tribal, backward and difficult areas. So far, the required number of 3640 PHC's on the population norm basis have been established, out of which only 1777 PHC's are functioning in govt. buildings and 292 PHC's buildings are under construction. Thus, there is a still a gap of 1571 PHC buildings.

18. **Community Health Centres:** In order to develop an effective referral system so as to provide specialist treatment facilities to the rural masses very close to their dwellings, the establishment of Community Health Centres at least at block level PHC in the first stage was taken up. There are 823 block level PHCs in the state and 350 Community Health Centres have been constructed and as many as 340 CHCs have started functioning with certain specialties. The target kept for the year 2001-02 is the establishment of 40 CHCs. For establishing the Community Health Centres, in the first phase construction part is taken up. After the construction work is completed, the establishment of the Community Health Centres with X-ray, Pathology, Ambulance services etc. is provided.

19. **U.P. Health System Development Project:** U.P. Health System Development Project aims to metamorphose the medical & health services of the State in to a modern, responsive and accountable system that will provide high quality, affordable and integrated services to the masses. The Project was launched on 15th Dec.2000 with an approx. cost of Rs.478 crore. During the next 5 years 117 health facilities (25 Distt. Hospital-male, 25 Distt. Hospital –female, 3 Combined Hospital, 28 Community Health centers and 36 Primary Health Centers) will be developed as Model units by the project. Besides this, to develop managerial and technical skills of doctors and paramedics rigorous training programme are being organized through out the State, so that more accountable and quality oriented system could be evolved.

20. According to latest information the specialists have provided 8478 fixed day services at 267 CHCs in 70 districts of the State since Jan.2001. During this time 7.30 lakh out- patients were treated, 14778 in- patients registered and 8794 patients were referred to District Hospitals for higher treatment. Success of this Fixed Days approach is also verified by the increased income of these centres. Under this scheme Rs-15.25 lakh has been generated by the registration of patients, and Rs-6.12lakh has been earned by the registration of in-patients and under other heads. Fifty percent of this income is being utilized by the medical facilities for their strengthening under the user charges system.

- To strengthen the finances for development of medical facilities the state government has enhanced the user charges for medical services from 1 July 2000. People living below poverty line have been exempted from this increase. Under this system, 10% charges (Minimum of Rs.1/-) will be increased for different medical services. According to latest information the state government from user charges has received Rs.10 crore.
- To standardize the minimal level of medical services and availability of facilities at different centres extensive" Standard Norms" have been prepared by the project. The project has initiated to make the services and facilities available at different levels according to these norms.
- To insure transparency in the system "**Citizen's Charter"** has been prepared for display at every medical facility. To insure quality development of medical services the project has taken many initiatives. In this context, hospitals of 3 districts have been taken on experimental basis.
- Work is in progress to insure the availability of necessary equipment and medicines at all the 117 model units to be developed by the project. Now the medicines will be purchased

by the generic name instead of by the brand name. List of 63 such medicines have already been finalized .

- The project is ensuring public–private partnerships to provide quality medical services
- To take care of the accidental cases a "**Trauma Care Unit**" is being established on experimental basis at the National Highway in Moradabad.

21. The components of the project are as under:

- Policy Reform,
- Management Development
- Institutional Strengthening:

Strategic Thinking And Action

- To build in capacity for formulating and reviewing strategies in the Health Headquarters:
- A Strategic Management Board (SMB) would be established to provide opportunity for line managers to work in a coordinated manner on strategic issues, and
- A strategy support group or research wing would conduct studies and prepare status papers for the SMB on key issues.

Strengthening Management Performance And Accountability

22. To have accountable managers who have the ability, tools and authority to make decisions to provide services more efficiently, the following activities are being planned:

- Developing the Health Management Information Systems (HMIS)
- Developing a result oriented appraisal system
- Management Training and Monitoring.
- Piloting financial delegation to district managers.

Strengthening Implementation Capacity

23. This is planned through development of the project management structure by strengthening the directorate, strengthening and re-organising regional and district offices, better manpower utilization by adhering to revise norms, minimum transfers, prompt follow up, disciplinary actions and contracting class-IV staff as far as possible, ensuring adequate flow of funds to the project by following the “Letter of Credit” system, enhanced user charges and retention of user fee fully / partly at the health facilities level for use on non-wage items alongwith a clear guideline of exemption to the poor are intended to improve local resource management.

Improving Health Service Quality And Access

- Improving clinical- service- quality through skill development, quality assurance system, upgraded facilities, equipment supplies etc.

- Health service norms developed for each level of health facility. The initial focus is to make existing facilities fully functional with staff, equipments and systems according to revised norms. This includes rehabilitation of PHCs and District Hospitals.
- Improving public health service quality through strengthened disease surveillance and control, food and drug quality control systems, waste management systems and Information, Education and Communication.
- Improving access to health services in under-served areas and disadvantaged populations through innovative approaches.

24. Besides, U.P. Health System Development Project, two Externally Aided Project have also been proposed. For these projects, an outlay of Rs. 100 Lakh each for Establishment of T.B. clinic in newly created districts and Establishment of 300 beds in Budaun Hospital is proposed for the year 2002-03.

National Programme

25. National Programmes for control and eradication of T.B., Malaria, Filaria, Leprosy, Eye Disease, AIDS and I.D.D. will continued during the Ninth Five Year Plan and during the year 2001-02 efforts are being made to bring down the occurrence rates in the various programmes. Special efforts are being made to finish the backlog of Cataract cases.

National Blindness Control Programme

26. Under the National Blindness Control Programme, Eye treatment facilities in department at 68 places, 81 mobile health units and Eye banks at six places have so far been established.

National Leprosy Control Programme

27. Under Technology Mission Plan, strengthening of district hospitals is taken on priority in which work plan includes availability of transportation facility for patient by non-govt. organizations, increase in availability of medical facilities and improvement in medico-legal and post-mortem facilities, Some of the goals include 25% increase in bed occupancy rate, reduction in death rate of admitted patients and 5% increase of new patients in out-door.

National Aids Control Programme

28. This is a cent percent Centrally Sponsored Programme which has been launched since 1992-93 in the State and is still continuing.

National T.B. Control Programme

29. This centrally sponsored scheme is funded 50% by the Central Govt. and 50% by the State Govt.. T.B. is one of the most serious health problems. According to National Survey 1.7% population is suffering from T.B. of which 0.4% are T.B. positive patients. If these patients are not treated in time, each patient will create at least one new T.B. patient per year. The objective of the

programme is to search 70% of the patients and to cure 80% of them. With the aid of World Bank to Govt. of India, it has approved a revised proposal for T.B. Control Programme in 4 of the 43 district, in which districts Lucknow and Barabanki were included during 1997-98 and district Unnao and Raebareli were included during 1998-99. For the year 2001-02 an outlay of Rs. 1000 Lakh has been proposed.

National Malaria Programme

30. This programme is also 50% centrally sponsored scheme. Central Govt. assistance to the tune of 50% is in the form of Malaria preventive medicine, equipment and provision of insecticides. The objective of the programme is to decrease Malaria by 0.5 at each 1000 population by the year 2000.

Family Welfare Programme

31. This Cent Percent Centrally Sponsored Scheme include mainly the following programmes:

32. **Reproductive And Child Health Programme:** The Reproductive and Child Health Programme has been launched in the State since April 1998. The present programme includes all the components of maternal and child health services, child survival and safe motherhood, family planning services, R.T.I./ S.T.I. and AIDS. The aim of the reproductive and Child Health Programme is to induce the confidence in the couple so that they can maintain sexual relationship without fear of pregnancy and contracting disease and can have a child when desired. The period of pregnancy, delivery and new born are safe and healthy. The couple is also looked and treated for R.T.I./ ST.I. and AIDS. The programme is funded by Government of India and World Bank, European Commission,UNFPA and UNICEF. The programme is being implemented in a phased manner in the State.

33. From April 1999, all the districts of the State are being covered under the programme. Under the special intervention, two districts have been identified as sub-project districts Raebareli has rural and urban coverage where as Firozabad has only urban coverage. The objectives of the programme are as:-

- To reduce birth rate to 21 per 1000
- To reduce Death rate to 9 per 1000
- To reduce infant mortality rate to <60 per 1000
- To reduce peri-natal mortality rate to <35 per 1000
- To reduce under 5 year age mortality rate to <10 per 1000
- To reduce under weight babies by 10%
- To increase couple protection rate to 60%

34. The State has achieved death rate (SRS-97) as 10.2 per thousand, infant mortality rate (SRS-97) as 84 per thousand, live birth and couple protection rate as on 31.3.1998 as 37.68. The Information, Education and Communication (IEC) activities have been strengthened by creating a

separate bureau in 1999-2000. The following achievements indicated that the programme has been successfully implemented to attain these goals:-

- As regards the availability of contraception methods/materials, it has been ensured that the target couple received them from the places nearest to their residences. The programme is being run totally on voluntary basis to avoid any complication of coerecion. The target couple are given full choice to select any method of their liking. Sterilization, Laparocropes, Tubectomy are very popular in the State as Laparascopes have been provided upto Tehsil level female Hospitals.

35. Under the reproductive and child health programme, the methodology of working and interventions are as under:-

(1) Active participation of influential persons, local leaders, educational institutions and Gram Panchayats is being ensured.

(2) Financial resources and other supplies are being allotted timely.

(3) Detailed monitoring and evaluation, as per prescribed norms, is done to ensure the quality of programme.

(4) For each category of officers and officials/workers several training programmes have been organized.

(5) Schemes like green card distribution is continued.

(6) Information, Education and Communication activities have further been strengthened by creating separate Bureau.

(7) For making programme a success and for effective monitoring and evaluation, consultants have been appointed.

(8) For pregnant mothers, essential obstetric care and emergency obstetric care have been strengthened at primary health centers.

(9) Provision has been made for 24 hrs delivery facilities in four different centres of the districts in the initial stages and the system is to be implemented in other centres of districts in future.

(10) Essential new born care has been introduced to reduce the IMR Peri-natal mortality.

(11) Interest free loan for moped has been provided to health workers who are posted at remote sub-centres.

(12) MTP services R.T.I/S.T.I and AIDs clinics have been strengthened.

(13) Infrastructure budget for major and minor civil work is being provided to all the districts of the State and deliveries are being helped by special provision of referral transport money through panchayats.

(14) Maximum cooperation of press, radio, TV has been ensured.

(15) Practitioners of Indian System of medicine have been involved in the programme.

36. **Universal Immunization Programme** :Universal Immunization Programme under technology mission of Government of India has been launched in the State so as to reduce Maternal Mortality and pere-natal mortality rate. Under this programme, children are being immunized against the six fatal diseases. This programe is accorded same priority as our family welfare schemes. Prophylaxis scheme is also being implemented in the State with following provisions.

- Oral Rehydration Therapy.
- Distribution of Vitamin solution to prevent blindness and eye disease.
- Distribution of Iron Folic acid tablets to prevent anemia in pregnant women and children.

37. The Medical Officer and all other health providers are being trained under Skill Based Training Programmes to provide quality care to the beneficiaries. The community participants like A.N.Ms, A.W.W, CH.w, GRAM PRADHAN, Other Panchayat Members, school teachers and member's of the Voluntary Health Association/N.G.Os are being trained under Awareness Generation Training Programmes. Through this training, community need assessment will be earlier and community need assessment will be easier and community participation will also be ensured.

National Aids Control Programme (NACP)

Mission

- UPSACS has the mission to effectively counter the epidemic of HIV in U.P. by adequate mechanisms to ensure the current low level of prevalence through multi faceted approaches of preventive measures keeping ethical concerns.

Vision

- To establish good practices in counselling, surveillance, STD control, Blood Safety measures, Clinical Management, Care & Support.
- To ensure that HIV preventive strategies reach the primary health care system enabling outreach at the grass root level.
- To strengthen the capacity building programmes at various levels for preparing the long term impact of the epidemic.
- To spearhead massive innovative interventions programmes to ensure behavious change.
- Develop culturally appropriate message for adolescents and youths.

NACP-I

- In U.P. the first case of HIV/AIDS was detected in 1987. The First Phase of AIDS Control Programme started in 1992 and completed in 1999. The main emphasis was given on:

(a)	(a)	Creation of infrastructure
(b)	(b)	Training of Medical staff
(c)	(c)	Mass Awareness about HIV /AIDS

NACP - II

(a)	(a)	Prevent HIV Transmission
(b)	(b)	Decrease the morbidity and mortality associated with HIV infection
(c)	(c)	Minimise the socio-economic impact resulting

PRIORITIES

(1) (1) Deliver cost effective Interventions against HIV/AIDS:

- Priority targetted inteventions for groups at high risk (CSWs, Migrant Workers, STD Clinic attenders),
- Preventive Interventions for the general community (conduct IEC & awareness compaigns, FHAC, folk media, Voluntary HIV testing promotion , training grass root level healthcare providers, Counselling Services in Blood Banks, STD clinics)
- Low Cost AIDS Care (treatment of opportunistic infections, NGO's and community based AIDS Care)

(2) (2) Strengthen Capacity

(3) (3) Institutional Strengthening

- Build implementation capacity of SACS
- Expansion and improvement of annual HIV Sentinel Surveillance.
- STD Surveillance through specific surveys like FHAC
- AIDS case Surveillance
- Conduct Training of Staff
- Build Capacity for Monitoring and Evaluation by Monthly Reports.

(4) (4) Inter-sectoral collaboration with private, public and voluntary sectors, integration with other programmes, industrials.

NINTH PLAN

38. In order to ensure the better quality of life of people, the main focus during the Ninth Plan is on strengthening of Primary Health Care.

39. The approved outlay for the Ninth Five Year Plan period for allopathy services is Rs 94,700 lakh, out of which the capital content is Rs 64001.00 lakh and the district sector schemes are of Rs 74055.01 lakh.

40. The anticipated expenditure during the Ninth Five Year plan is expected to be Rs. 55685.04 lakh. During the Ninth Five Year Plan period 53 Community Health Centres were established in the rural area. Besides this in the urban area 200 beded Hospital in Varanasi, 60 beded hospital in district Jalaun, 30 beded hospital Rajajipuram, Lucknow and out-patient facilities at Gomtinagar hospital in Lucknow were also commissioned. Under the externally aided project 300 beded hospital in district Basti was also established.

41. In the rural area according to the Government of India norms 3640 Primary Health Centres were functioning and 340 Community Health Centres have also been established. In the rural area

18565 sub-centres are functioning to provide the medical care services to the pregnant mothers and child care to the newly born babies.

TENTH FIVE YEAR PLAN

42. The proposed target for the Tenth Five Year Plan are as follows:

Item	Details	Unit	Target Proposed
1	Establishement of District hospital in newly created district	No	10
2	Establishment of Urban P.H.Cs	No	100
3	Establishment of sub-centres	No	1944
4	Establishment of Community Health Centres	No	200
5	Birth Rate	Per 1000 Population	22.00
6	Death Rate	Per 1000 Population	9.00
7	Infant Mortality rate	Per 1000 Population	72.0
8	Mother mortality rate	Per 1000 Population	400 per lakh
9	Total fertility rate	Per 1000 Population	3.3 per lakh
10	Couple protection rate	Per 1000 Population	36.2 percent
11	Anti natal care	Per 1000 Population	70.0 percent
12	Institutional birth	Per 1000 Population	38 percent 0f 13
13	Delivery through trained personal	Per 1000 Population	65.0 percent

43. The proposed outlay for the Tenth Five Year Plan is Rs 2044.81 crore, out of which Rs 993.92 crore is proposed for externally aided programmes. Rs 329.47 crore is proposed under P.M.G.Y schemes. Rs 21.42 crore is proposed for Eleventh Finance Commission programme. Establishment of district hospitals in newly created districts, strengthening of Directorate, divisional and district offices and other district level hospitals. During the tenth five year plan it is also proposed to strengthen the present infrastructure.

44. The schemes under the 100% centrally sponsored schemes will continue as per the instruction of Government of India.

ANNUAL PLAN 2002-2003

45. The proposed outlay for the Annual Plan 2002-2003 is Rs 249.30 Crore out of this Rs 116.28 crore will be spent on the externally aided projects. The proposed outlay for the P.M.G.Y schemes is Rs 52.16 crore. The Malaria and T.B.programmes under the fifty percent basis will be covered during this year. The proposed outlay under the Eleventh Finance Commission programme is Rs 10.86 crore.

46. During the year 2002-2003, 25 new Community Health Centers are proposed to be established. 30 new community health centre's building will be taken for construction and construction work under the district plan for 75 P.H.Cs building will be taken up.

47. Under the World Health Project in 28 districts the renovation, extension and provision of rural and district male and female hospitals will be provided an outlay of Rs 116.28 crore.

Challenges In Improving The Health Status

48. An analysis of government expenditure on health care indicates that it is regressive, though some services, such as immunization and non-hospital outpatients' care are pro-poor. Out of every Rs. 100/- spent in public sector on curative health care services in U.P. the poorest 20% of the population receives Rs. 10/- on health services while the richest 20% received Rs. 41/- . Public spending in U.P. is clearly less pro-poor than spending in many other states. Unless an adequate and reliable supply of medicines and medical supplies flows to the primary health care facilities on a regular basis, these facilities will continue to be under-utilized by intended beneficiaries and the poor. Adequate funding of the personnel cost is another critical constraint. Besides filling of staff vacancies, allocations are also needed for improving the capacities and performances of practitioners now working in public health service delivery.

49. It is very clear that the private sector has to play a key role in the delivery of health services in U.P. However, there is several standards and quality assurance systems in both public as well as private sectors. Virtually, there is no effective regulation in the private sector. The private sector provides no information about its performance and has no system for patient protection or fair pricing. There is absolute dearth of information regarding how well private care is delivered in U.P.

50. While the private sector and private providers will have to play an important role in the health sector of the state. It must be re-emphasised that the role of public sector will retain its critical importance. It must be appreciated that the cost of treatment is among the highest in those states where the public health infrastructure is less developed. This fact applies to government and private hospitalisation as well as to outpatient treatment. Where public health system is well developed the treatment cost of both public and private sector facility is low. Access to health care is directly related to the cost of health care. It is amply clear that in U.P. the cost of private care is exorbitantly high in comparison to both the cost of public sector facilities as well as the bearing capacity of the population, particularly the poor.

51. The decline in infant and child mortality rate for the past few decades are traceable to government sponsored preventive health initiative, including immunization camps, installation of clean water points in rural areas etc. The time has come when these efforts have to be intensified. The challenge before U.P. is huge by any standard. It can only be surmounted if the private sector, NGO and the Govt. join hands. The public agencies and NGOs should focus greater resources on development and widespread dissemination of public health information messages aimed at improving community members capacity to safeguard their own and their children's health.

52. In view of the above mentioned facts, particularly high cost of hospitalisation it seems that 'health insurance for hospitalisation' is an important option which needs to be explored. This option has often been discounted on the ground that such insurance will be beyond the means of the poor. The truth is that if entire public sector health expenditure that is happening is taken along with the private expenditure, such insurance seems to fall in the area of the plausible. It is also felt that if the primary health care system functions in a proper way the insurance coverage will not be needed for domiciliary treatment. In other words the insurance cover will be needed only for hospitalisation. It is proposed that direct government expenditure in the health sector be limited to capital expenditures. Whatever the government pays for the current expenditure may be routed through the insurance

system. The Insurance payments for various illness and procedures can be fixed on lines of various experiences/models at the global level (like the Medicaid in the United States). Both the government and the private hospitals will have to compete with each other for patients. Such a managed competition is likely to raise efficiency of both segments of health care system. At present there are no regulations on the quality or price of private health care in U.P. Since the very operation of the health insurance system could perform a watchdog function, the insurance system will be in a better position to enforce the principles of moral hazard than any government regulatory mechanism.

53. It is clear that UP's progress in improving the health status of its citizens has been slow and that the burden of ill health falls disproportionately on the poor, the socially deprived and women and children. It is clear that strengthening of the health system must draw on the strengths of both public and private provisioning.

AYURVEDIC AND UNANI

54. India has a rich heritage of well documented health care system of life, i.e; Ayurveda. Along with Ayurvedic system, the system of Unani medicine is also well recognised . The Govt. of U.P. is well aware that this system offers the kind of medicines which are within the physical and financial reach of the patient. In order to give a boost to Ayurvedic and Unani system, it is necessary that the available infrastructure in Ayurvedic and Unani hospitals should be strengthened and sufficient supply of the standard medicines should be ensured.

Aims and Objectives

- To ensure the availability of Ayurvedic and Unani System of medicine to the masses at large at an affordable cost .
- To promote research and development and also to strengthen the infrastructural facilities presently available in Ayurvedic and Unani colleges.
- To ensure availability of sufficient and standard medicines in Ayurvedic/ Unani hospitals, while strengthening the infrastructural facilities presently available in the hospitals.
- To create and establish new hospitals in areas which are so far not covered by Ayurvedic/Unani hospital facilities.

55. Keeping the above factors in view the thrust areas for the Tenth Five Year Plan are :

- Strengthening of infrastructural facilities, availability of adequate and standard medicines alongwith medical equipments in all Ayurvedic/Unani hospitals.
- Creation of required teaching and non teaching positions and infrastructure in Govt. Ayurvedic and Unani Colleges of the State as per norms laid down by the Central Council of Indian Medicines.
- To promote research and development projects in Ayurvedic and Unani colleges of the State.

- Establishment of new Ayurvedic and Unani hospitals in areas so far not covered by Ayurvedic/ Unani hospital facilities.
- Creation of sufficient supervisory staff at District and Regional level for optimal utilisation of man power engaged in Ayurvedic/Unani system of medicines.

56. Schemes of the Ninth Plan being proposed to be continued in the Tenth Plan are as follows:

- Establishment of Ayurvedic Hospitals in Urban Areas (DS)
- Strengthnening of Directorate
- Establishment of Unani Hospitals in Urban Areas (DS)
- Construction of buildings of Ayurvedic/Unani Hospitals
- Construction of buildings of Ayurvedic/Unani Colleges and Attached Hospitals
- Expansion of Ayurvedic and Unani Colleges and attached Hospitals :-

57. Establishment of Ayurvedic Hospitals in Rural Areas :- Under this scheme, during Ninth Plan period, 280 hospitals were established. There are still many uncovered rural areas hence it is proposed to establish 210 hospitals during Tenth Five Year Plan.

58. Strengthening of Ayurvedic/Unani Hospitals Under Prime Minister Gramodaya Yojana:- Under this scheme as per guidelines of PMGY, funds for adequate Ayurvedic and Unani medicines and other essential consumables/ repair of essencial equipment, repair/ replacement of furnitures, strengthening repair and maintenance of the infrastructure will be provided to approximately 2000 hospital situated in rural areas. Priority will be given to ensure potable water supply adequate tiolet facilities and waste management. Also special emphasis will be given to strengthen the existing infrastructure of 20% of districts identified on the basis of Infant Mortality Rate (IMR), Crude Birth Rate (CBR) in 2001 census .

59. Establishment of Unani Hospitals in Rural Areas :- In the Ninth Plan Period, 16 Unani hospitals were established in the rural areas.

60. Expansion of existing State Pharmacies:- At present there are 2 State Pharmacies, one in Lucknow and other in Pilibhit. These 2 Pharmacies supply good quality of medicines to all the 2200 hospitals of the State. It is expected that under Prime Minister Gramodaya Yojana (PMGY) major funds for the purchase of medicines will be provided during the next Five Year Plan period. In view of this the role of these State Pharmacies becomes all the more important. Already in 2001-2002 Central Government has released grant to the tune of Rs. 80.00 lakh to upgrade Lucknow Pharmacy and it is expected that Pilibhit Pharmacy may also get grant for upgradation in the year 2001-2002 itself.

61. Expansion of Ayurvedic/Unani Drug Control and Testing Labs:- There is only one Drug Testing Lab in Lucknow. For the upgradation of this lab Government of India has released an amount of 65.00 lakh in 2001-2002.

New Schemes proposed for Tenth Five Year Plan

62. In order to combat with the needs and challanges of the present time, following NEW SCHEMES are being proposed :-

63. **Establishment of District and Regional Ayurvedic and Unani Offices** :- At present, there are 2200 Ayurvedic and Unani Hospitals dispersed in 70 districts of the State. Normally 4 bedded hospital comprises of one Medical Officer, one Pharmacist, one Wardboy and one Sweeper. Hospitals with 15/25 beds have additional medical and paramedical staff comprising of Nurses and Sisters etc.. For effective adminstrative control, meaningful supervision and guidance to the officers and employees posted in various Ayurvedic and Unani hospitals, as a bare minimum, District level office is required in each district. However, till the completion of Ninth Five Year Plan, only 48 districts of the State are having Ayurvedic / Unani offices. Hence it is proposed to establish District Offices in the remaining 22 districts during the Tenth Five Year Plan period.

64. For establishment of District Office, post of one Ayurvedic/Unani Officer, one Senior Clerk, one Accountant, one Steno-cum-Typist, one Data Entry Operator and one class IV employee will be created in each District. Since post of District Ayurvedic / Unani Officer will be filled by the promotion from amongst Medical Officers and hence there will be no additional requirement of funds. Department has a large number of class III employee as dependents of deceased employees on super numerary post. Hence Class III employees in the districts can easily be adjusted against proposed posts. Data Entry Operator will be employed on contractual basis.

65. To meet the above expenses an outlay Rs. 360.00 lakh has been proposed for the Tenth Five Year Plan.

Construction of Hostels

66. It is proposed to establish 5 male and 5 female hostels of 20 rooms each with capacity of 40 students in 10 different colleges. Besides construction of these hostels, it is also proposed to equip them with proper furnitures and fixtures. For the above, a sum of Rs. 500.00 lakh is provided in the Tenth Five Year Plan.

Promotion of Research Activities in Ayurvedic and Unani Colleges

67. It is, proposed that research in Ayurvedic/Unani system should be given special thrust in the Tenth Five Year Plan. In order to achieve this, a provision of Rs. 165.00 lakh is being proposed out of which 80.00 lakhs will be specifically earmarked for developing infrastructure facilities for research in Ayurvedic and Unani colleges. Remaining amount of 85.00 lakh will also be utilised for promoting research activities as follows :-

Upgradation of Colleges as per norms of CCIM

68. It is proposed to establish 7 new departments in Ayurvedic and 5 new departments in Unani colleges and create required teaching and non-teaching positions and infrastructural facilities as per norm of CCIM. Department had already prepared exhaustive scheme for the above. An outlay of Rs. 1425.00 lakh has been proposed for the Tenth Five Year Plan.

Establishment of new Ayurvedic/Unani Drug Testing Labs

69. At present, there is only one Drug Testing Lab situated at Lucknow. Presently there are as many as 3000 private pharmacies manufacturing Ayurvedic and Unani medicines. Therefore, it is proposed to establish 2 new Drug Testing Labs in the Tenth Five Year Plan. Out of these 2 labs one will be established in western part and other will be in eastern part of the State. For this a sum of Rs. 50.00 lakh will be provided in the Tenth Five Year Plan.

Strengthening of Ayurvedic/Unani hospitals in Urban Areas

70. Under PMGY Ayurvedic and Unani hospitals situated in rural areas will be getting adequate medicines and infrastructural support during the next five year plan period. However, for hospitals situated in urban areas there is no such scheme. In order to remove this disparity a new scheme of strengthening of Ayurvedic/Unani hospitals in urban areas is being proposed. Under this scheme, hospitals situated in urban areas will be provided with additional funds for medicines and strengthening of infrastructure. For this a sum of Rs. 75.00 lakhs is being provided in Tenth Five Year Plan.

71. During the Tenth Five Year Plan, an outlay of Rs.7500.00 lakh has been proposed, which included Rs.1000.00 lakh for the Annual Plan 2002-03.

HOMEOPATHY

72. There is no denying fact that the burden of the medical care of such large population (17 crore) is also shouldered by Homoeopathic system of medicine. The popularity of homoeopathy medicine is not only confined to the poor and the illiterate peasantry but the patrons of this system are also found amongst intelligentia and the rich and even amongst the practitioners of allopathic medicines. The people take recourse to this system of medicine not merely because of the non availability of the practitioners of modern system of medicines, but because of the efficacy of this system which has no side effects as well as the cost, effectiveness and presenting inherited diseases.

73. The Homoeopathic system of medicine in the state started developing and expanding from the 3rd five-year plan. Now this system is continuously getting popularity in rural as well as in urban areas and more people are getting attraction towards this system of medicine. Various steps and effeorts have been taken by the state government for all round development of this system of medicine.

74. The target to establish 300 urban and 600 rural dispensaries was fixed in Ninth Plan against which on account of constraints of resources, only 255 rural dispensaries could be opened. In the field of Medical education, the construction of three state Homoeopathic Medical Colleges of Lucknow, Kanpur and Allahabad was started and their speedy construction is going on. The position of outlays and expenditure in Homoeopathy from Eighth Plan is given as under:-

Outlay And Expenditure

(Rs. in lakh)

Sl. No.	Plan period	Outlay	Expenditure

1	2	3	4
1.	Eighth Plan(1992-97)	1039.00	1767.38
2.	Ninth Plan(1997-2002) (Anticipated)	3500.00	4190.00

Objective And Strategy

- Keeping in view the needs of the Homoeopathic services and achievements made so far the following main objectives are proposed for Tenth Plan (2002-07).
- Strengthening of homoeopathic system of medicine and their expansion in rural and urban areas where facilities, at present, are not still adequate,
- Greater attention to mitigate the regional imbalances, according to preference to areas having concentration of Scheduled Castes/Scheduled Tribes and urban slums in the matter of coverage and location of health services,
- Main thrust has to be towards better capacity utilization and completion. It is equally necessary to consolidate the existing infrastructure and make it yield better result,
- To consolidate the existing facilities under homoeopathic medical education and augment according to needs of time,
- Active community participation and involvement of voluntary organizations in homoeopathic programmes.
- Training and education of doctors and para-medical workers and
- Population control and qualitative improvement in human life so as to develop human resources.

Proposal For Tenth Plan

75. Keeping the above objectives in view, the details of the programmes of homoeopathic system of medicine, in brief, are as follows;

Establishment Of Hospital/Dispensaries

Rural

76. During Tenth plan period, 600 rural dispensaries have been proposed to establish including 125 dispensaries for the Annual Plan, 2002-2003 for this out lay of Rs. 1229.83 lakh is being proposed for Tenth Plan period including 150.00 lakh for Annual Plan, 2002-2003 for this programme.

Urban

77. There are only 89 urban dispensaries are functioning in the state, serving about 3.40 crore people. Only 300 urban dispensaries are proposed to be opened during Tenth Plan period, including

66 dispensaries in 2002-2003. The outlay for this programme is proposed Rs. 658.84 lakh for Tenth Plan including Rs. 10.00 lakh for the Annual plan, 2002-2003.

Establishment of Govt. Homoeopathic Hospitals In 100 CHCs

78. At present 316 CHCs are functioning in the State and their number is likely to increase in Tenth Plan. The Government have decided to establish all three pathies (Allopathy, ISM & H) at CHC level so that the patients may be treated according to their choice. Keeping the above objectives in view, 100 homoeopathic hospitals are being proposed during Tenth Plan for which an outlay of Rs, 212.00 lakh has been proposed.

Construction Of State Homoeopathic Dispensaries

79. Most of the Homoeopathic Dispensaries are functioning in rented/rent-free buildings which adversely at affects on the quality of this pathy. Due to paucity of funds it would not be possible to construct all the buildings of State homoeopathic dispensaries, hence, during Tenth Plan period, the construction of building of 100 dispensaries is being proposed for which an outlay of Rs. 200.00 lakh has been proposed.

Strengthening, Expansion And Renovation Of State Homoeopathic Medical Colleges

80. There are seven State Homoeopathic Medical College in the State, but they are not at par with CCH norms. The State Government has decided to strengthen and construct the buildings of 3 State Homeopathic Medical Colleges (Lucknow/Kanpur & Allahabad) in Ist phase at the estimated cost of Rs. 4843.44 lakh, out of which Rs. 2706.55 lakh are likely to be spent by March 2002 and the teaching and administrative blocks and girls hostel have been constructed. To complete the rest work, an outlay of Rs. 1800.00 lakh has been fixed for the Tenth Plan, including Rs. 200.00 lakh for 2002-2003 and also for the Strengthening of rest 4 colleges an outlay of Rs, 413.33 lakh is proposed.

Pradhan Mantri Gramodaya Yojana (PMGY)

81. To ensure the better medical services to the rural masses, this programme aims to provide sufficient medicines, furniture, equipments etc. to the rural dispensaries. To meet this objective an outlay of Rs. 2500.00 lakh has been proposed for the Tenth Plan, including Rs. 500.00 lakh for the Annual Plan, 2002-2003.

82. During the Tenth Five Year Plan an outlay of Rs.7500.00 lakh has been proposed, which included Rs.1000.00 lakh for the Annual Plan 2002-03.

MEDICAL EDUCATION

83. State Government is financing 7 Medical Colleges of the State including K.G. Medical College, Lucknow. These Medical Colleges alongwith their are imparting Graduate (MBBS/BDS), Post-graduate (MD/MS/PG Diploma) and Super-speciality (DM/M.Ch) Medical and Para-medical (including Pharmacy and Nursing) education and training. In addition to education & training the

College hospitals and Institutes are providing speciality and super-speciality medical care, modern treatment facilities to patients and simultaneously conducting research in different field of medical sciences. In Ninth Plan provision of outlay of Rs. 5000.00 lakh was made but in first 4 years i.e., from 1997 to 2001 the actual Outlay given in respective years were only Rs. 1000.00, Rs. 1000.00, Rs. 800.00 and Rs. 200.00 lakh respectively. Accordingly plan schemes were proposed but only Rs. 1559.92 lakh could be utilised in these four years. In the current financial year 2001-2002, an outlay of Rs. 1500.00 lakh has been proposed for different works.

84. Main problem which the Medical Education is facing is recognition of its medical degrees by Medical/Dental Councils of India. Continuation of recognition of MBBS & BDS degrees of all 7 colleges is pending and 1/3 of PG courses of different colleges are yet to be recognized. These Councils have laid down standards of education and teaching facilities viz. building and space, teaching and ancillary staff, equipments and other facilities. Deficiency of Teaching and other staff, equipments, other ancillary staff, laboratory and teaching space and other facilities as per standard requirements laid down by MCI/DCI are the main hindrances in the recognition of colleges and their degrees. Removal of deficiencies as enumerated in Inspection Report of colleges will need expenditure of few hundred crore. For teaching/research 12 separate schemes have been proposed which are self explainatory. Strengthening of Directorate including legal cell has also been proposed in view of increased and frequent litigations in admission and administrative matters.

85. Government has already decided opening of Medical University to introduce uniformity and regulation of Medical Education specially in view of opening 4 Medical and 14 Dental colleges in private sector. These colleges are affiliated to different Universities having no expertise and experience of Medical Education. Because of acute shortage of trained paramedical personnel specially in view of rapid advancement in biomedical technology. Also in order to make regular arrangements for Medical, Dental (Graduate and Post-Graduate) admission through competitive entrance tests it has become necessary to establish the university at the earliest.

86. During the Tenth Five Year Plan an outlay of Rs. 8000.00 lakh has been proposed which included Rs. 1000.00 lakh for the Annual Plan 2002-03.

SANJAY GANDHI POST GRADUATE INSTITUTE OF MEDICAL SCIENCES

87. Sanjay Gandhi Post Graduate Institute besides being a center of excellence for patient care, teaching and research on complex diseases belonging to various existing specialities, is also committed to join hands with the State Health and Medical Education sectors. It has developed several modern information technology based solutions to achieve various ideal health targets. It is also desirous of playing major role in improving the status of State Medical Colleges by upgrading the standards of medical education. It is involved in continuing medical education programmes for the teachers in their colleges. It has got the technology for wider dissemination and sharing of resources.

88. Following specialities are to be added in the Tenth Five Year Plan in order of priority.

Establishment of a Center for Accident and Trauma

89. There is no accident and Trauma center in the country. It is estimated that 2190 patients die and 17520 patients are injured only in Lucknow district every year. Hence, it is proposed to build a well-equipped center for the care of acutely injured and also for generating skilled medical and paramedical manpower personnel for the care of a trauma victim. It would have a facility for quick and safe transportation, care and rehabilitation of these patients. It will cost about Rs.6000.00 lakh, which includes Rs.1750.00 lakh for building, Rs.3800.00 lakh for equipment & air ambulance, and Rs.650.00 lakh for infrastructure including manpower.

Critical Care Medicine

90. An outlay of Rs. 500.00 lakh has been proposed for the Tenth Five Year Plan (2002-07)

Oncology and Cancer Center

91. Estimated load of new cancer patients in the state is around 80,000 to 100000 every year. There is no comprehensive center for the treatment of these patients. Institute has an excellent specialty in surgical and radiation therapy facilities. It is essential to supplement existing facilities with medical oncology and other deficient areas, which will cost about Rs.175.00 lakh on building, Rs.3157.00 lakh on equipments and Rs.43.50 lakh on manpower.

Establishment of TELEMEDICINE and school of Minimally Invasive Surgery

92. Telemedicine is a new health technology which has potential to link hospitals, doctors and patients with communication and information technology for developing Tele-consultation, Tele-education, sharing of patient- records and hospital management etc. This Institute has been carrying out several telemedicine projects with the help of external assistance. The time now has come to establish a permanent set up which envisages to network all the medical colleges and district hospitals of the state with this Institute for providing the specialized tele-education and tele-consultation for welfare of the patients and doctors sitting in remote areas and to help the government for effective and timely disaster management as and when required.

93. There is no center in the country, which has formal training programmes in minimally invasive surgery. Minimally Invasive Surgery obviates the need for open operation and hence reduces the hospital stay of the patients. It offers a quick recovery to the patients and thus drastically reduces the cost of treatment. It requires special skills and equipment to execute this procedure.. This center is created to prepare highly skilled medical and paramedical manpower. It will apply all modern tool of information technology for utilizing online human resource world over.

Center for Organ Transplantation

94. Sanjay Gandhi Postgraduate Institute is the only comprehensive center in the region for Kidney, Bone Marrow and Liver Transplantation. It has performed more than thousand kidney transplants during last three years. It has been consistently performing largest number of kidney transplants in the country. The proposed center would establish cadaveric organ transplant

programme, transplantation of multiple organs and high-level research in the use of synthetic organs and prevention of transplant rejections.

Center for Molecular Medicine

95. Recent advances in the field of Human Genetics, in particular the Human Genome Project, has led to the emergence of the concept of Molecular Medicine with the aim of mapping of all the genes & sequencing of the entire human genome by the year 2005. This shall result into identification of all the diseases causing genes, both monogenic as well as polygenic which is bound to revolutionise the practice of medicine in coming years. With the establishment of Medical Genetics as one of the six super-specialities in the first phase at SGPGI the stage is now set to embark upon establishment of a Centre of Molecular Medicine. ICMR has already recommeded this project for funding Rs.400.00 lakh and it is expected that money will be released very soon.

Pulmonary Medicine

96. With the large bulk of critically sick patients non-existence of pulmonary medicine component is a major missing link and it has become essential to develop it at this stage.

Biomedical Engineering Workshop

97. With the availability of more and more sophisticated and expensive equipments it has become essential to develop a facility to maintain and repair this equipment. This center will also train Biomedical engineers to provide manpower to the country

Centre for Bio-informatics

98. SGPGI has already been identified as one of the six centres in the field of Bio-informatics with an in principle sanctioned grant of Rs.200.00 lakh.

School of Health Informatics

99. This School is planned for training manpower for the use of Information Technology in Medicine.

Wellness Clinic

100. We are shifting our focus from **illness to wellness** are and in the process of establishing a health care center with the concept of holistic medicine.

Assistance Under Indo - French Assistance Protocol For FF 42 M

101. Institute had submitted a project to the Government of France for FF 72 M under Indo-French Assistance Protocol out of which FF 30 M have been sanctioned. A request for sanctioning the remaining FF 42 M has been submitted to the State Government requesting them to forward the proposal of the Institute to Government of India so that the same may be pursued and assistance may be got sanctioned.

Projects Submitted For Assistance Under O.E.C.F. Debt Relief Fund:

102. Institute has also been trying to get the external assistance out of the OECF grants and our following proposals are under consideration of the Government of India. Establishment of a Centre for Accident and Trauma Services at SGPGI, Lucknow - assistance from OECF Debt Relief Grant Aid. Rs. 5250.00 lakh. Consolidation of Phase I and initiation of Phase II for upgradation of the standards of Medical Health Care in Northern India under OECF, Japan under Health Sector Rs. 21569.00 lakh. Institute has been pursuing the above proposals with the Government of India and is hopeful to get the above assistance for the development of the Institute as soon as the ban imposed by the Government of Japan is lifted.

Infrastructure Support

103. This is a project submitted to Department of Bio-technology for research facilities at SGPGI and to establish a core Central Research facility.

104. During the Tenth Plan an outlay of Rs. 35159.00 lakh has been proposed which included Rs. 1800.00 lakh for the Annual Plan 2002-2003.