Rural Health Care System in India

Rural Health Care System – the structure and current scenario

The health care infrastructure in rural areas has been developed as a three tier system (see *Chart 1*) and is based on the following population norms:

Table 1.

Centre	Population Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

As on March, 2011, there are 148124 Sub Centres, 23887 Primary Health Centres (PHCs) and 4809 Community Health Centres (CHCs) functioning in the country

Sub-Centres (SCs)

1.2. The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM) / Female Health Worker and one Male Health Worker (for details of staffing pattern, see ***Box 1*** and for recommended staffing structure under Indian Public Health Standards (IPHS) see **Annexure I**). Under NRHM, there is a provision for one additional second ANM on contract basis. One Lady Health Visitor (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Ministry of Health & Family Welfare is providing 100% Central assistance to all the Sub-Centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Health Worker is borne by the State Governments (Also see para 2.4 for NRHM additionalities). Under the Swap Scheme, the Government of India has taken over an additional 39,554 Sub Centres from State Governments / Union Territories since April, 2002 in lieu of 5,434 Rural Family Welfare Centres transferred to the State Governments / Union Territories. There are 1,48,124 Sub Centres functioning in the country as on March 2011.

Number of Sub Centres existing as on March 2011 increased from 146026 in 2005 to 148124 in 2011. There is significant increase in the number of Sub Centres in the States of Chhattisgarh, Haryana, Jammu & Kashmir, Karnataka, Maharashtra, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura and Uttarakhand.

Primary Health Centres (PHCs)

1.3. PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services (BMS) Programme. As per minimum requirement (Box-1), a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff (See Annexure-I for IPHS norms). Under NRHM, there is a provision for two additional Staff Nurses at PHCs on contract basis. It acts as a referral unit for 6 Sub Centres and has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services. (Also see para 2.4 for NRHM additionalities). There were 23,887 PHCs functioning in the country as on March 2011.

At the national level, there is an increase of 651 PHCs in 2011 as compared to that existed in 2005. Significant increase is observed in the number of PHCs in the States of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Haryana, Jammu & Kashmir, Karnataka, Maharashtra, Nagaland, Uttarakhand andUttar Pradesh

Community Health Centres (CHCs)

1.4. CHCs are being established and maintained by the State Government under MNP/BMS programme. As per minimum norms (Box-1), a CHC is required to be manned by four Medical Specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff (See Annexure-D for IPHS norms). It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations (Also see para 2.4 for NRHM additionalities). As on March, 2011, there are 4,809 CHCs functioning in the country.

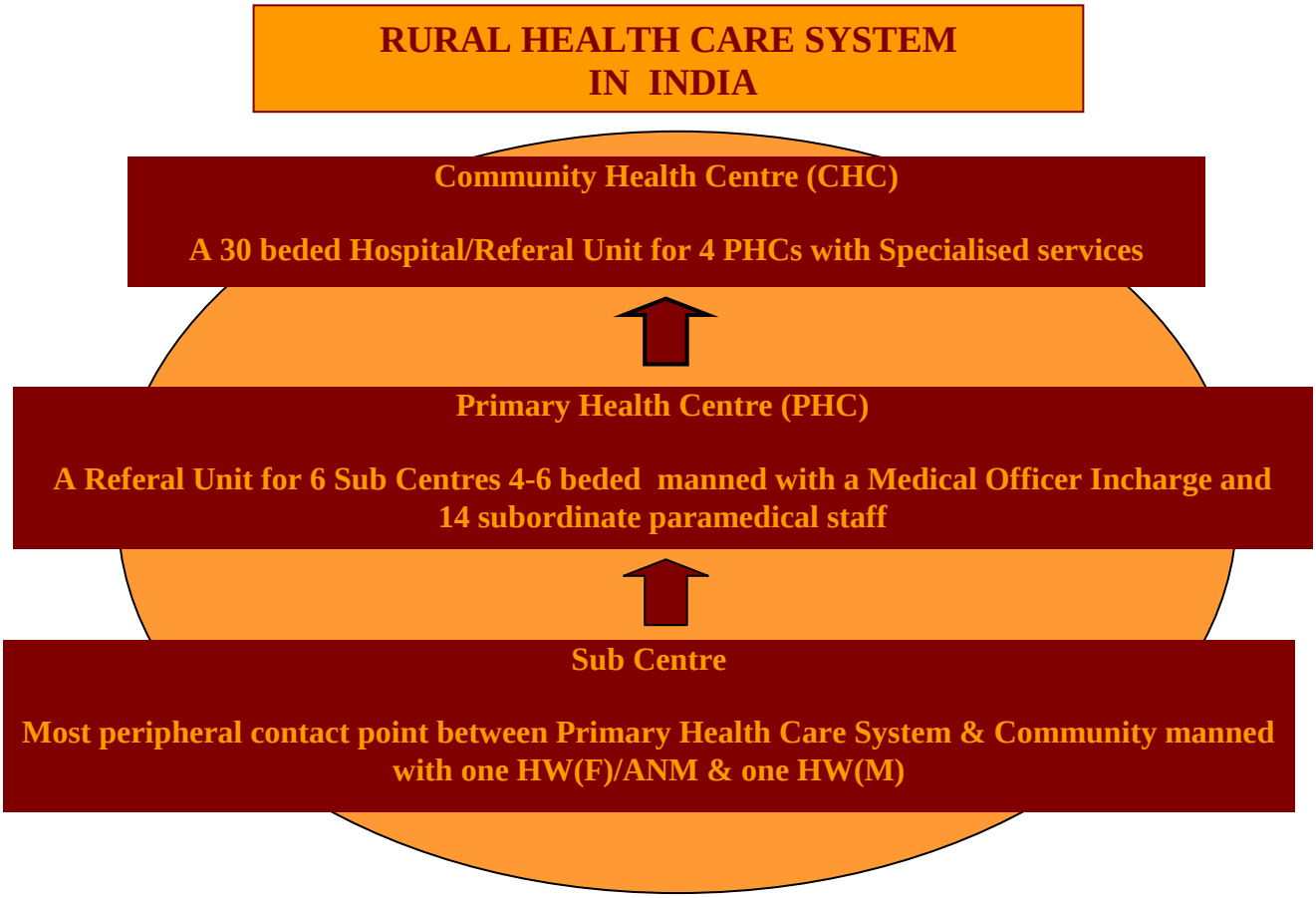
At the national level there is an increase of 1463 CHCs in 2011 as compared to that existed in 2005. Significant increase is observed in the number of CHCs in the States of Arunachal Pradesh, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Punjab, Odisha, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh and West Bengal

1.5. The details of the population norms for each level of rural health infrastructure and current status against these norms are given in ***Box 2***.

First Referral Units (FRUs)

1.6. An existing facility (district hospital, sub-divisional hospital, community health centre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for Emergency Obstetric and New Born Care, in addition to all emergencies that any hospital is required to provide. It should be noted that there are three critical determinants of a facility being declared as a FRU: i) Emergency Obstetric Care including surgical interventions like Caesarean Sections; ii) New-born Care; and iii) Blood Storage Facility on a 24-hour basis.

Chart 1.



2. Strengthening of Rural Health Infrastructure Under National Rural Health Mission

2.1. The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh. The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

2.2. NRHM aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); integration of vertical Health & Family Welfare Programmes, optimal utilization of funds & infrastructure, and strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream AYUSH into the

public health system. It further aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health. It seeks decentralization of programmes for district management of health and to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure. It also seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

Box 1.

STAFFING PATTERN

A.	STAFF FOR SUB - CENTRE:	Number of Posts
1.	Health Worker (Female)/ANM	1
2.	Additional Second ANM (on contract)	1
3.	Health Worker (Male)	1
4.	Voluntary Worker (Paid @ Rs.100/- p.m. as honorarium)	1
	Total (excluding contractual staff):	3
B.	STAFF FOR NEW PRIMARY HEALTH CENTRE	
1.	Medical Officer	1
2.	Pharmacist	1
3.	Nurse Mid-wife (Staff Nurse)	1 + 2 additional Staff Nurses on contract
4.	Health Worker (Female)/ANM	1
5.	Health Educator	1
6.	Health Assistant (Male)	1
7.	Health Assistant (Female)/LHV	1
8.	Upper Division Clerk	1
9.	Lower Division Clerk	1
10.	Laboratory Technician	1
11.	Driver (Subject to availability of Vehicle)	1
12.	Class IV	4
	Total (excluding contractual staff):	15
C.	STAFF FOR COMMUNITY HEALTH CENTRE:	
1.	Medical Officer #	4
2.	Nurse Mid– Wife(staff Nurse)	7
3.	Dresser	1
4.	Pharmacist/Compounder	1
5.	Laboratory Technician	1
6.	Radiographer	1
7.	Ward Boys	2
8.	Dhobi	1
9.	Sweepers	3
10.	Mali	1
11.	Chowkidar	1
12.	Aya	1
13.	Peon	1
	Total:	25

:Either qualified or specially trained to work as Surgeon, Obstetrician, Physician and Pediatrician. One of the existing Medical Officers similarly should be either qualified or specially trained in Public Health).

Note: The above is the minimum norm for staffing pattern. However, additional staff has been prescribed under IPHS as given in Annexure I of this Chapter.

Box 2.

RURAL HEALTH INFRASTRUCTURE - NORMS AND LEVEL OF ACHIEVEMENTS (ALL INDIA)				
S.No.	Indicator	National Norms		Present Average Coverage
1	**Rural Population (2011) (Provisional) covered by a:**	General	Tribal/Hilly/Desert	
	Sub Centre	5000	3000	5624
	Primary Health Centre (PHC)	30000	20000	34876
	Community Health Centre (CHC)	120000	80000	173235
2	Number of Sub Centres per PHC	6		6
3	Number of PHCs per CHC	4		5
4	**Rural Population (2011) (Provisional) covered by a:**			
	HW (F) (at Sub Centres and PHCs)	5000	3000	4008
	HW (M) (At Sub Centres)	5000	3000	15955
5	Ratio of HA (M) at PHCs to HW (M) at Sub Centres	1:6		1:3
6	Ratio of HA (F) at PHCs to HW (F) at Sub Centres and PHCs	1:6		1:13
7	**Average Rural Area (Sq. Km) covered by a:**			
	Sub Centre	--		21.05
	PHC	--		130.54
	CHC	--		648.43
8	**Average Radial Distance (Kms) covered by a:**			
	Sub Centre	--		2.59
	PHC	--		6.44
	CHC	--		14.36
9	**Average Number of Villages covered by a:**			
	Sub Centre	--		4
	PHC	--		27
	CHC	--		133

2.3. Following are the core and supplementary strategies of NRHM:

2.3.1. Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.

- Promote access to improved healthcare at household level through the female health activist (ASHA).

- Health Plan for each village through Village Health Committee of the Panchayat.

- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).

- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).

- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.

- Integrating vertical Health and Family Welfare programmes at National, State, District, and Block levels.

- Technical Support to National, State and District Health Missions, for Public Health Management.

- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.

- Formulation of transparent policies for deployment and career development of Human Resources for health.

- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc. promoting non-profit sector particularly in under served areas.

2.3.2 Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost. Promotion of Public Private Partnerships for achieving public health goals. Mainstreaming AYUSH - revitalizing local health traditions.

- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.

2.4. NRHM Plan of Action relating to Infrastructure and Manpower Strengthening

2.4.1 Component (A): Accredited Social Health Activists

- Every village/large habitation will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.

- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.

- She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.

- She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.

- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi Worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.

- She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.

- She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

- Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year.

- Prototype training material to be developed at National level, subject to State level modifications.

- Cascade model of training proposed through Training of Trainers including contract plus distance learning model

- Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

2.4.2 Component (B): Strengthening Sub-Centres (SC)

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

- Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.

- In case of additional Outlays, Multipurpose Workers (Male)/ Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered.

2.4.3 **Component (C): Strengthening Primary Health Centres (PHCs)**

Mission aims at strengthening PHCs for quality preventive, promotive, curative, supervisory and outreach services, through:

- Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunisation) to PHCs

- Provision of 24 hour service in at least 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.

- Observance of Standard treatment guidelines & protocols.

- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need.

2.4.4 **Component (D): Strengthening Community Health Centres (CHCs) for First Referral Care**

A key strategy of the Mission is:

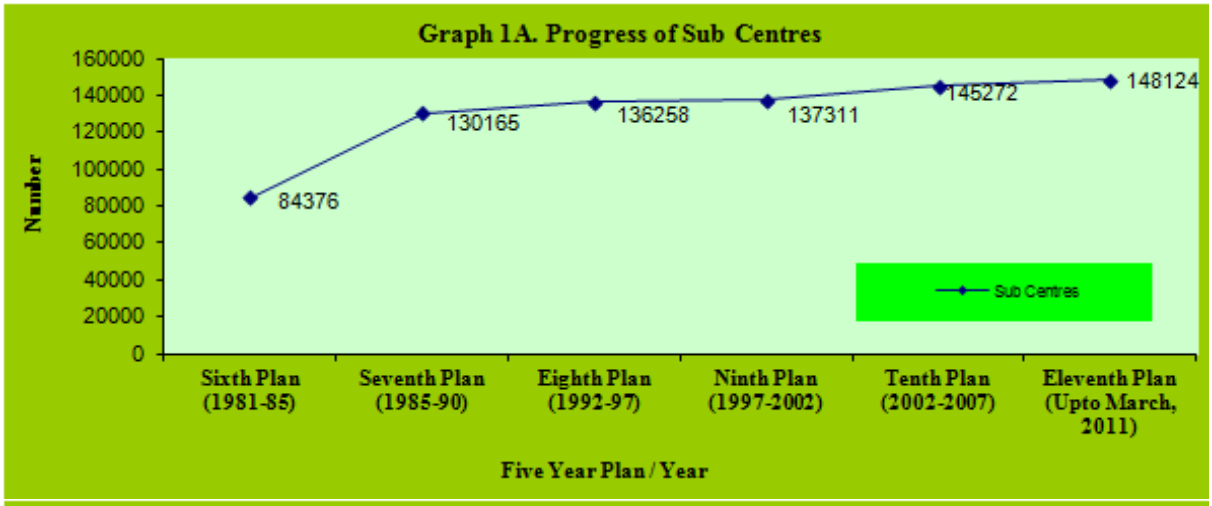
- Operationalising existing Community Health Centres (30-50 beds) as 24 hour First Referral Units, including posting of anaesthetists.
- Codification of new Indian Public Health Standards" setting norms for infrastructure, staff, equipment, management etc. for CHCs.
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.
- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.
- In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

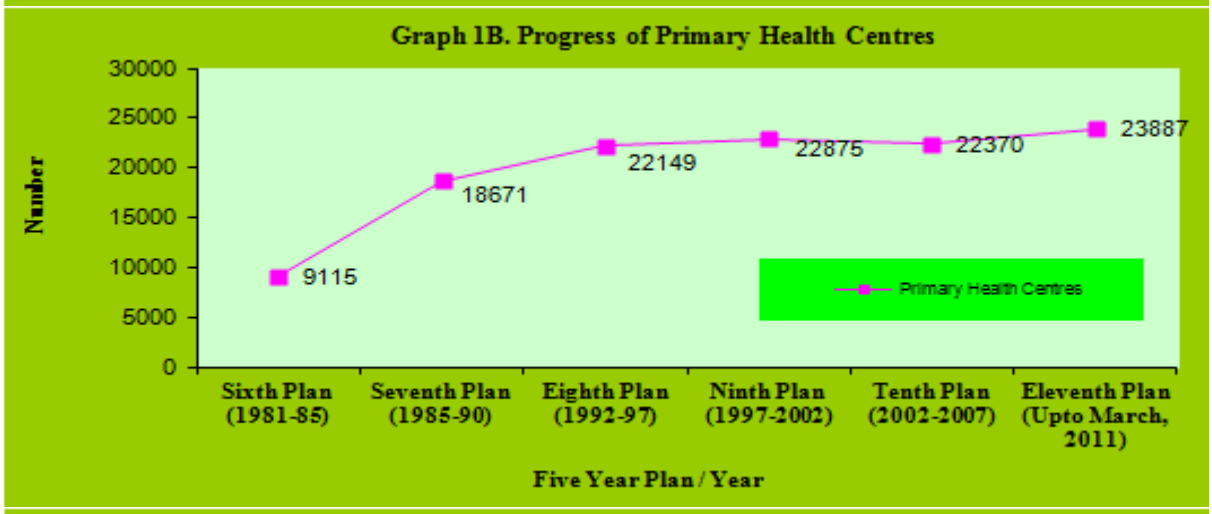
3. Rural Health Infrastructure - a statistical overview

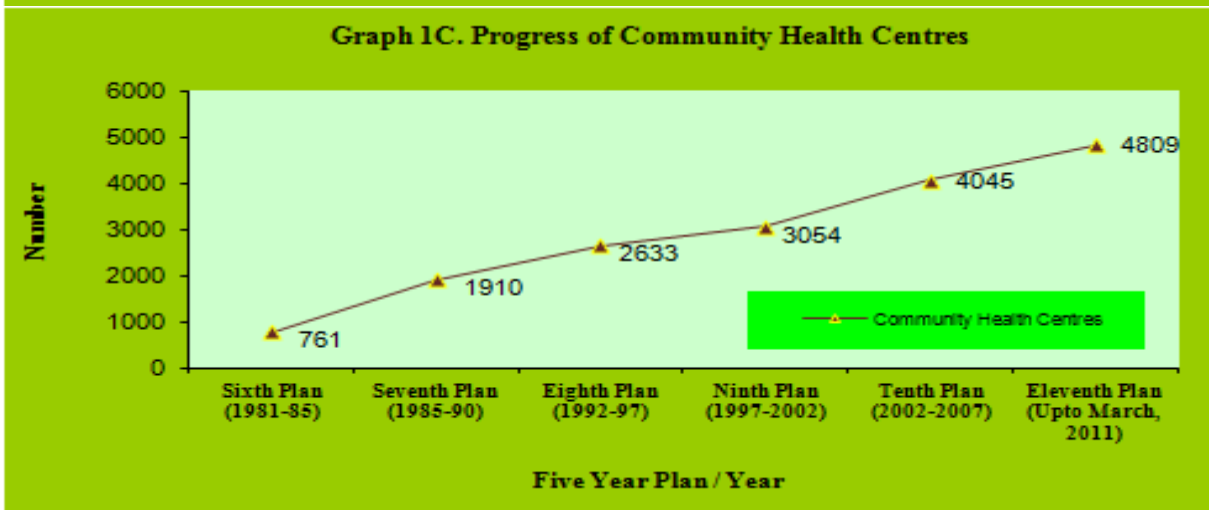
The Centres Functioning

3.1. The Primary Health Care Infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System. Progress of Sub Centres, which is the most peripheral contact point between the Primary Health Care System and the community, is a prerequisite for the overall progress of the entire system. A look at the number of Sub Centres functioning over the years revealed that at the end of the Sixth Plan (1981-85) there were

84,376 Sub Centres, which increased to 1,30,165 at the end of Seventh Plan (1985-90) and to 1,45,272 at the end of Tenth Plan (2002-2007). As on March, 2011, 1,48,124 Sub Centres are functioning in the country.



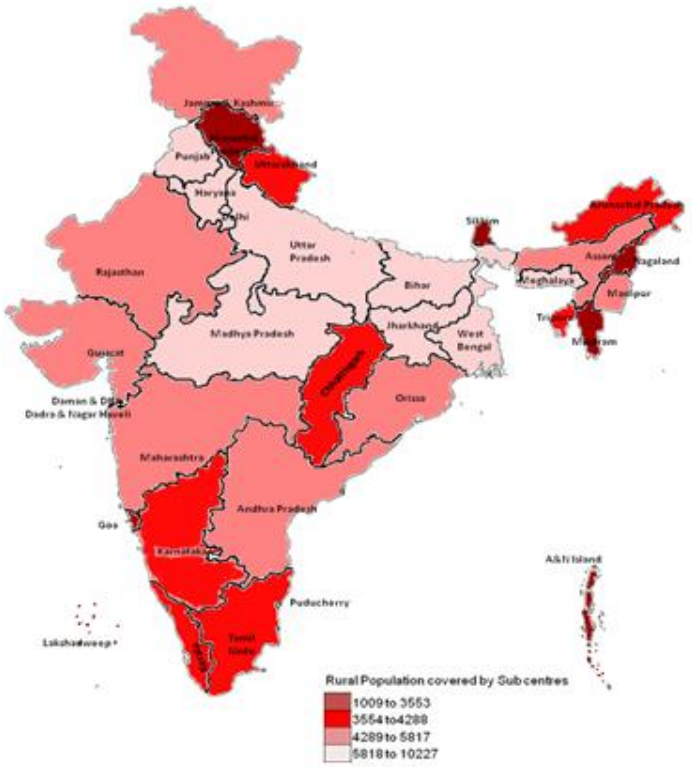




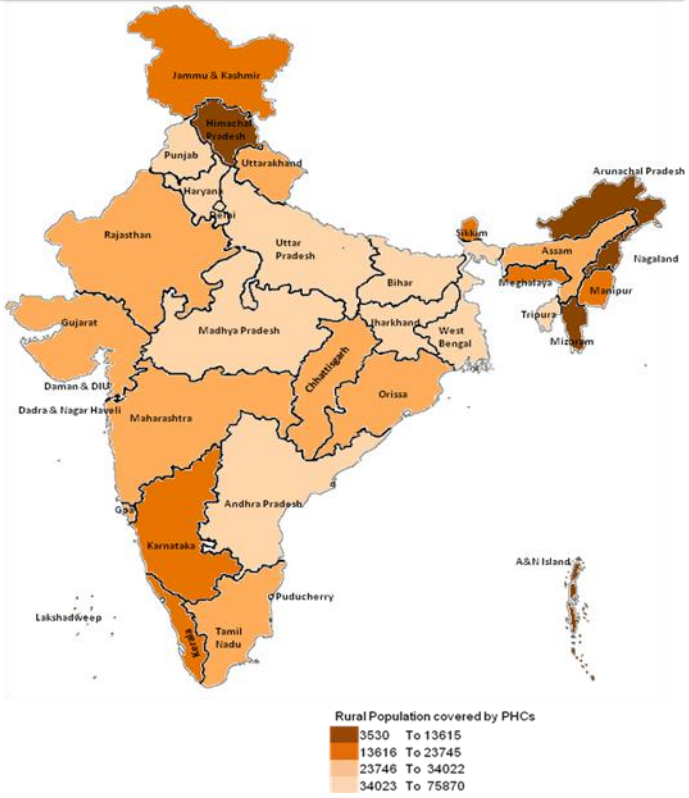
Similar progress can be seen in the number of PHCs which was 9115 at the end of Sixth Plan (1981-85) and almost doubled to 18671 at the end of Seventh Plan (1985-90). Number of PHCs rose to 22370 at the end of Tenth Plan (2002-2007). As on March, 2011, there are 23887 PHCs functioning in the country. A number of PHCs have been upgraded to the level of CHCs in many States. In accordance with the progress in the number of Sub Centres and PHCs, the number of CHCs has also increased from 761 at the end of Sixth Plan (1981-85) to 1910 at the end of Seventh Plan (1985-90) and 4045 at the end of Tenth Plan (2002-2007). As on March, 2011, 4809 CHCs are functioning in the country.

3.2. **Statement 1** presents the number of Sub Centres, PHCs and CHCs existing in 2011 as compared to those reported existing in 2005. As may be seen from the Statement 1, at the national level there is an increase of 2098 Sub Centres, 651 PHCs and 1463 CHCs in 2011 as compared to those existing in 2005. This implies an increase of about 43% in number of CHCs, about 2.8% in number of PHCs and about 1.4% in number of Sub Centres in 2011 as compared to 2005. There is significant increase in the number of Sub Centres in the States of Chhattisgarh, Haryana, Jammu & Kashmir, Maharashtra, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura and Uttarakhand. Significant increase is also observed in the number of PHCs in the States of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Haryana, Jammu & Kashmir, Karnataka, Maharashtra, Nagaland, Uttarakhand, Uttar Pradesh. In case of CHCs, significant increase is observed in the States of Arunachal Pradesh, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Madhya Pradesh, Odisha, Punjab, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh and West Bengal. The average population covered by a Sub Centre, PHC and CHC was 5624, 34876 and 173235, respectively. The State-wise variations in the average population covered by a Sub Centre, PHC and CHC are represented in the Map 1 to 3 below, respectively

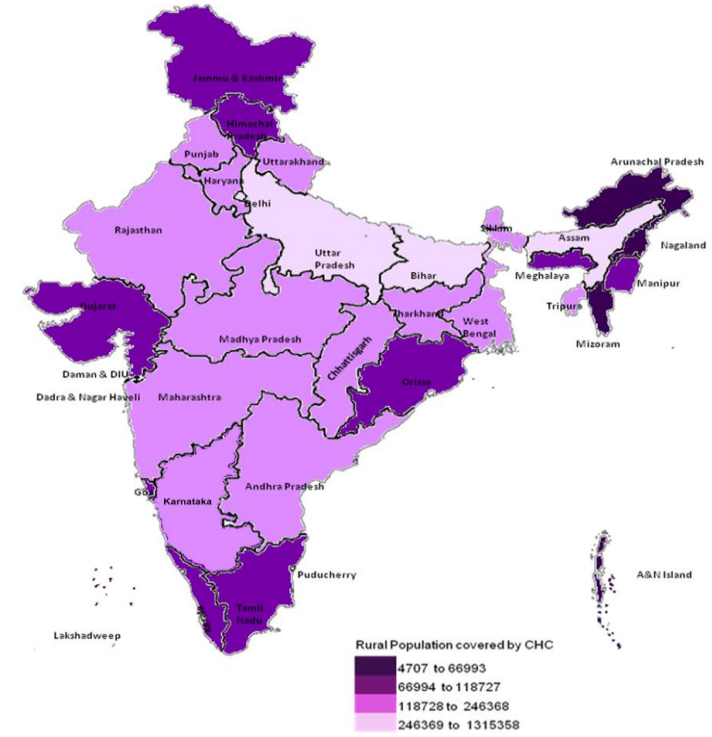
Map 1. Average Rural Population (2011 – Provisional) Covered by a Sub Centres



Map 2. Average Rural Population (2011- Provisional) Covered by a PHC



Map 3. Average Rural Population (2011- Provisional) Covered by a CHC

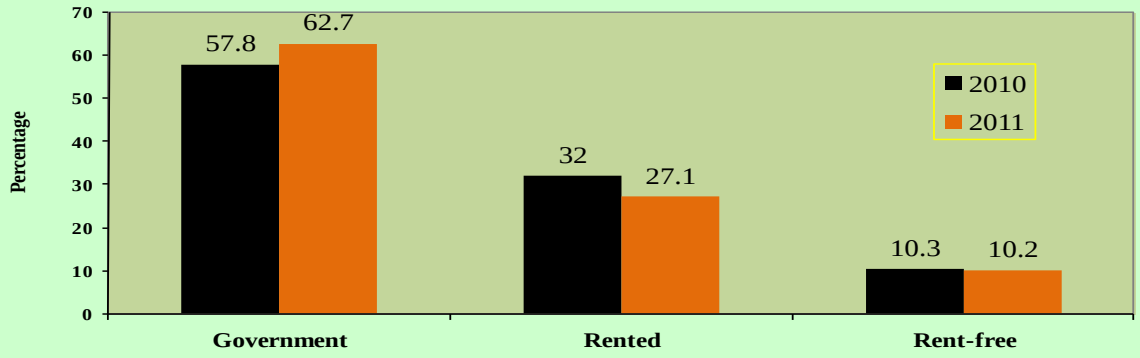


Note: It may be noted that the all India analysis presented below for infrastructure and manpower is based on the data received from various States / UTs. The States / UTs which do not have relevant data for a particular item / category, are excluded while calculating percentages for facilities functioning in Government buildings, manpower vacancies and shortfall etc. Comparative position of infrastructure and manpower for 2010 and 2011 is given in Statements 12-15.

Building Status

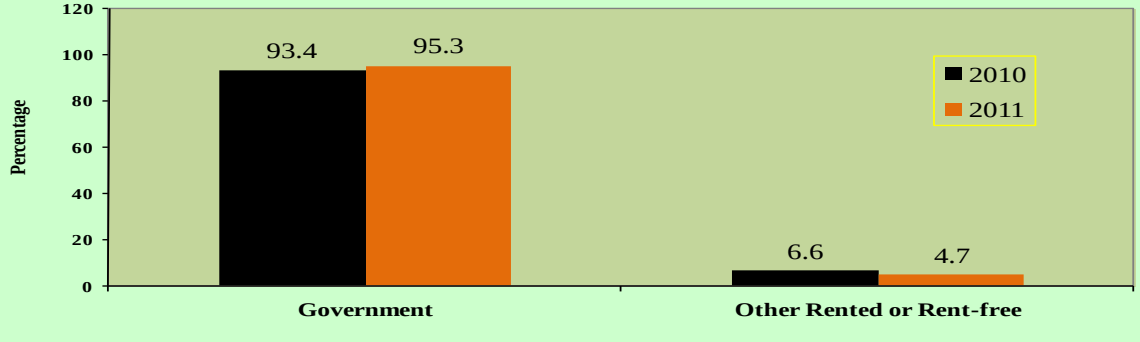
3.3. As on March, 2011, 62.7% of Sub Centres, 86.7% of PHCs and 95.3% of CHCs are located in the Government buildings. The rest are located either in rented building or rent free Panchayat/ Voluntary Society buildings

Graph 2A. Building Position of Sub Centres



Graph 2B. Building Position of PHCs

Graph 2C. Building Position of CHCs



3.4. **Statement** 2, **Statement** 3 and **Statement** 4 give the comparative picture of the status of buildings for Sub Centres, PHCs and CHCs, respectively, in 2011 as compared to that in 2005. As may be seen, percentage of Sub Centres functioning in the Government buildings has increased from 50% in 2005 to 62.7% in 2011 mainly due to substantial increase in the government buildings in the States of Assam, Chhattisgarh, Goa, Haryana, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Orissa, Punjab, Rajasthan, Sikkim, Tripura, Uttarakhand, Uttar Pradesh and West Bengal

Percentage of Sub Centres functioning in the Government buildings has increased from 50% in 2005 to 62.7% in 2011

Percentage of PHCs functioning in Government buildings has increased significantly from 78% in 2005 to 86.7% in 2011

The % of CHCs in Govt. buildings has increased from 90% in 2005 to 95.3% in 2011.

3.5. Similarly, percentage of PHCs functioning in Government buildings has also increased significantly from 78% in 2005 to 86.7% in 2011. This is mainly due to increase in the Government buildings in the States of Assam, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Nagaland and Uttar Pradesh.

3.6. Number of CHCs functioning in Government buildings have increased appreciably in 2011 as compared to 2005. The percentage of CHCs in Govt. buildings has increased from 90% in 2005 to 95.3% in 2011.

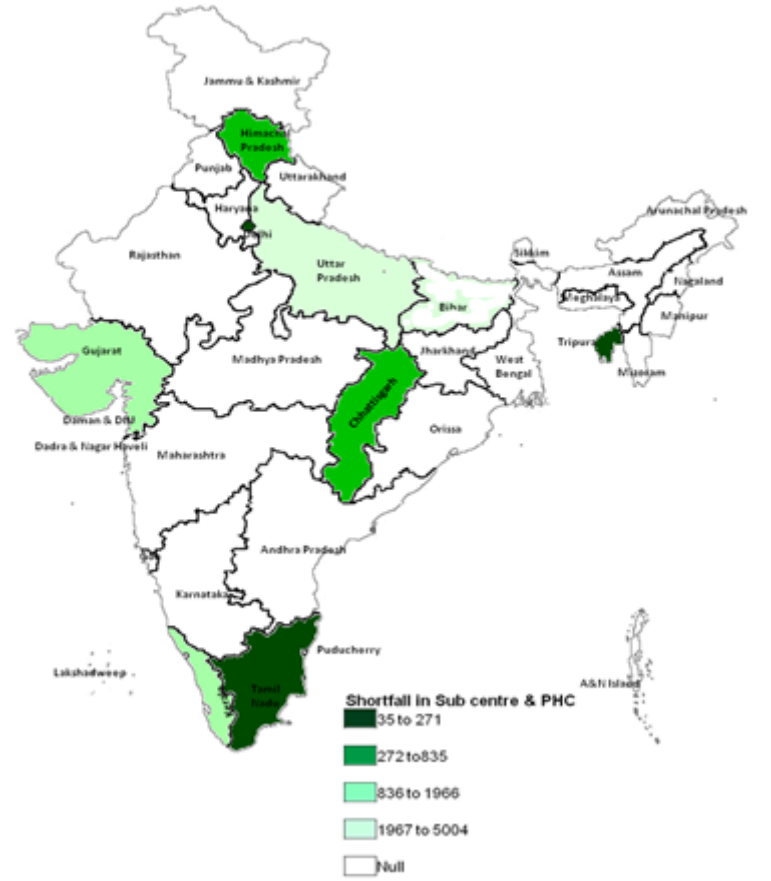
3.7. Comparative State-wise status of buildings for Sub Centres, PHCs and CHCs in 2010 and 2011 is available at Statement 13 and Graph 2A.

Manpower

3.8. The availability of manpower is one of the important prerequisite for the efficient functioning of the Rural Health services. As on March, 2011 the overall shortfall (which excludes the existing surplus in some of the states) in the posts of HW(F) / ANM was 3.8% of the total requirement as per the norm of one HW(F) / ANM per Sub Centre and PHC. The overall shortfall is mainly due to shortfall in States namely, Chhattisgarh, Gujarat, Himachal Pradesh, Kerala, Tamil Nadu, Tripura and Uttar Pradesh. The State-wise variation in shortfall of ANMs is depicted in the Map 4 below.

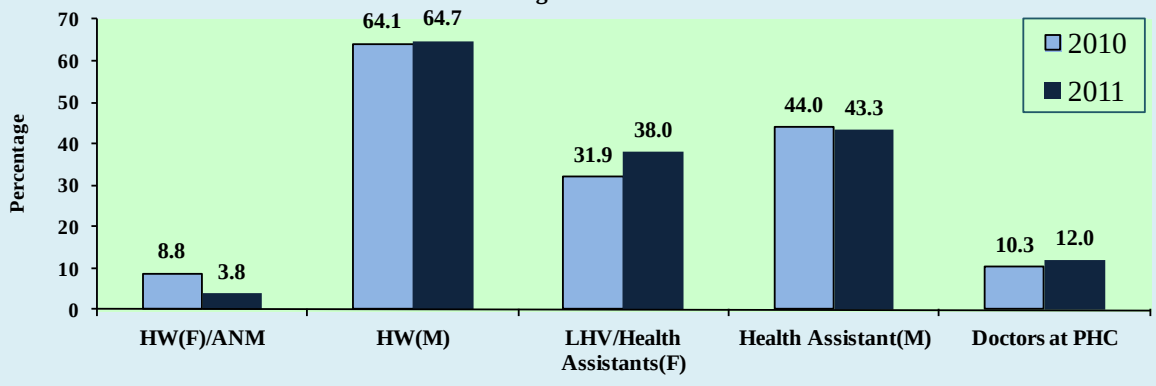
As on March, 2011 the overall shortfall in the posts of HW(F) / ANM was 3.8% of the total requirement, mainly due to shortfall in States namely, Chhattisgarh, Gujarat, Himachal Pradesh, Kerala, Tamil Nadu, Tripura and Uttar Pradesh. For allopathic Doctors at PHCs, there was a shortfall of 12.0% of the total requirement for existing infrastructure as compared to manpower in position.

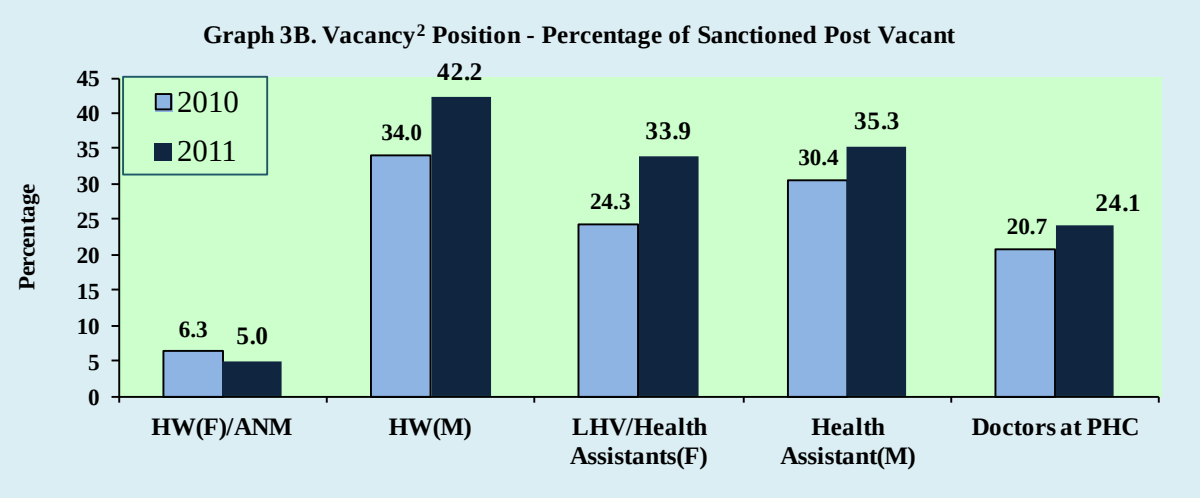
Map 4. Shortfall in number of ANM at Sub Centre & PHC



Similarly, in case of HW(M), there was a shortfall of 64.7% of the requirement. In case of Health Assistant (Female)/LHV, the shortfall was 38% and that of Health Assistant (Male) was 43.3%. For allopathic Doctors at PHC, there was a shortfall of 12.0% of the total requirement. This is again mainly due to significant shortfall in Doctors at PHCs in the States of Chhattisgarh, Gujarat, Karnataka, Madhya Pradesh, Nagaland, Orissa, Rajasthan and Uttar Pradesh. Even out of the sanctioned posts, a significant percentage of posts are vacant at all the levels. For instance, 5% of the sanctioned posts of HW(Female)/ ANM were vacant as compared to 42.2% of the sanctioned posts of Male Health Worker.

Graph 3A. Shortfall[1] - Percentage of shortfall as compared to requirement based on existing infrastructure

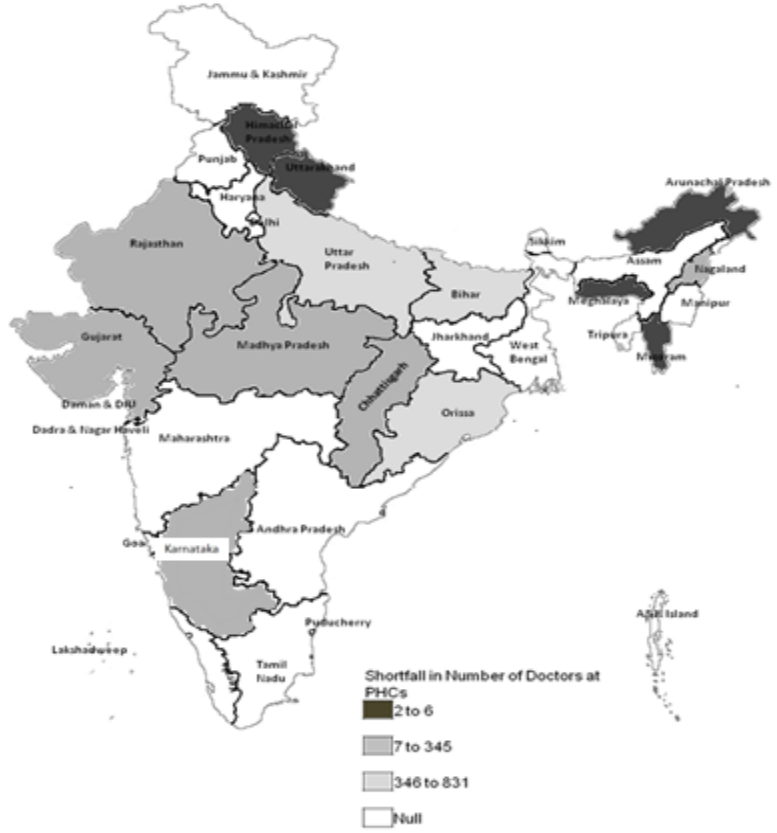




[1] Shortfall is against requirement for existing centres; [2] Vacancy is against sanctioned posts

At PHCs, 33.9% of the sanctioned posts of Female Health Assistant/ LHV, 35.3% of Male Health Assistant and 24.1% of the sanctioned posts of doctors were vacant. The State-wise variation in the shortfall of Doctors at PHCs is presented in the Map 5 below

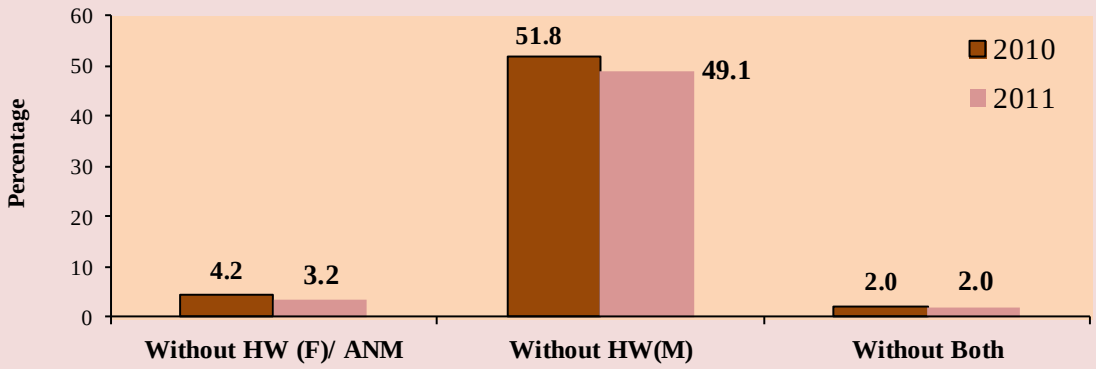
Map 5. Shortfall in number of Doctors at PHCs



3.9. At the Sub Centre level the extent of existing manpower can be assessed from the fact that 3.2% of the Sub Centres were without a Female Health Worker / ANM, 49.1% Sub

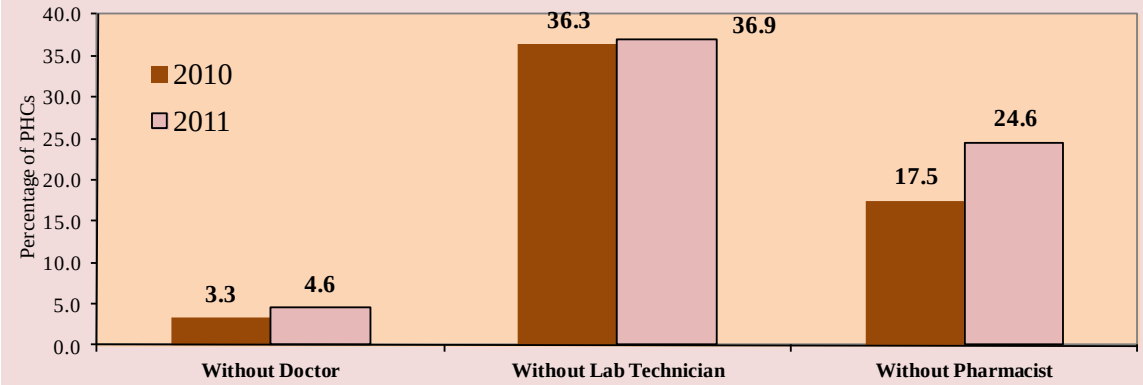
Centres were without a Male Health Worker and 2% Sub Centres were without both Female Health Worker / ANM as well as Male Health Worker.

Graph 4. Percentage of Sub Centres functioning without ANMs or/and HW(M)



3.10. PHC is the first contact point between village community and the Medical Officer. Manpower in PHC include a Medical Officer supported by paramedical and other staff.

Graph 5. Percentage of PHCs without Doctor, Lab Tech., Pharmacist

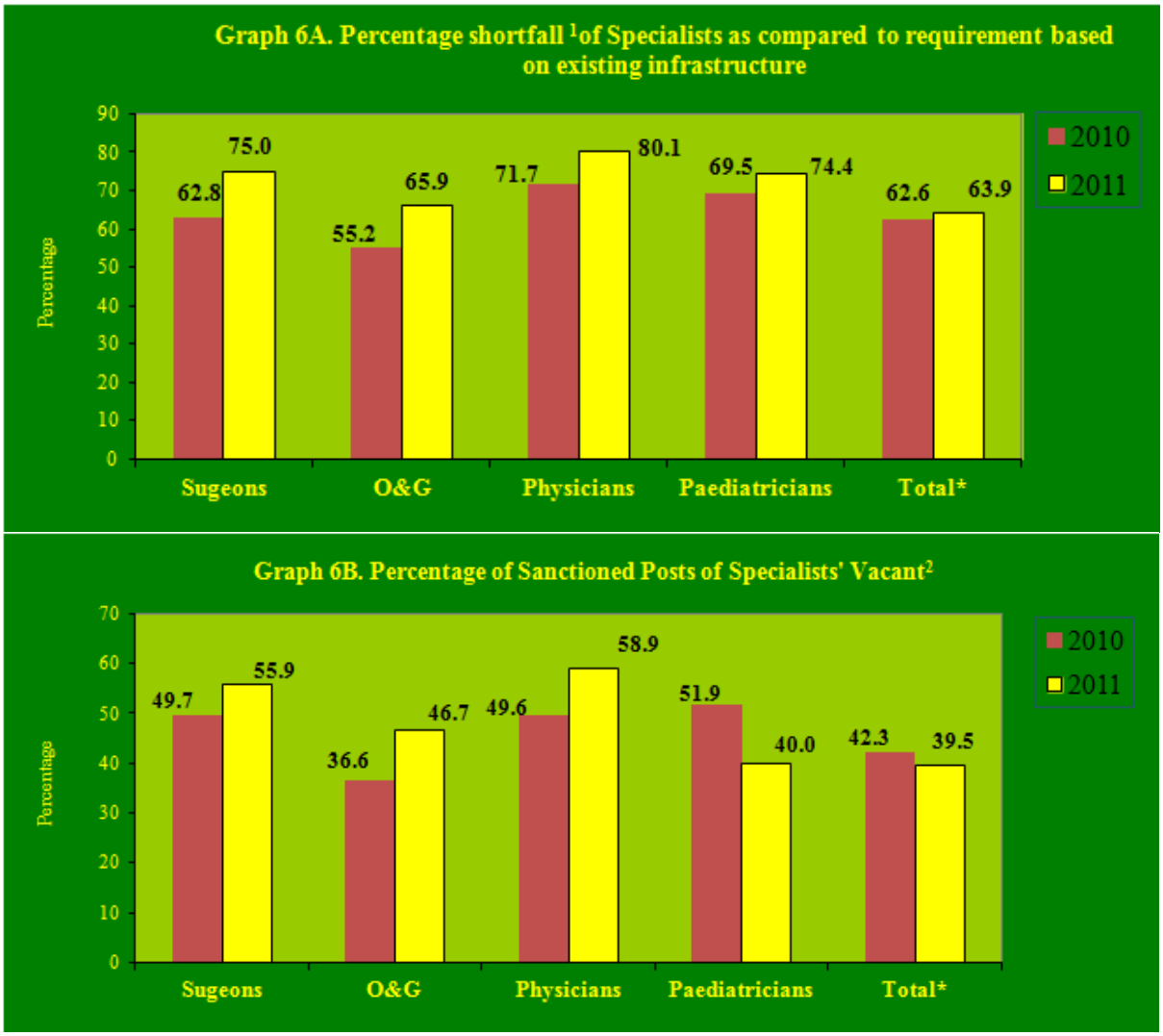


As on March, 2011, 4.6% of the PHCs were without a doctor, 36.9% were without a Lab technician and 24.6% were without a Pharmacist.

The Specialist doctors at CHCs have increased from 3550 in 2005 to 6935 in 2011. However, as compared to requirement for existing infrastructure, there was a shortfall of 75% of Surgeons, 65.9% of Obstetricians & Gynaecologists, 80.1% of Physicians and 74.4% of Paediatricians. Overall, there was a shortfall of 63.9% specialists at the CHCs as compared to the requirement for existing CHCs.

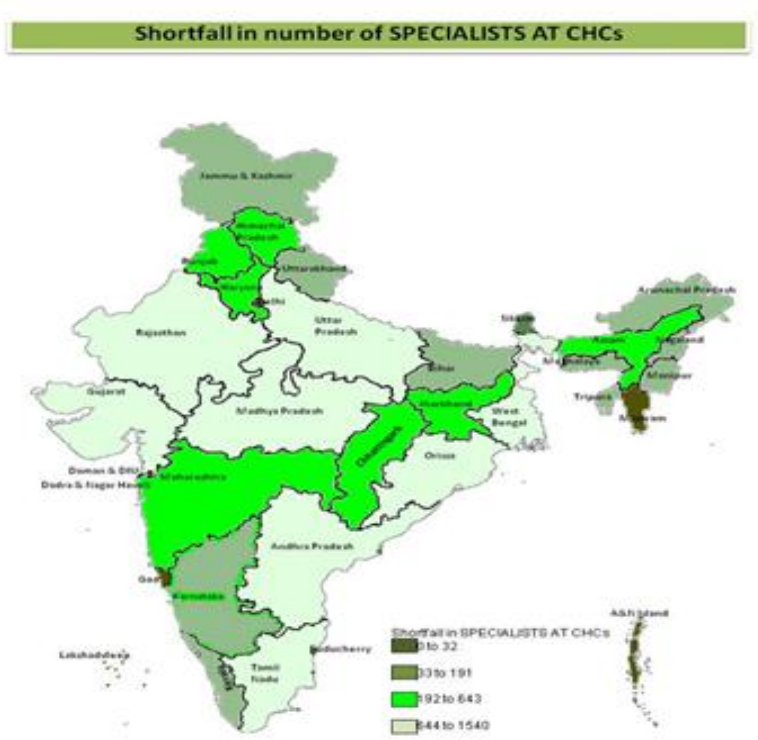
3.11. The Community Health Centres provide specialized medical care in the form of facilities of Surgeons, Obstetricians & Gynaecologists, Physicians and Paediatricians. The current position of specialists manpower at CHCs reveal that as on March, 2011, out of the sanctioned posts, 55.9% of Surgeons, 46.7% of Obstetricians & Gynaecologists, 58.9% of Physicians and 40% of Paediatricians were vacant. Overall 39.5% of the sanctioned posts of specialists at CHCs were vacant. Moreover, as compared to requirement for existing infrastructure, there was a shortfall of 75% of Surgeons, 65.9% of Obstetricians & Gynaecologists, 80.1% of Physicians

and 74.4% of Paediatricians. Overall, there was a shortfall of 63.9% specialists at the CHCs as compared to the requirement for existing CHCs. The shortfall in Specialists is significantly high in most of the States.



[1] Shortfall is against requirement for existing Centres
[2] Vacancy is against sanctioned posts
Category-wise breakup of Specialists at CHCs does not include the figures for the States of Kerala and Uttar Pradesh

The State-wise variations in the shortfall of Specialists is presented in Map 6 below. However, along with the Specialists, about 11798 General Duty Medical Officers (GDMOs) are also available at CHCs as on March, 2011.



3.12. When we compare the manpower position of major categories in 2011 with that in 2005, as presented in **Statement** 5 to **Statement** 11, it is observed that there are significant improvement in terms of the numbers in all the categories. For instance, the number of ANMs at Sub Centres and PHCs (**Statement** 5) have increased from 133194 in 2005 to 207868 in 2011 which amounts to an increase of about 56%. Similarly, the allopathic Doctors at PHCs (**Statement** 6) have increased from 20308 in 2005 to 26329 in 2011, which is about 29% increase. Moreover, the Specialist doctors at CHCs (**Statement** 7) have increased from 3550 in 2005 to 6935 in 2011, which implies an appreciable 95% increase.

3.13. Looking at the State-wise picture, it may be observed that the increase in ANMs is attributed mainly to significant increase in the States of Andhra Pradesh, Assam, Bihar Chhattisgarh, Goa, Haryana, Jammu & Kashmir, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Orissa, Punjab, Rajasthan, Uttarakhand, Uttar Pradesh and West Bengal. Similarly, there is significant increase in the number of Doctors at PHCs in the States namely Andhra Pradesh, Jammu & Kashmir, Karnataka, Kerala, Manipur, Mizoram, Nagaland, Punjab and Uttarakhand. In case of specialists, appreciable increase is noticed in the States of Andhra Pradesh, Chhattisgarh, Goa, Jammu & Kashmir, Karnataka, Madhya Pradesh, Nagaland, Punjab and West Bengal. Significant increase in the number of paramedical staff is also observed when compared with the position of 2005.

3.14. Comparative State-wise status of manpower in 2010 and 2011 at Sub Centres, PHCs and CHCs is given in Statements 14 and 15 and in Graphs 3 to 6.

Annexure I. Manpower Recommended Under Indian Public Health Standards (IPHS)

Sub Centre			
S.No.	**Personnel**	**Existing**	**Recommended**
1.	Health Worker (Female)	1	2
.2.	Health Worker (Male)	1	1 (funded and appointed by State Government)
3.	Voluntary worker to keep the Sub Centre clean and assisting ANM. She is paid by the ANM from her contingency fund @ Rs. 100 per month	1 (optional)	1 (optional)
Primary Health Centres			
S.No.	**Personnel**	**Existing pattern**	**Recommended**
1.	Medical Officer	1	3 (At least 1 female)
2.	AYUSH practitioner	NIL	1 (AYUSH or any ISM system prevalent locally)
3.	Account Manager	NIL	1
4.	Pharmacist	1	2
5.	Nurse - Midwife (Staff Nurse)	1	5
6.	Health Worker (Female)	1	1
7.	Health Educator	1	1
8.	Health Assistant male and female	2	2
9.	Clerks	2	2
10.	Laboratory Technician	1	2
11.	Driver	1	Optional; vehicles may be out-sourced
12.	Class IV	4	4

Annexure I. Manpower Recommended Under Indian Public Health Standards (IPHS) (Contd..)

Community Health Centre		
S.No.	**Personnel**	**IPHS Norm**
A.	**Clinical Manpower**	
1.	Block Health Officer	-
2.	General Surgeon	1
3.	Physician	1
4.	Obstetrician / Gynaecologist	1
5.	Paediatrics	1
6.	Anaesthetist	1
7.	Public Health Manager	1
8.	Eye Surgeon	1
9.	Dental Surgeon	1
10.	General Duty Medical Officer	6
11.	Specialist of AYUSH	1
12.	General Duty Medical Officer of AYUSH	1
B.	**Support Manpower**	
S.No.	**Personnel**	**IPHS Norm**
1.		
a.	Staff Nurse	19
b.	Public Health Nurse	1
c.	ANM	1
2.	Pharmacist / compounder	3
3.	Pharmacist - AYUSH	1
4.	Lab. Technician	3
5.	Radiographer	2
6.	Ophthalmic Assistant	1
7.	Dresser	2
8.	Ward boys / nursing orderly	5
9.	Sweepers	5
10.	Chowkidar	5
11.	Dhobi	1
12.	Mali	1
13.	Aya	5
14.	Peon	2
15.	OPD Attendant	1
16.	Registration Clerk	2
17.	Statistical Assistant / Data entry operator	2
18.	Accountant / Admin. Assistant	1
19.	OT Technician	1